# AN ASSESSMENT OF ONGOING CONCERNS AT THE VETERANS CRISIS LINE

## HEARING

BEFORE THE

## COMMITTEE ON VETERANS' AFFAIRS
## U.S. HOUSE OF REPRESENTATIVES

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**Tuesday, April 4, 2017**

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**Tuesday, April 4, 2017**

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

The Committee met, pursuant to notice, at 10:02 a.m., in Room 334, Cannon House Office Building, Hon. David P. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Wenstrup, Radewagen, Bost, Poliquin, Higgins, Bergman, Gonzalez-Colon, Walz, Takano, Brownley, Kuster, O'Rourke, Rice, Correa, Sablan, Esty, and Peters.

Also present: Representative Young.

## OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order. Before we begin today, I would like to ask unanimous consent for our colleague Representative David Young from Iowa to sit on the dais and participate in today's hearing. Without objection, so ordered. Welcome, David.

With that procedural note out of the way, welcome and thank you all for joining us this morning. We are here today to discuss a topic that is a top priority for me, for this Committee, for the Secretary and his staff, and for the entire military and veteran community: the prevention of suicide among those who have served this country.

Sadly suicide is an epidemic affecting not just servicemembers and veterans, but our Nation as a whole. However, in the last year the Department of Veterans Affairs released the most comprehensive analysis of veteran suicide data to date and found that the risk of suicide was 21 percent higher for veterans than it was for nonveterans. Probably the most important mission for us in this room is to ensure that the VA meets the needs of veterans actively contemplating taking their own life.

The Veterans Crisis Line, VA's 24/7 suicide prevention and crisis intervention hotline for veterans, servicemembers, and their loved ones, is a critical tool for the accomplishment of that mission. The Veterans Crisis Line is meant to be VA's first line of defense for those in the midst of life's worst moments. We cannot quantify the number of lives that have been saved since the VCL was introduced a decade ago. But we know that more than 2.6 million calls have been answered and emergency responders have been dispatched to those in need almost 70,000 times.

The demand for Veterans Crisis Line services, which now include a call option, an online chat option, and a texting message option, are growing. However, over the last year the Veterans Crisis Line has been the subject of three major investigations by the VA Inspector General and the Government Accountability Office that have also found serious management or organizational and quantitative deficiencies in virtually every facet of the VCL's operation.

In February of 2016 the IG found that some calls placed to the Veterans Crisis Line were sent to voice mail and that the Veterans Crisis Line staff failed to promptly monitor the quality of the services provided and in some cases did not receive proper orientation or ongoing training.

Four months later in June of 2016, GAO found that the VCL failed to meet its call wait time goal and neglected to monitor the quality of the text message service. Five months later in November 2016 Congress passed Congressman Young's legislation, the No Veterans Crisis Line Call Should Go Unanswered Act in recognition of the findings made by the IG and GAO and the need for the Veterans Crisis Line to institute a robust quality management plan. Yet just last month the IG published another report which found that the Veterans Crisis Line had failed to adequately respond to a veteran caller with urgent needs; that the VA had instituted a VCL governance structure riddled with deficiencies and that failed to include clinical perspectives and input; and that the VCL was not appropriately training and overseeing certain staff.

Perhaps most troubling, the IG also found that VA had failed to implement a single action to address the recommendations made in the IG's initial report even though VA had agreed with all of the recommendations and committed to implementing corrective actions no later than September.

I understand that the recommendations that GAO made and the report last summer are still open. Given that, I question whether VA has yet to fully comply with the requirements of the No Veterans Crisis Line Should Go Unanswered Act either. That is not to say that VA has not taken significant steps in the last year to address the VCL's shortcomings. Last year the Veterans Crisis Line has been realigned to the Office of Member Services. The number of calls that are routed to backup call centers has been drastically decreased and VA has stood up an additional VCL call center in Atlanta, Georgia. I believe those are positive developments and I hope to visit the VCL in person in the coming months to see for myself.

However, there is very clearly a need for more to be done and soon so that we can be assured that every veteran or family member who contacts the Veterans Crisis Line gets the urgent help he or she needs every single time without fail or delay. As a physician I am particularly upset that the clinical input is not being appropriately incorporated into operations and management of the Veterans Crisis Line. A crisis line by its very definition is not like any other call line. For an entity like VCL every missed opportunity can result in a tragic loss of life. According to VA's own data, 20 veterans a day die by suicide. Those stakes, the 20 lives per day, are simply too high for the Veterans Crisis Line not to perform at the highest level.

VA is fortunate to have an abundance of mental health and suicide prevention experts working here in D.C. and across the country and their knowledge and expertise should be incorporated into the Veterans Crisis Line processes and procedures at every level. I look forward to hearing this morning about how VA is going to make sure that that happens and when all the recommendations for improvement that the IG and GAO have made over the last year are going to be fully implemented.

I also look forward to hearing any and every suggestion our witnesses or my fellow Committee Members might have, what more we can do to improve not only the Veterans Crisis Line but also VA's other mental health and suicide prevention programs as well. Our mission will not be over until a single servicemember or veteran ever feels helpless or hopeless enough to consider suicide.

I appreciate our witnesses for being here to discuss this important topic with us this morning. And with that I will yield now to my Ranking Member Walz for any opening statements that he might have.

**OPENING STATEMENT OF TIMOTHY J. WALZ, RANKING MEMBER**

Mr. WALZ. Well thank you, Chairman Roe. And thank you for holding this. I would like to note that this week we will have the extension of the Choice Act, the sunset provision and some of the changes that need to be done in that. I want to thank the Chairman for tackling a challenging subject and doing it in a manner that not only is going to get it to the floor, you are going to get it to the floor in a suspension vote and I assume we are going to get a unanimous vote. That speaks volumes to your leadership and I am grateful for that.

I would like to take just a minute on, I think it is sometimes important and we forget this, the history of how the Crisis Line came about. At this time I would like to thank Mr. Young from Iowa because this Crisis Line runs deep through the heart of Iowa in its genesis.

Back in 2007 my then colleague Representative Leonard Boswell, himself a Vietnam War helicopter pilot, brought the story of one of his constituents forward, a young man from Iowa, Joshua Omvig, who served his country honorably, came home for Thanksgiving, and took his life in his parents' basement on the evening of Thanksgiving because of PTSD. I think it is important for all of us sitting on this panel to recognize suicide and suicide prevention is not something new. Leonard was able to bring that to the floor, pass it, and sign it into law, which one of the provisions was the creation of the Crisis Line, one of the first acts and one of the first bills I had the privilege of working on in 2007. So it is not surprising that there is a deep sense of ownership and a desire to make this work. I think this Committee with an understanding that continuing to provide oversight, continuing to provide improvements and enhancements, is critical. For many of us once you get on this Committee you start to see many of these things.

There is much in place but I think our frustration lies with implementation. That is where I encourage all of us to stay actively engaged. I worry that sometimes we pass a piece of legislation and

we watch the signing ceremony and we send that out the door to go on. If there is any lesson I have learned here is do not send it out the door without being on top of it. Do not continue to come back.

So Chairman, I too share you concerns over the IG report on the Crisis Line. You said it exactly right. This is a zero sum proposition. I know we are going to hear statistics that we improved from 31 percent dropped calls to less than one percent. We need to look into those numbers. But again, this is the one area where we are shooting for perfection. This is beyond Six Sigma. This is every single one of those calls is life and death. Every single one of those interventions is life and death. If it is viewed anything short of that, we are certainly failing.

So I want to hear exactly what we are going to do. How we are going to figure that part out. I still believe this was one of our greatest assets. The numbers seem to support that. I do want to be very clear about this, that I am absolutely certain that the VA Crisis Line and those professionals and picked up and answered the phone have saved lives. It has happened. We know it has happened. That does not change the fact, though, that in the progress there are issues.

The IG's finding includes issues like this: lack of training for quality assurance supervisors, lack of clear procedures and policies, insufficient data collection and analysis, failure to oversee contractors with backup call centers, and lack of leadership and governance. These are reoccurring issues we see time and time again at the VA and they are one of the areas and the main concern that the GAO puts the VA on the high risk list. These have not been addressed. The folks sitting out here, and I want to be clear, another failing in my opinion, and we need to expand our definition of accountability, the director of this critical service to our veterans, the director position, was left open for ten months. So we can talk all we want about the folks down the line answering the phone. But once again, no leadership, no director, no HR function, no training, no accountability, no following the GAO.

So this accountability piece that people are rightfully on extends to a much broader area. So you know the statistics. The Chairman said it. I am very interested. I, again, I applaud, Chairman Roe has a way of asking the right questions. In my opinion that is what leadership is all about. What is the fix? How is it going to be done? What are the suggestions? Because what I certainly do not want to hear is someone using semantics to tell me, well, they were actually placed in a queue, not placed on hold. If you are in a crisis life and death situation, you do not give a damn if it is on hold, in a queue, voice mail, somewhere else. You need a trained professional to pick up the phone as quickly as possible and direct you to the services to save your life.

So I look forward to the testimony from folks. I appreciate you all being here. Again, I would ask my colleagues up here, our colleague from Iowa started this in 2007. We have got another colleague from Iowa that worked to enhance upon it. For all of us, it is our responsibility to fix this. I yield back.

The CHAIRMAN. Thank the gentleman for yielding. Joining us on our first and only panel this morning is the Honorable Michael J.

Missal, VA Inspector General; Kayda Keleher, the Legislative Associate for the National Legislation Service for the Veterans of Foreign Wars of the United States; Melissa Bryant, the Director of Political and Intergovernmental Affairs for Iraq and Afghanistan Veterans of America; and Steve Young, VA's Deputy Under Secretary for Operations and Management, who is accompanied by Matt Eitutis—did I get that right, Matt? I am amazed I got that right. The Acting Executive Director of the Office of Member Services. Thank you all for being here this morning. And Mr. Missal, we now recognize you for five minutes.

**STATEMENT OF MICHAEL J. MISSAL**

Mr. MISSAL. Thank you, Chairman Roe, Ranking Member Walz, and Members of the Committee. Thank you for the opportunity to discuss the OIG's recent work on the operations of the Veterans Crisis Line.

The tragedy of veteran suicide is one of VA's most critical issues. The rate of suicide among veterans is significantly higher than the rate of suicide among U.S. civilian adults. VA's most recent estimate calculates that 20 veterans commit suicide a day. Of these veterans approximately 14 have not been seen by VA. The VCL is essential to reduce veteran suicide for those who call in crisis.

In our February 2016 VCL report we identified several problems with the VCL, including crisis calls going to voice mail, a lack of a published VHA directive to guide organizational structure, quality assurance gaps, and contract problems. Our February 2016 report resulted in seven recommendations and VHA concurred with the findings and recommendations. VHA provided an action plan and timeframe to implement those recommendations by September 30, 2016. However, as of today all seven of those recommendations remain open.

In June 2016 we received an allegation related to the experience of a veteran with the VCL and its backup call centers. As a result of the complaint and in light of the open recommendations from our February 2016 report, we expanded our scope to conduct an in depth inspection of the VCL. We also received in August 2016 a request from the Office of Special Counsel to investigate allegations regarding training and oversight deficiencies with social service assistants who assist call responders. Our March 2017 VCL report made the following findings.

We substantiated that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. We also identified deficiencies in the internal review of the matter by the VCL staff. In the interests of privacy, information specific to this veteran is not included in our report. However relevant information has been provided in detail to VHA.

With respect to the governance structure, operations, and quality assurance functions, we identified a number of deficiencies. Among other findings, we reported that there was a lack of effective utilization of clinical decision-makers at the highest level of VCL governance; a lack of permanent leadership during much of the last few years; a failure to collect the appropriate clinical data necessary to assess performance; deficient oversight of the backup centers; lack of background and training and quality management

principles; and the limited experience of supervisors in the new Atlanta call center.

With respect to the allegations referred by the Office of Special Counsel, we found that the VCL lacked the process for monitoring the quality of performance by social service assistants and deficiencies in SSA training.

All 23 recommendations from our 2016 and 2017 VCL reports remain open today. They fall into the categories of governance, operations, and quality assurance. Governance recommendations include the establishment of a VCL directive that guides structure, roles, and responsibilities; appropriate collaboration between clinical and administrative leadership; and lines of authority that delineate that clinical policy decisions be made by clinical leadership.

Operations recommendations include information technology infrastructure improvements, a better tracking of updated policies and procedures and related staff training, and that contractors be held to the same standards as the VCL.

Quality assurance recommendations include QA leadership be fully trained in QA principles; negative clinical outcomes evaluated in order to improve; quality data be used to enhance performance; call recordings be used for quality assurance; and that the performance for the Canandaigua and Atlanta call centers be analyzed separately.

We recognize the difficulties and challenges in operating a crisis hot line. Our 2016 and 2017 reports identified various challenges facing the VCL and their mission to provide suicide prevention and crisis intervention services to veterans, servicemembers, and their family members. Until VHA implements fully the open 23 recommendations from our two reports, they will continue to have challenges meeting VCL's critically important mission.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or other Members of the Committee may have.

[THE PREPARED STATEMENT OF MICHAEL J. MISSAL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. Ms. Keleher, you are recognized for five minutes.

**STATEMENT OF KAYDA KELEHER**

Ms. KELEHER. Chairman Roe, Ranking Member Walz, and Members of the Committee, on behalf of the men and women of the VFW and our Auxiliary, I would like to thank you for the opportunity to present our views on the Veterans Crisis Line before the Committee.

In 2007, Department of Veterans Affairs Health Administration, VHA, established a suicide hotline which became what we know today as the Veterans Crisis Line, or VCL. Since then, the responders at VCL have answered more than 2.8 million phone calls, over 62,000 text messages, and have initiated emergency dispatch services more than 72,000 times. While these numbers are impressive, the VFW believes more must be done to improve the VCL.

Since the GAO report released in May 2016, VA has worked to improve the VCL in many ways. These efforts have been successful

in bringing the number of calls sent to backup centers drastically down. In fact, during the first week of November 2016, the VCL had over 3,000 rollover calls. Now over the first week of March, VCL only had 28 rollover calls. Yet without being able to promise every veteran it is practical for the two current VCL centers to answer every call, it is imperative that VCL continues contracting SAMHSA approved backup call centers.

Even with the impressive drop in rollback phone calls, the VFW worries about quality of crisis intervention provided while VA currently focuses on quantity of calls answered. While precise numbers of non-veterans and veterans not in mental health crisis who dial into VCL are unknown, it is publicly recognized call lines are sometimes clogged up by them. Last year it was publicized that four callers called the VCL to harass responders thousands of times. Estimates said those four people made up more than four percent of incoming VCL calls. Even in light of the most recent VA OIG report, veterans have self-proclaimed that they call VCL for non-crisis issues, such as to complain about a doctor or try to schedule an appointment because it is the only VA number that they can find.

For this reason, the VFW believes expanding VA's Office of Patient Advocacy would greatly benefit VCL. By improving and expanding patient advocacy offices throughout VA, employees of these offices would have better visibility and means to assist non-crisis patients. If veterans become more aware of the patient advocate mission and capabilities, non-crisis callers to VCL would decrease. The VFW urges this Committee to conduct extensive oversight of the VA patient advocate program to ensure veterans are able to have their non-emergency concerns answered and addressed without having to call into the VCL.

Employees of VCL undergo extensive training before being able to answer crisis calls and it takes an additional minimum of six months before responders are able to answer, chat, and text conversations. While this training is thorough, it was not until late December that VCL had the capability to record their calls. Staff at VHA and VCL currently monitor some calls for quality assurance, but a better constant process must be implemented. This would ensure these recordings are being used to improve the training and capabilities of VCL responders. It would also assist with ending allegations of responders not understanding or following protocol and knowing their resources.

There is zero doubt clinical oversight is a necessity for VCL. Clinical decisions must be made by clinicians, not operations and administrative staff. Leadership running VCL must also have clinical background. This would ensure veterans calling VCL receive the best clinical judgment and assistance. Clear guidelines must be established for VCL so non-clinicians are not forcing a clinically based crisis line to operate as a business. VHA must also establish clinical and operational policies specific to VCL. This would allow for easier protocol standards to be understood and met on a constant basis, while establishing guidance and regulations to be followed by employees without clinicians stepping on the toes of operations or operations stepping on the toes of the clinicians. This can be done with better collaboration between VCL, VHA member serv-

ices, and the Office of Suicide Prevention. If the goal of VCL is to intervene for veterans in need of immediate assistance while they are in a mental health crisis, the VCL should be working with the subject matter experts in suicide prevention and outreach for VA.

The VCL clinical advisory board must also be more involved. Currently the board only meets once a month for a one-hour phone conference meeting. This group was intended to assist VHA member services and collective expertise of clinicians to improve the veteran experience, efficiencies of employees, and increased access to VCL. The board's charter was later changed by member services leadership and the VFW thinks it is clear that a one-hour phone call every month is not enough.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions you or other Members of the Committee may have.

[THE PREPARED STATEMENT OF KAYDA KELEHER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. Ms. Bryant, you are now recognized for five minutes.

**STATEMENT OF MELISSA BRYANT**

Ms. BRYANT. Chairman Roe, Ranking Member Walz, Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America and our more than 425,000 members, thank you for your time two weeks ago as IAVA introduced She Who Borne the Battle Campaign. We look forward to working with you and your staff to fully recognize and improve services for women veterans.

We also thank you for the opportunity to share our assessment of ongoing concerns with the Veterans Crisis Line today. Mental health and suicide prevention remains one of the top concerns of our members, where 75 percent of respondents to our recent survey still believe troops and veterans are not getting the care they need for mental health injuries.

I am here today not only as IAVA's Director of Intergovernmental Affairs but also as a former Army captain and a combat veteran of the Iraq War. I was a military intelligence officer, a leader of men and women in combat, and I bore witness to the trauma and anguish several of my friends and soldiers endured when dealing with suicide. While I am eternally grateful that my soldiers received mental health interventions, I mourn the loss of my sisters and brothers in law who lost their battle and died by suicide. I am giving voice to all of us who served and the invisible wounds of war as I speak today.

In 2007 IAVA fought for and celebrated the passage of the Joshua Omvig Suicide Prevention Act, which among other things requires the establishment of the VCL. IAVA signed an agreement with the VCL in 2012 and continues to partner with them today to ensure our vets are aware of the critical services the VCL offers as well as to provide crisis support to clients who are seeking help from IAVA's rapid response referral program, or RRRP. To date our RRRP veteran transition managers have referred nearly 200 clients to the VCL. These clients share both positive and negative stories

of their experiences with the VCL. IAVA wants to get to a place where all feedback we receive about the VCL is positive.

The VA has publicly addressed VCL's inability to handle call volume and its reliance upon a backup call center to field these calls. But they have not addressed the additional findings of the IG report that point to larger, more systemic issues: the VAL.'s governance structure, operations, and quality assurance protocols.

IAVA strongly urges the VA to reconsider its management structure at the Veterans Crisis Line. There must be a dual leadership structure in which an operations lead can oversee the functional aspects of the call line while a clinical lead oversees the clinical aspects. These roles must be complimentary and cooperative to ensure the success and safety of both clients of the VAL. and the responders who are answering their calls.

Finally the Office of Suicide Prevention must be heavily engaged with the operations, quality assessment, and oversight of the VAL. IAVA implores the VA to also consider whether the level of clinical support provided to each call responder is appropriate, how the VAL. is addressing self-care among responders, and what mechanisms are in place to prevent staff burnout and experienced responders from moving on. Compassion fatigue is real. Moreover, applying a sterilized quality assurance protocol that could easily be templated for determining a customer service rating for your home cable installer is woefully insufficient for our veterans.

We would expect that the Veterans Crisis Line would fall under the purview of two laws championed by IAVA. The Clay Hunt SAV Act, which requires the annual evaluation of VA's mental health and suicide prevention program, and the Female Veterans Suicide Prevention Act, which goes a step further to require analysis of these programs by gender. Our She Who Borne the Battle Campaign is anchored in the fact that women veterans are the fastest growing population yet often go unrecognized. We do not know how many women veterans use the VAL., nor how effective the VAL. is in providing support for women, or even if they are welcomed by a responder that is answering their call. As part of our She Who Borne the Battle Campaign we recognize that the motto of the VA functions as a symbolic barrier perceived by many women veterans like myself, emblematic of our lack of parity and care compared to our male counterparts. Perhaps this culture is trickling down to the VAL. A holistic program evaluation including gender specific data should be conducted to know for certain.

We point to IAVA's RRRP program as a model for mental health case management. This high tech, high touch program has served over 7,800 clients to date, 20 percent of them women, connecting them with quality resources and benefits, many of whom may not have been eligible for VA care due to other than honorable discharge status. We put a strong emphasis on client follow up and customer satisfaction at RRRP. Programs like RRRP complement the VAL. and are valuable partners by supporting veterans and their families who are not in immediate crisis but are at risk if these types of services are not provided. Often veterans have seen bad news stories about the VA or have had a bad experience and they come to us instead. We are often one of the best on ramps for veterans into VA support.

I cannot stress enough the gratitude IAVA has for those who staff the VAL. call lines and are there to support the hundreds of thousands of calls received per year. In our latest survey 20 percent of respondents had reached out to the VAL. on their own behalf or on behalf of a loved one. This is a critical, often live saving resource for our community. Sixty-five percent of our latest survey personally know a post 9/11 veteran who has attempted suicide while 58 percent know a veteran who died by suicide. As one of those respondents who personally knows veterans who have either attempted or died by suicide, this issue is deeply personal to me and one we must resolve swiftly.

Thank you again for the opportunity to share IAVA's assessment of the VAL. We look forward to working with you and the VA in the months ahead to improve this essential resource. Thank you for your time. I look forward to any questions you may have.

[THE PREPARED STATEMENT OF MELISSA BRYANT APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. Mr. Young, you are recognized for five minutes.

**STATEMENT OF STEVE YOUNG**

Mr. YOUNG. Good morning, Chairman Roe, Ranking Member Walz, Members of the Committee, Congressman Young, my hometown congressman, thank you for the opportunity to discuss the Department of Veterans Affairs Office of the Inspector General's report on the Veterans Crisis Line. I am accompanied today by Matthew Eitutis, Acting VHA Member Services Executive Director.

The primary mission of the VAL. is to provide 24/7 world class suicide prevention and crisis intervention services to veterans, servicemembers, and their families. Any person concerned for a veteran's or military servicemember's safety or crisis status should call the VAL. by dialing the National Suicide Prevention Hotline 1–800–273–8255, press one to reach a VAL. responder. You can also reach the VAL. by texting 838255 and a VAL. responder will text you back. We also offer online chat at veteranscrisisline.net, and vets.gov.

Since 2007 VAL. has answered nearly 2.6 million calls and dispatched emergency services to calls in crisis over 67,000 times. In 2009 Veterans Chat launched, providing an online, one to one chat service for veterans who prefer reaching out for assistance using the internet. Since its inception we have answered nearly 314,000 requests for chat. We added text services in November 2011, resulting in nearly 62,000 requests for text services received to date. On average, over 99 percent of calls on a daily basis are answered by the Canandaigua, New York and Atlanta, Georgia call centers. Less than one percent roll over to backup centers.

When a veteran calls VCL, we have two objectives. The first to answer the call and effectively assess the risk of the caller. As I have detailed in my written testimony, since early January we have answered over 99 percent of our calls without rollover. Our second objective is to provide sound crisis intervention services to our veterans.

A quality management system has been implemented to monitor the effectiveness of the services provided by VCL. and identify opportunities for continued improvement. As required by law, VA will submit a report containing this document outlining the quality management plan to the House and Senate Committees by May 27th.

We appreciate OIG's review and take their recommendations seriously. We are pleased to say we are strengthening our structure so the Veterans Crisis Line, the Office of Suicide Prevention, and the Office of Mental Health Operations are fully integrated to ensure clinical services are optimized. Care is seamless from the time the veteran reaches out to the VCL and arrangements are made to ensure the veteran is safe and timely care and assistance is provided.

We submitted a recommendation that OIG close six of the seven recommendations from the report published in February 2016 and action plans have been developed to address all of the recommendations for the March 2017 report, with the expectation that they will all be implemented by December 2017. During the time period of the second IG investigation, VCL. was in the process of transitioning leadership from one organizational element to another and concurrently standing up the Atlanta call center. New responders were hired and trained over the course of three months, averaging 40 new responders being deployed every two weeks. The standard training cycle includes three weeks of classroom instruction and three weeks of preceptorship prior to being released to independent work. This training took other VCL responders away from their regular duties. All this while performing some of the most profound and important work imaginable, addressing the needs on average of over 2,000 veterans a day and dispatching immediate assistance to 60 veterans a day who are in crisis.

The OIG investigation concluded shortly prior to the tipping point of VCL. consistently answering 99 percent of calls. Since this tipping point we have had 43 days with no calls rolling over. Furthermore in the past six months VCL has more than doubled the capacity to ensure appropriate access to veterans. Today the combined facilities employ 661 professionals and VA is hiring more to handle the growing volume of calls. VCL is the strongest it has been since its inception in 2007. VCL has forwarded over 416,000 referrals to local suicide prevention coordinators on behalf of veterans to ensure continuity of care with their local VA providers.

Despite all this, there is still more that we can do. We appreciate OIG's review of VCL. We are committed to strengthening our governance structure so VCL, Office of Mental Health Operations, and the Office of Suicide Prevention are fully integrated to ensure optimal clinical services. We are committed to seamless care from the time the veteran reaches out to VCL, arrangements are made to ensure that the veteran is safe, and we ensure that the veteran receives timely care and assistance. We are also grateful that Congress provides the resources necessary to give veterans in crisis access to these necessary services.

Thank you and Mr. Eitutis and I look forward to your questions.

[THE PREPARED STATEMENT OF STEVE YOUNG APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Young. And I will now yield myself five minutes. And I am going to go to another hearing, a mark-up in another Committee, for just a minute. So I am going to ahead.

First of all, I think you, the Veterans Crisis Line does some of the most important work that is done in the VA. I think when a warrior gets home, or even does not leave home, and contemplates suicide—I was thinking about this when you all were giving your testimony about the number of patients I have seen over the years in my practice that I tried to diagnose a breast cancer, or a ovarian cancer, or a uterine cancer, and all that I went through to save their lives and then they went through to save their lives. And that is what you do. I think the thing that worried me the most in practice, the objective things I could see I could go after the treat. The subjective about how I am going to behave is very, very difficult. And that is why, as Mr. Walz said, we have to get this as right as we can. Because you really will never quantify how many people that never did something, but you may have stepped in at exactly the right time.

So I am going to just ask a couple, three questions, and then let a discussion go forward. A question I think I first have, at the end of your testimony is why were not all these things that the IG and GAO did a year ago, I hear exactly the same thing, Mr. Young, that was said a year ago that never happened. Why is that going to happen now?

Mr. YOUNG. We have submitted plans to the IG. However they requested additional demonstration that we have sustained the improvements that we put in place. We have submitted now 386 documents just recently, just in the last few weeks, to demonstrate that compliance with their recommendations.

The CHAIRMAN. Okay. Well I think things are getting better. The second thing I want to know, this is a constant turmoil in medical practice, is the, Mr. Missal mentioned this, this debate over what the clinicians want to do and what the people who run it want to do. I think that is a huge deal. Because those decisions ought to be made, many of those decisions I think should be made by medical professionals. I may be biased, but when you have the bureaucrats in there telling you what to do, when a clinician knows this is the most effective way to provide this care for people, I would like a discussion from anyone who would like to jump in on that. Because I think that is a critical, and maybe Ms. Bryant, if you want to start with that?

Ms. BRYANT. Yes, Chairman. As I stated in both my oral and written testimony, IAVA feels very strongly that a clinician needs to be in position of leadership in managing the Veterans Crisis Line. Even within our own RRRP team we recognize that the clinical decisions are often very highly tailored, individualized for that specific case, for that veteran who is in crisis. And you cannot simply, I understand the call volume is a challenge. And I understand that, you know, it is hard to template an SOP in which you can at least evaluate the responders' response or handling of a call, but you have to at least try to individualize that as best as possible and you have to do that with a clinician not just in the loop but is there with equal decision-making authority as the operations lead.

The CHAIRMAN. And why would you not, back to Mr. Young, why would you not want to have that?

Mr. YOUNG. The Veterans Crisis Line does have a Ph.D. trained social worker that is the clinical lead of the Veterans Crisis Line. It is organizationally aligned right now under Member Services but the Crisis Line itself is a led by a Ph.D. trained social worker. And in fact the entire leadership team has 140 years collectively of mental health experience that lead the Veterans Crisis Line itself.

The CHAIRMAN. Well in your testimony you said that the VAL. is the strongest it has been since its inception, and do you have any metrics that you have measured to prove that?

Mr. YOUNG. I think that first of all the volume, and I know that is not the end all be all, that is only one piece of it, is the volume of calls that are being answered today, the timeliness of the calls being answered on average within eight seconds, the calls being answered by VA trained staff themselves, not rolling over to backup call centers, 99.8 percent being answered by VA trained staff. Since our tipping point on Friday the 13th of January was when we first hit zero rollovers. But in addition to that we have processes in place to evaluate the quality of the calls. We have established silent monitoring. Since the IG's recommendations, we have put in place call recording, so we can go back and review the calls with the responders, ensure that they have established rapport or established, properly assessed the risk, followed procedures for linking people in to referrals if needed. And if that, if there are shortcomings, to be able to pull them off and retrain and reeducate around the proper procedures.

The CHAIRMAN. Okay. My time is expired. Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Mr. Chairman. Captain Bryant, and I know you do not maybe have the data in front of you, what are the major negatives that you hear from people who have used this? What are their concerns with it?

Ms. BRYANT. Yes, Congressman. So I do actually have a few from our rapid response program, comments on the quality of feedback from the VAL. So on negative experiences, number one we had one of our case managers visit the VAL. within their floor. And it was worth noting that they were unable to provide referrals outside of the VA. So that seemed to be a challenge, especially when you are looking at total case management for a client who calls in. We understand that the VAL. will then make appointments within the VA and they could even track those appointments through their database. However, what if there are services that are required that go outside the scope of what the VA can provide? So that was one major drawback that we saw.

Beyond that, negative experience included a representative saying, we will not do that, and then they let the caller hang up. It is important to note that the way our partnership works with the VAL. is that if a veteran in crisis calls our RRRP team, we give a warm handoff to the VAL. We stay on the line. We have an entire SOP that we follow where we ensure that they are put in contact with the VAL. before we hang up. And then we do follow up with that client to ensure that they have gone to their appointments or they have done whatever regimen was recommended by the VAL.

So a lot of what we are hearing on the negative side speaks to the length of the time to answer the phones. At one point there was a call that took 16.5 minutes for the veteran transition manager to get in touch with the VAL. responder. Clearly these stats are not satisfactory.

Mr. WALZ. Okay. No, thank you. Mr. Young, I am going to, again I want to keep this in perspective. This is about a decade long. Now we are at the point where we are recording calls, we are starting to do that. Is that frustration apparent? I mean, do you understand where we would come from? Are there best practices that were there? Or is there no civilian comparison to show how we could do this best? Why it took ten years to start addressing the recent IG report?

Mr. YOUNG. That frustration is apparent, Congressman, absolutely. We want to, this is an evolutionary process. And I think we have made remarkable progress from 2007 to today. But there is so much more to be done. And fulfilling the OIG's recommendations are a key step in raising the bar and making the Veterans Crisis Line even better than it is today.

In direct answer to your question about are there standards out there, there are accrediting entities around crisis intervention centers. The American Association of Suicidology is who our crisis line is accredited by. In the same way we ensure that those that we work with that do provide the rare instances of backup, that they also are accredited by those accrediting bodies. We will be going through a reaccreditation process later this year with the American Association of Suicidology to ensure that we are meeting their standards for what a crisis line should be.

Mr. WALZ. Mr. Young, in your opinion, would it lead to a lack of service? Why did we not have a director? I am at the point now where my major number one crisis in the VA is the ability to fill leadership positions over critical agencies. Is that a problem? Did anybody say, dang, we need a director in this situation?

Mr. YOUNG. Yes, Congressman. Filling key leadership positions has been a challenge over time. Broadly speaking, when we speak of medical center director positions in particular, you know, we have had a significant number of vacancies across the country in this positions. And today I believe we have only 16 of those positions open and we are, you know, rapidly working toward getting them filled.

In the case of the Veterans Crisis Line, we advertised for that position. We had three candidates, none of whom were what we wanted in terms of the caliber to lead it. Fortunately we had a highly talented individual who was not interested in the job long term that was willing to step in and help us build this program as we were building it up. He has since moved on. He, you know, intended all along to just be there a short time. And now, again, we have an acting director for the Veterans Crisis Line, a Ph.D. trained social worker, and we are actively recruiting right now to fill that job again.

Mr. WALZ. We need to help you with that. I will close on this. This is just, this is not to you. This is to the folks listening right now. The press release that came out after the IG report said you

had fixed the problems. I would be very careful saying you fixed the problems with the VAL., just a suggestion. I yield back.

The CHAIRMAN. Thank you, Mr. Walz. Mr. Bilirakis, you are recognized for five minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it so much. Mr. Young, among the list of actions VA is taking in response to the most recent IG report is, and I quote, ensuring all staff are educated on policies to include roles and responsibilities. My goodness, I would think so. I mean, it concerns me that an employee working for a program as critical as this one in some instances did not know what his or her role was. Was it evident that all staff was thoroughly educated on relevant policies? Again, I just, I am astounded by this. Why would that be the case? And how do you plan on ensuring a complete understanding of program and agency policies moving forward? Again, I mean, is this widespread? I would like to ask the rest of the panel as well. But if you could respond, Mr. Young? And will you have similar assurance for backup call center staff as well?

Mr. YOUNG. Congressman, yes. It is an expectation, absolutely, that employees understand their roles and responsibilities. I think I will defer to Mr. Eitutis to go ahead and give us some details on that.

Mr. EITUTIS. Sure. The goal of the Veterans Crisis Line renovation is to do exactly what the OIG recommended. And so we took the original recommendations from OIG in February of 2016 very seriously and immediately started working on canonizing processes. The timing of the second OIG investigation was within a handful of months of the ending of the first and the publishing of the first OIG recommendation. Taking an organization where there are few to no SOPs, any standard operating procedures, no formal curriculum for responder training, no formal curriculum for SSA training to make sure that our SSA staff that coordinate emergency dispatches and attempts, there was very little to nothing in regards to documentation. That takes time to do that. And the beginning of another investigation on the heels of beginning to address those things that need to be place, while it is important to document those, we feel very confident at this point where we have documented the procedures and canonized the processes for the responders that are taking these tough calls, 2,000 a day, and making sure that our SSAs are full trained. We have certified that training. We have canonized the processes for both of those critical functions inside the VCL.

Mr. BILIRAKIS. Ms. Bryant, what do you think about that?

Ms. BRYANT. IAVA wants to see the VAL. brought to a level to where, as I stated during my testimony, that all feedback is positive. We think that it is encouraging to hear that the VAL. has taken steps in recent months to address some of the issues. But we still believe it does not go far enough. We still believe that a stronger clinical program is needed. We are hearing steps in the right direction, but we want to see more. We really want to see more in the training. We really want to see more in taking care of the responders who are receiving these calls. We really want to see more in seeing that clinical lead being the, really setting the standards for how these responders not only receive calls but then also

receive care themselves. Again, I go back to what I said during my testimony. Compassion fatigue is real. We understand that a strong clinical program requires a one to ten ratio of responders to clients. We want to see these types of standards applied as the VAL. goes forward with its reorganization.

Mr. BILIRAKIS. Thank you. Mr. Young, in the IG report it was noted that when calls were placed in a queue at a backup call center, the line was not answered until a representative was available. There was no process to route the call from one backup center to another. Is there a process now in place?

Mr. YOUNG. We currently are answering 99.84 percent of the calls ourselves. So it is the rare instance of a call that is going to a backup call center. Yesterday we answered 2,406 calls and seven went to a backup call center. So it is the rare circumstance now where we are even using the backup call center.

Mr. BILIRAKIS. But is there a process in place now?

Mr. YOUNG. I will defer to Matt on that.

Mr. EITUTIS. There is a process. And historically what the VCL has done, they are a part of the National Suicide Prevention Lifeline Network, which consists of 160 other call centers across the country. So NSPL is managed by a contractor, the Mental Health Associates of New York City. We are in current negotiations to redefine what that backup looks like now that we have actually created near 100 percent success for VA VCL. to be able to handle that volume. Historically what has happened prior to where we are today with the access that we have inside VCL, we had four of those 160 centers in the National Suicide Prevention Lifeline as part of our contract where they would take our calls. Unfortunately the volume that we were rolling over, when you roll over 3,000 to 4,000 phone calls per week, that is problematic to other call centers that have their own core mission of providing services for their communities and for their states. And so we believe that the right thing to do was to be able to actually demonstrate to NSPL and SAMHSA and MHANYC that we are going to take care of our own and make sure that we enter into a new generation in regards to rollovers and what that means in regards to catastrophic support.

Mr. BILIRAKIS. Well thank you. Mr. Chairman, I yield back. I have some questions but I will submit them for the record. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. Mr. Missal, your report highlights several concerns with VAL. governance. In your opinion, should the VAL. remain under Member Services? Or should it be transferred back under the VHA Clinical Administrative and Suicide Prevention Office?

Mr. MISSAL. I do not know if there is necessarily a right answer as to what the structure should be. We do feel very strongly that both Member Services and the clinical staff have important things to contribute to the VCL. What we identified was that the clinical staff felt marginalized and that they were not contributing their fair share or what they wanted to do to make this as effective a crisis hotline as possible. So it has got to be a better balance of contributions from the clinical side with respect to Member Services.

Mr. TAKANO. You know, I am troubled by knowing about the chronology of the leadership of the VAL. Am I correct that we really have not filled that position for the seven years it has been in existence? Go ahead.

Mr. MISSAL. It was filled before. It was open for a significant amount of time in the last couple of years. It was filled for a short time in 2016. The director left and I do not believe they had a permanent leader in place, at least since our review ended in December 2016.

Mr. TAKANO. Well can Mr. Young or anyone give me an idea of just the chronology? Since we just, one of the things I am very troubled by with the VA is a lack of continuity of leadership at the very top, but this is not the very top. This is kind of a, you know, a program within the VA. Can you give me an idea of just the chronology of the leadership?

Mr. YOUNG. That was actually before my time and before I had an awareness of it. But I will defer to Matt to see if he can give us a little bit more insight.

Mr. EITUTIS. Sure. There has always been a clinician in charge of the Veterans Crisis Line despite the fact that the Veterans Crisis Line was realigned to Member Services last year. The Veterans Crisis Line has always been led by a director. Our current acting director has got 30 years of emergent psychiatric experience and is an expert in crisis management. And with 140 years collectively throughout our entire leadership team of mental health care experience.

Mr. TAKANO. Yeah, but I want to get some idea of just to put a director in place, I mean to have them there for one or two years, it just does not seem to me enough time to establish a good program and a good vision.

Mr. YOUNG. So Congressman, I am sorry. I do not know that history. So I will have to take that for the record and bring that back to you.

Mr. TAKANO. If you would, thank you. I appreciate that. Back to the Inspector General, is VA on track to address the 23 open recommendations in your estimation?

Mr. MISSAL. We have been working with them with respect to the 2016 recommendations. Mr. Young pointed out they have provided us recently with a lot of documentation that we are reviewing. We would like nothing better than to close out the open recommendations as quickly as possible. I think there is sometimes a misunderstanding of exactly what our recommendations require and we spend time talking to them to make sure they understand. And let me give you an example which I think relates to some of the discussion on governance issues and the fact that we identified that there was not a clear understanding of the roles and responsibilities in our 2016 report. And here we said they need a VCL handbook. What we got in return was an employee handbook. And we said an employee handbook can provide guidance on handling personnel matter such as the tardiness of employees, or dress, etcetera. It does not ensure people at the VCL understand their responsibilities. And that is what we are going to need to close out that recommendation. We certainly communicated that on more than one occasion.

Mr. TAKANO. Does the hiring freeze affect any ability here to get the VAL. really on track?

Mr. YOUNG. The VCL positions are exempted from the freeze.

Mr. TAKANO. They are exempted? Okay. Thank you for letting me know. You know, I would appreciate for the record later any additional processes the VA, such as the one you mentioned, should put in place to oversee the backup call center contracts. We do not have the time but if we can get that later for my office, I would appreciate it. Thanks.

Mr. YOUNG. Sure.

The CHAIRMAN. I thank the gentleman for yielding. I now yield to Mrs. Radewagen for five minutes.

Mrs. RADEWAGEN. I want to thank the Chairman and Ranking Member for holding this hearing today. Thank you, Mr. Chairman. And I want to thank the panel for coming here to share their testimony.

I also want to say hello to you, Ms. Bryant. Her colleagues with the IAVA have been to my office several times now and have helped provide my staff with information on a variety of veterans' issues and legislation. I am glad you could be here to share the IAVA's perspective on today's hearing.

Ms. Bryant, based on your testimony, IAVA's Rapid Response Referral Program does try to address these aspects of caring for female veterans. Would you please share with us more about the RRRP and how VA might be able to replicate aspects of the program to improve the VAL.?

Ms. BRYANT. Yes, Congresswoman. First I would like to point out the director of our RRRP program behind me, Vadim, who is sitting directly behind. One of the things that we speak about of RRRP, we specialize again in high tech, high touch. Which means not only is there the warm handoff to VAL. when there is a veteran actively in crisis, actively suicidal, but then we follow up. And that is really the model we would like to see the VAL. replicate, is the follow up care, to ensure that, okay, you have made an appointment for a veteran in crisis, but did they go? Was that effective? We continue to follow up, not once, but a few times. It just depends on, again, individual case by case basis. And that is the strength of the RRRP program, is that it allows for the individualized case management, depending on what the needs of that veteran are. And it is not limited in scope to what the VA can provide. It also is for any other program that is available to veterans where RRRP can be an advocate for that veteran and allow for everything ranging from whether it is legal services, to mental health care, etcetera.

Vis a vis our women veterans, as we know intrinsically as women veterans, that we do not always receive a welcoming greeting when we go to the VA and by and large when we call the VAL. Unfortunately I do not have the data on that so I cannot speak definitely to that aspect, but I can speak as a woman veteran of the experience sometimes being cold or dismissive when women are in crisis. And that is the difference between what the RRRP program does versus what we are hearing in negative feedback for the VAL.

I do want to also caveat there is positive feedback. And we again do not want to see the VAL. fail. We cannot continue to have the statistic of 20 veterans a day committing suicide. Thank you.

Mrs. RADEWAGEN. Mr. Young, Ms. Bryant's testimony notes that we do not know how many women veterans use VAL., nor how effective VAL. is at providing support for women. Do you have gender specific caller and outcome data that you can share with us today? Does VAL. track the gender of all callers? To what extent are VAL. staff trained to take into account a caller's gender? And does VAL. have a specific protocol for female callers? If so, please describe it.

Mr. YOUNG. Thank you, Congresswoman. The first thing I would like to just add on to the comments that Ms. Bryant just made and to share that for every intervention that occurs, every time that we dispatch somebody to intervene in a crisis situation and deliver them to care, we follow up and ensure that they did indeed get to a medical center and receive the care that they were dispatched to do.

As it relates to women veterans and the Veterans Crisis Line, we do honor any requests from a caller, a woman veteran, to speak to a woman responder. If we receive such a request, we will honor it. Similarly, any conversation that go into sexual trauma, we will ask the caller if they would like to speak to a person of a specific gender and we will honor that whenever that occurs.

Mrs. RADEWAGEN. Thank you. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentle lady for yielding. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I thank you and the Ranking Member for holding this hearing. I think there are probably a lot over very important Committee hearings that are going on today. But I think this hearing today is by far and away the most important that we can have here on Capitol Hill. And it just, it still affects all of us, I think, very, very much that indeed I think we are losing more life when our men and women soldiers return home than their experience on the battlefield. And we know we train our men and women very well and prepare them for the battlefield to avoid loss of life. And we have got to do equally the same in terms of preparing the men and women in these call centers to address this high level of suicide. And Captain Bryant, I want to thank you for bringing up the issues around women and women suicide. And we know that women, veteran women are six times more likely to commit suicide than women in, regular women living in our communities. And so, Mr. Young, I, we passed a bill to say we need to look at data vis a vis our women veterans and to bifurcate that data so that we understand what best practices are in terms of treating our women in relationship to suicide. Can you share with us where we are with that and how we are doing?

Mr. YOUNG. Thank you, Congresswoman. The first thing that I would say, just to go back to the last answer that I gave, is that we do know that the percentage of callers to the Veterans Crisis Line that are women is 13 percent of our callers. The specific question that you are asking, I am going to have to take that for the record and bring that back to you.

Ms. BROWNLEY. Thank you. I just believe that that is a problem in and of itself, when you express data that only 13 percent of the women are using the call center. Because I feel intuitively that there is a reason for that. There are more that need it but do not. And I think that is, we have got to really drill down to understand that. And you know, which kind of makes me want to ask, you know, what are we doing just in general outreach to veterans early on when they leave service that they know this service is available to them? And what are we doing on a sort of an ongoing basis so that we, that men and women know that this service is available to them? What are we doing?

Mr. YOUNG. VA has had a pretty aggressive effort at advertising the suicide prevention hotline, 1–800–273–TALK, press one, to utilize the National Suicide Prevention Hotline as a pathway into the Veterans Crisis Line, as well as our texting, as well as the online chats. And putting the online chat available right on the Vets.gov page so that it is available for veterans. We also have research that occurs and we have a mental health focused research center in the Rocky Mountains that is focused specifically on suicide. We have a center of excellence based in New York that looks specifically at the ideas of how do we convey the availability of these services. How effective are these communications that we put out about the availability of suicide prevention services and the utilization of those services? So there are efforts underway.

Ms. BROWNLEY. So if a veteran goes to see a doctor for primary care, does a provider continue to provide that information to veterans?

Mr. YOUNG. Thank you, Congresswoman, for that reminder. Because we do have suicide screens, depression screens that are a routine part of every primary care visit to try to identify veterans that may be at risk for suicide.

Ms. BROWNLEY. Thank you. And to the IG, if I may, just very, very briefly because my time is about to run out. But it seems to me that we need to have better information. It seems as though we get sort of an annual follow up to how things are going as opposed to sort of interim reports. Because I think that we need to be really vigilant about making sure that we are adhering. I get frustrated because I hear a report from you and then I hear on the VA's side and they do not seem to add up all the time. And I certainly would like to know more information as we move forward about how we are doing on this. So by the time we end 2017 we know that everything has been adhered to and instituted. So my time has run out. But if you could follow up with me on that, I would appreciate it. I yield back.

Mr. MISSAL. Sure.

The CHAIRMAN. I thank the gentle lady for yielding. General Bergman, you are recognized for five minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. Folks, having been fortunate enough to wear the cloth of our Nation for 40 years, I am honored to be among you today. And we know that all of us have had experiences where those we served with chose different means to end their lives. There is no way to even measure what an impact that has on the families and on the unit members that served with these folks. Because you are always wondering, could you have

done something different? Could we have had one more conversation?

I heard Captain Bryant say, I believe, or someone said about the goal was all feedback being positive. I would suggest to you all feedback needs to be relative. Because the one thing that is common in all these situations is they are all different. And we hear more than we, when we are not talking.

So anyway, Mr. Missal, your report mentioned that the VAL. managers were unaware of the performance standards in the contract. If they were unaware of the standards, how were they monitoring the contractors' performance?

Mr. MISSAL. Our report identified that they were not adequately monitoring the contractors' performance, and we made a recommendation relative to this finding.

Mr. BERGMAN. So they were aware but just monitoring of the standards?

Mr. MISSAL. They were not totally aware of all the responsibilities under the contract.

Mr. BERGMAN. Okay. Mr. Young, I understand that the VA is working on a new contract to support the VAL. which will include the OIG's recommendations, correct?

Mr. YOUNG. That is correct, sir.

Mr. BERGMAN. Okay. How will this contract be different?

Mr. YOUNG. I will go ahead and defer to Matt, who is the person on the ground working that.

Mr. EITUTIS. That is a good question, Congressman. So what we are working on, we are in current contract negotiations to make sure that the veteran experience, whether it takes place in the VCL or one of the backup contract call centers, is a symmetrical veteran experience. That includes some very core competencies that we believe that the backup contract call center should demonstrate proficiency on.

One is the service level and we are asking them to abide by the same service level that we have implemented inside the Veterans Crisis Line. There is no standard in regards to the percentage of calls answered within so many seconds. We have adopted the National Emergency Number Association's service level. That is 95 percent of your calls being answered in 20 seconds or better. We are right there, we are just shy of 94 percent. We are expecting our backup contract center to be able to perform at the same rate.We are also expecting them to adopt our training that we have for our responders as well as our SSAs that coordinate our dispatches.

In addition to that, we are asking them to adopt very similar key performance indicators and quality measures. We measure 21 different measures on our quality performance program. We have done over 4,000 of them since VCL came into Member Services. They include eight very critical elements that assess suicidal ideation, third party outreach, as well as assessing past suicide and current issues with the veteran. And those items are going to be included in the current contract and we are under negotiations right now.

We are also establishing some separate positions inside my compliance department to make sure that they are reviewing routinely the performance of the backup contract call centers to ensure that

the veteran experience is as symmetrical as we can possibly make it between the backup contract call centers inside NSPL versus VCL.

Mr. BERGMAN. Okay. Thank you. I think I heard Mr. Young, someone mentioned about a call roll rate of one percent?

Mr. YOUNG. Less than one.

Mr. BERGMAN. Less than one percent. Okay. With a call roll rate of less than one percent, is there sufficient volume to warrant this contract?

Mr. YOUNG. We think that it is important that we still have a means to support us if we should have failures. As an example, this morning in Canandaigua, New York we had some problems with the phone lines. Now we were able to roll things over, able to handle it all within our existing staff. But if that had been a larger problem, we need the mechanism to be able to have that backup. So we are working with, as we are developing the contract our intention is to roll over actually a few more than we are rolling over right now because we need them to be able to maintain critical mass to maintain their competency working with veterans' crisis issues. So right now we are at 99.84 percent. But we are going to deliberately roll over a few more than that so that they can maintain that competency level.

Mr. BERGMAN. Okay. Thank you. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Esty, you are recognized for five minutes.

Ms. ESTY. Thank you, Chairman Roe and Ranking Member Walz for today's incredibly important hearing. And when Secretary Shulkin was with us a couple of weeks ago he flagged that as with us this is his highest priority. It is a tragedy for the country when we lose a man or a women in uniform on the battlefield. It is a stain on our society when we lose them when we come home. And I know we are all committed in our effort to reduce those numbers and do everything we can, and I want to applaud all of your efforts. But I think we can agree not good enough. And we need to do better. So I want to thank you for your efforts in this but recognize we have, we need to maintain a sense of urgency about doing better for each and every one, every one of those calls that does not get answered in time. And my office has had those calls directly to our office, and then have had to deal with staffers afterwards to try to deal with talking people back down.

So I wanted to talk a little bit, Mr. Young, that Captain Bryant talked about and flagged the importance of supporting the responders. So I want to know what are we doing to better support those answering these calls, both in terms of their training, respite? What are we looking to, for example, for best practices? Are we looking at the national centers? Or how are we figuring out the right way to support the people on the front lines taking those calls every day?

Mr. YOUNG. Sure. Thank you. No, you are absolutely right. This is the most profound and important work imaginable. And many years ago I was a suicide intervention counselor at a crisis line. I know on a personal level the impact that it has working with somebody who may be horribly depressed, actively suicidal. It takes a toll on the human beings that are doing this work.

One of the very first things that has been so important for us to do is to get staffed up so that we have the ability to be able to pull people off the phone so they can decompress for a while. We have wellness programs in place at both centers to be able to support our employees. I would like to defer to Matt to give a little bit more detail on some of those very specific things that we are doing to support the employees.

Mr. EITUTIS. Thank you. I believe that the photo of one of our responders in New York, Robert Griffo, who was photographed in regards to the recipient of the Oscar for the work done at the Veterans Crisis Line. Robert's dedication is significant. But what you see in that photograph is the grief and the burden associated with doing this work. And the first thing that we owed our Veterans Crisis Line responders that are now up to 523 responders, was in the 200 range a year ago, the first thing that we owe Robert and his peers, as well as the SSAs, was to decompress the work load for them. Rolling over 3,000 phone calls meant that every single time there was a responder available a call was going to them. And so we owed them making sure that we could internally take care of all of that volume, and making sure that we had enough space between calls to allow some room between calls to allow these responders and SSA to be able to disenroll from the actual telephone system and walk away and get the help that they need, or to take some time to be able to reconstitute in between these phone calls. And so creating near 100 percent success was the first thing.

The second thing we have done is establish a wellness coordinator at each campus, both in Atlanta, Georgia and Canandaigua, New York. The third thing that we are doing is we are developing a program called Employee Readiness and Resiliency. Because we believe that an employee when they come to work, they should have time to be able to get ready to do this type of work. It should not be to just walk in, sit down, and start dealing with some of the toughest work that you can possibly find to do. And so we are implementing that program.

We are also hiring clinicians that will be a part of a process that will be available internal to our employees at any given time, 24 hours a day, at both campuses that will support those employees. But make no mistake whatsoever, these employees know that when they have a tough call and when they need a minute to reconstitute or when they need to be debriefed in regards to some of these tough calls, that is their call. And they know they have the opportunity to make that decision.

Ms. ESTY. Well, thank you. Because I think that is tremendously important. I will follow up because I see my time is out. But on the warm handoff, that is what I am hearing a lot, and that follow up. We want to make sure clinicians are actually looped back in. So I want to follow up in writing. Thank you very much for the work you do.

The CHAIRMAN. I thank the gentle lady for yielding. Mr. Poliquin, you are recognized for five minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much. Thank you, Mr. Ranking Member. I appreciate all the witnesses for being here today. This is incredibly important to everybody I know in this country.

The wonderful thing about these hearings, Mr. Chairman, is that we are all on the same page. We have folks here who have fought for our country and given us our liberties, and now they are at very high risk, a lot of them. And when you see 20 veterans who commit suicide every day, that should be a real wake up call for us. I do not know what the number is in the rest of our country among our fellow Americans, but I am sure it is not as high here.

So my question goes to you, Mr. Missal. Am I pronouncing your name correct, sir?

Mr. MISSAL. No, it is actually Missal.

Mr. POLIQUIN. Missal. Mr. Missal, okay. When, I am reading your reports here, and when was the first time that you folks at the—let me back up a little bit. You are the IG at the VA?

Mr. MISSAL. Yes.

Mr. POLIQUIN. And you are appointed by the President of the United States?

Mr. MISSAL. Correct.

Mr. POLIQUIN. And you have complete independence at the VA?

Mr. MISSAL. I am sorry?

Mr. POLIQUIN. You have complete independence at the VA?

Mr. MISSAL. We do, yes.

Mr. POLIQUIN. Right? So you have unfettered access to all this data, and what have you. Do you have subpoena power?

Mr. MISSAL. We do have subpoena power for documents.

Mr. POLIQUIN. Got it. Okay. When is the first time that you folks found that there were problems with the crisis hotline over at the VA, roughly?

Mr. MISSAL. We issued a report in February of 2016 which identified a number of problems. I started in—

Mr. POLIQUIN. Okay, and how long did that—

Mr. MISSAL [continued]. I am sorry?

Mr. POLIQUIN [continued]. How long had that report gone on? It was February 2016, but how far back did you—

Mr. MISSAL. We looked back to 2014 for that.

Mr. POLIQUIN. Okay. Okay. So roughly you know there have been problems there for a couple of years, roughly?

Mr. MISSAL. Correct.

Mr. POLIQUIN. Okay. And you have 23 recommendations that were supposed to be fixed last September that have not been fixed, correct?

Mr. MISSAL. Seven of the recommendations should have been fixed, or rather VA said they could fix by September 2016. The other 16 recommendations are from our report that was just issued in March—

Mr. POLIQUIN. In March of this year? Okay. Got it. So my question to you, Mr. Missal, is that do you think it is reasonable with 20 veterans per day committing suicide that the VA has not fixed what they were supposed to fix six months ago?

Mr. MISSAL. This is why we consider this such an important program.

Mr. POLIQUIN. Okay.

Mr. MISSAL. Why we give it such great attention.

Mr. POLIQUIN. Okay. Good. It is not money, right? Because the budget we have talked about here, Mr. Chairman, has gone up I

think threefold in the last ten years, or something to that effect. Okay. So it is not money. It is something at the VA. Who is responsible? Who is the head banana there that is responsible for fixing these problems? Who is that person?

Mr. MISSAL. I think it ultimately goes up to the Secretary.

Mr. POLIQUIN. Okay. Okay. And who reporting to the Secretary is responsible for this problem? This set of problems?

Mr. MISSAL. There are a number of people within the VCL, from the VCL Director all the way to the Secretary.

Mr. POLIQUIN. Okay. So we can, I have a terrific staff member in the back room, Dennis Cakert, he can find out through the Web site or what have you who is specifically responsible so we can get on the phone with that person, find a way to do that. I think I have that authority to do that as a Member of Congress, correct?

Mr. MISSAL. Sure.

Mr. POLIQUIN. Okay. Neither of those individuals is here today, is that correct?

Mr. MISSAL. I am sorry?

Mr. POLIQUIN. Are any of those individuals in that line of, that chain of command here today? In this room?

Mr. MISSAL. Mr. Eitutis is in that line.

Mr. POLIQUIN. Great. Why have these problems not been fixed?

Mr. EITUTIS. Sir, we took the original recommendations from OIG very seriously. When—

Mr. POLIQUIN. Yeah, I am sure you did. But why have they not been fixed?

Mr. EITUTIS. Well we have been working on them since we received the first OIG report last winter.

Mr. POLIQUIN. Mm-hmm.

Mr. EITUTIS. And we had submitted, actually of the original seven recommendations we submitted recommended closures for those seven recommendations on ten different occasions. In June, October, and then most recently in March. And so we do take it seriously. Again—

Mr. POLIQUIN. Let me, I am reclaiming my time, please, make sure I understand this. Seven of the 23 were supposed to be fixed by September. Is that correct, Mr. Missal?

Mr. MISSAL. That is what they originally said, yes.

Mr. POLIQUIN. And that is what you said, correct?

Mr. EITUTIS. The response from VA was originally that we would have those closed by September—

Mr. POLIQUIN. Okay, were you involved in that response?

Mr. EITUTIS. No, I was not.

Mr. POLIQUIN. Okay. But someone above your chain of command was?

Mr. EITUTIS. Somebody different, yes.

Mr. POLIQUIN. Who was that?

Mr. EITUTIS. Dr. David Carroll.

Mr. POLIQUIN. Okay. How do you spell his last name?

Mr. EITUTIS. C-a-r-r-o-l-l.

Mr. POLIQUIN. Okay. That will be easy to find his number to give him a call. Do you know why those seven problems have not been fixed yet?

Mr. EITUTIS. Yes, I do. And so for context associated with what I had mentioned earlier, I believe that the lack of documentation, the lack of formalized and canonized processes surrounding responder work, SSA dispatches, and referrals, much of that was not in documentation. There was not much that was in documentation.

Mr. POLIQUIN. Okay, why did you tell us it was going to be fixed in September?

Mr. EITUTIS. Well that is a very good question. And so taking an organization from having very little being actually documented and not having canonized curriculum—

Mr. POLIQUIN. Yet you have 360,000 employees at the VA. How can you not have documentation?

Mr. EITUTIS. Well again, we take this seriously and—

Mr. POLIQUIN. It does not sound like you take it seriously enough in my opinion. You know, we are on the same page. We want to help you—

The CHAIRMAN. The gentleman's time has expired.

Mr. POLIQUIN [continued]. —20 of them are dying per day. So we want to help you do that. But I am not quite sure I am very satisfied with these answers, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding. Ms. Rice, you are recognized.

Miss RICE. Thank you, Mr. Chairman. Mr. Young, you had mentioned before, one of the frustrations I feel, and I am not speaking for anyone else on the Committee, is that there are parts of the VA that work really, really well around the country and could be qualified as best practices. And yet the VA is not very good at identifying those programs that work and then implementing them elsewhere. So when you talked about the center of excellence in New York, can you just expound a little bit? Can you explain what that is and why you pointed to them as something that was effective?

Mr. YOUNG. Sure. Thank you, congresswoman. The center of excellence works around the issue of suicide and they focus on doing epidemiological studies around suicide. They focus on the communication and how we are conveying the availability of suicide prevention services and how effective that communication is working in relation to getting veterans linked in to the care that they are needing.

Miss RICE. So they do that analysis based on the program as it exists now? Or is it just general information about suicide in general? Are you talking about specifically within the VA?

Mr. YOUNG. Specifically in VA, and specifically with the Veterans Crisis Line.

Miss RICE. Okay, specifically with that. Were they asked to do that or did they take that upon themselves, the center?

Mr. YOUNG. You know, that actually predates my coming onto the scene in this position. So I do not know its history in terms of how it was established, when it was established. I just simply know what they are doing now.

Miss RICE. And what they are doing you think is good. And how does that get exported to other, to the VCLs?

Mr. YOUNG. Well the center of excellence works in partnership with the Veterans Crisis Line in evaluating the work that they do and—

Miss RICE. But how are their recommendations implemented? And are they? I mean, you have an IG who has done a report that says these 23 things should be done and the VA has not gotten around to most of them. So when you say the center of excellence is going a really great job, how is that measurable?

Mr. YOUNG. I think that some of the things that we can turn to talk about the effectiveness of the Veterans Crisis Line, we talk about, A, the number of calls that we are receiving, you know, over 2,000 a day, 189 texts, 79 chats. But more importantly 371 times, just yesterday, 371 times yesterday, that the Veterans Crisis Line referred veterans to suicide prevention coordinators. We have over 400 suicide prevent coordinators spread throughout the Nation and 371 times yesterday we referred veterans to them for care and then those suicide prevention coordinators link up with the veterans and ensure that they are getting in and receiving the care that they need.

Miss RICE. So is that the kind of follow up that Ms. Bryant mentioned about within the, is there that kind of follow up?

Mr. YOUNG. It is part of the follow up that Ms. Bryant referenced. But in addition to what Ms. Bryant referenced, whenever we dispatch anybody out to do a rescue, if you will, yesterday we had 63 times that we dispatched people to rescue or to intervene in a veteran that was either suicidal or actively in a state of crisis, where they were needing care. We follow up on every single one of those and make certain that they have gotten in and gotten the care that they need.

Miss RICE. When you talked before about having three resumes of people for the position to head up the VAL., is that right?

Mr. YOUNG. Say again, please?

Miss RICE. The resumes that you were talking about that you found to be insufficient for the position of running the VAL., right?

Mr. YOUNG. Correct.

Miss RICE. What, I mean, so it is not a, it is not as if you are not getting resumes. What qualities are you looking for in hiring this person? And is there anything that we can do, clearly it is not a money issue, I do not think. It is not an applicant issue. You are getting applicants. What are you looking for?

Mr. YOUNG. We had, when we stood up the Atlanta call center, had over 1,000 applicants of those responder positions. Among our responders, we have 99 that have bachelor's degrees, 377 with master's degrees, and 14 with Ph.Ds. These are really highly qualified individuals. Our current leadership, the acting leadership in the Veterans Crisis Line, has a Ph.D. We have 140 years collectively of mental health experience among the leadership in the Veterans Crisis Line. So I am hopeful that this next round, as we are advertising and looking for a new leader for the Veterans Crisis Line, that we are going to have success in getting a highly qualified individual to come in and be able to lead those already very well qualified and high level responders.

Miss RICE. It seems to me that that should just be priority number one.

Mr. YOUNG. Absolutely.

Miss RICE. Given the need for it. Thank you. I yield back.

The CHAIRMAN. I thank the gentle lady for yielding back. Let us see, next is Miss Gonzalez, you are recognized for five minutes.

Miss GONZALEZ-COLON. Thank you, Mr. Chairman. And I want to thank you, you and the Ranking Member, for having this Committee hearing. And I think this is very important. And I just have a task force with veterans organizations in San Juan last Sunday. And this was one of the main issues they were asking for. So most of the questions have been answered, so I do not want to be repetitive. But I want to say that Chairman Roe has emphasized the need to provide the best health care services to the heroes of our Nation. In San Juan we have got over 93,000 veterans that do not receive the same benefits as those that live in the mainland. So my question would be, one, if we got enough data to identify the sex, the state, territory, or statistics about age or one of the mechanisms to those people who call to the Veterans Line, Mr. Young?

Mr. YOUNG. Thank you, Congresswoman. I do not have that information here with me today. I can take that for the record and bring it back to you.

Miss GONZALEZ-COLON. But it is available?

Mr. YOUNG. We certainly have information available on the phone numbers that the phone calls come from.

Miss GONZALEZ-COLON. Area code, yes.

Mr. YOUNG. Although with cell phones today, who knows. My cell phone is Tampa, Florida, you know, but that is not where I live. So it is not always an absolute where the person is calling from.

Miss GONZALEZ-COLON. Besides the area code, do we have what sex they are or age of those callers?

Mr. EITUTIS. Yes. We use a customer relationship management software that is currently being replaced with an even more advanced version of CRM and that is going to allow us to be able to build a number of different areas and sub-areas for us to be able to collect a lot of data that we can then reflect on, do the analysis, and make some additional programmatic changes based on the epidemiology associated with the analysis and partnering with the centers of excellence that Mr. Young referred to as well as with the Office of Suicide Prevention's expert, as well as Office of Mental Health Operations.

Miss GONZALEZ-COLON. Can you provide the Committee or at least this Congresswoman the data regarding those calls from the last report?

Mr. EITUTIS. Yes, we will take that.

Miss GONZALEZ-COLON. Thank you. I do not know if you are aware that a group of 86 congressmen and congresswomen just sent a letter to the Secretary. I am included in those Members. We are very upset and aware of the situation. Do you already correct or establish text monitoring to the system of text calls?

Mr. YOUNG. Thank you, Congresswoman. Yes, we do accept texts. As a matter of fact just yesterday 79 texts that we dealt with yesterday. But since the advent of the texting option, which was in November of 2011, we have had over 62,000 texts that we have responded to.

Miss GONZALEZ-COLON. But do we already correct the issue regarding who is making the monitoring or the testing of the timelines of the answering of those texts? Or no?

Mr. YOUNG. I am sorry, can you—

Miss GONZALEZ-COLON. Do we already have tests about the timelines of the answering of those texts? Or no?

Mr. YOUNG [continued]. Yes.

Miss GONZALEZ-COLON. Because the last report just said that 14 texts were unanswered by the VA.

Mr. YOUNG. So we have processes in place to respond to, to all of the phone calls, the texts, the online chats in a timely manner. I will defer to Matt to talk details on that.

Mr. EITUTIS. We do have that data and we test that system in regards to making sure that texts and chat are properly working. We do the same thing with option seven that we rolled out in 2016, where we added the option that has the language on every single major medical center in the country. We added the language if you are having thoughts of suicide, press seven. That work comes to us. We even test that as well. And so we test all of our modalities to make sure that they are up and running. I would be glad to provide that—

Miss GONZALEZ-COLON. Question, do we have just two call centers? Or do we have more than that?

Mr. EITUTIS. We have two main call centers, on in Atlanta, Georgia and one in Canandaigua. And then our current backup contract call center with NSPL is out of Portland, Oregon.

Miss GONZALEZ-COLON. Okay. Thank you. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentle lady. Mr. Peters, you are recognized.

Mr. PETERS. Thank you, Mr. Chairman. And thanks to everyone for being here. And I do want to just echo that we really, we appreciate your sense of urgency about this. We think this is of the highest priority and so appreciate your spending some time with us. And I had some specific questions about the backup call center contracts because it looked from the GAO and IG reports that there are some things missing.

I want to call your attention to a program we have in San Diego. The county government and other entities have been using 211 services. You just dial 211 on your phone and it is a clearinghouse for benefits, emergency services, social services. One of the programs coincidentally, it is not a VA program, it is called Courage to Call, which often receives calls from veterans or servicemembers in crisis and sometimes they refer to the VA. Now the county ties its payments directly to wait times. And I do not know if you have any objective, so if each call is not picked up by a live person within 30 seconds the payment is diminished automatically. And there is a referral for each call, a warm hand off we have been talking about, to another live person at an agency where the professionals have been vetted for things like customer service and cultural sensitivity. So Mr. Eitutis—is that?

Mr. EITUTIS. Eitutis.

Mr. PETERS. Eitutis, backwards. Eitutis. You had talked about, you had given some pretty encouraging metrics about the background call centers. But I was not clear about how you enforce those.

Mr. EITUTIS. Well we are developing a table of penalties right now through our contract negotiations with the contractor that oversees that National Suicide Prevention Lifeline. And so the table of penalties that were previously nonexistent in previous versions of the contract, we are going through that right now.

Mr. PETERS. And I would maybe, do you think something like a, you know, a failure to answer within a certain time might be automatically tied to payments as part of the contract?

Mr. EITUTIS. Well we believe that they should be able to establish based on the way that we design the contract, that they should establish the same service level that we have implemented inside our organization with a minor exception. And that is if and when we have a catastrophic situation where we cannot get to all of our phone calls, if any of them, that would be a different set of circumstances. However, the actual experience for the veteran when they contact the backup call center versus us should be symmetrical.

Mr. PETERS. So I would just say, I would suggest to you then on an quantitative measures, like the amount of time on the phone waiting, it is great to think about tying that directly to performance so you do not have to go through the appeals process and charge them with a penalty. And I just commend that process to you for the objective side. On the non-objective side, you know, there are issues about how to measure the quality of the experience and I think that is more difficult. But a lot of that has to do with training. And in the report there is a lot of suggestion that there is a lack of training for even the VA staff and superiors, supervisors. So we know the people answering the calls, they have very stressful jobs. The call center requires particular kinds of skills. How do you, what do you want to do to ensure a healthy work environment and retention in order to provide veterans the best service both inside and then in the contract services as well?

Mr. YOUNG. Sure. Thank you, Congressman. The first thing that I would say is that our turnover rate is less than four percent right now at both of the call centers. It is slightly less in Atlanta than it is in Canandaigua. But we have got by way of comparison to the rest of government we have a very attractive turnover rate right now for employees. I will defer to Matt on the details for the rest.

Mr. EITUTIS. So anytime we have the opportunity to hire a supervisor or a senior official inside the Veterans Crisis Line we try to take advantage of the talent that we actually have and the experience that we have inside the Veterans Crisis Line. One example of that Julianne Melane, who has been with the Veterans Crisis Line for years, who is now one of our senior deputies at the Canandaigua, New York campus who has taken tens of thousands of these phone calls as a responder. And so she understands what the process is. She understands what that veteran experience should consist of in regards to the 13 non-critical elements in our quality assurance program, our eight critical elements. And those will be symmetrical in the contract associated with the veteran experience when it comes to backup support.

Mr. PETERS. Yes, and I just want to, I mean, again. I think that is terrific. I am sure you have great employees, many of whom get it. It is just a question when you contract this stuff out, how do

you enforce it? And maybe we could follow up and hear some more ideas. How you enforce the qualitative aspects of that is not clear to me.

Mr. EITUTIS. Sure. So the other thing we are doing is we are setting aside several positions inside my internal controls and compliance department that will do nothing but dedicated work towards making sure that the backup contract call center is actually doing what they are supposed to be doing based on the new contract that is going to be place by the 1st of July.

Mr. PETERS. Okay. Well thank you. My time is expired. And but I do appreciate your attention to that and look forward to working with you. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Higgins, you are recognized.

Mr. HIGGINS. Thank you, Mr. Chairman. I think it should be noted that prior to 2007 when VAL. was initiated, veterans had a crisis hotline. It was each other. We called each other. And it is startling to me that since the government got involved it seems like the suicide rates have increased.

Mr. Young, who is responsible for hiring at VAL.?

Mr. YOUNG. The individual responsible for hiring at the VCL. would be Mr. Eitutis as the Director of Member Services, and then we have an acting Director of the Veterans Crisis Line itself.

Mr. HIGGINS. Okay. Are you aware of how many veterans live in the United States? How many living veterans we have in the United States of America? It is 22 million.

Mr. YOUNG. I was going to say, I know the number but—

Mr. HIGGINS. According to the numbers that I am reading, of 594 employees, 23 percent are veterans. So is this Committee to understand that out of 22 million veterans across the country, 137 are available that have the skills described as to hold a degree in a field relating to social science with a focus on social work and mental health counseling? Is this the best that we can do for our veterans, that out of 22 million from sea to shining sea, 137 of them are available to answer the phone on a crisis hotline?

Mr. EITUTIS. No, sir. That is not the best we can do. What I would tell you is that we actually exceed 40 percent of our staff as being veterans. We hired as many as we possibly could. We exhausted every veteran certificate that we had in Atlanta, Georgia when we hired those positions. The other thing I would tell you is that we are in cooperation with the Office of Mental Health Operations to establish a next generation of VCL. in regards to outreach that will include peer support specialists that would have background and experience with mental health and substance abuse and those types of issues, as well as being a veteran. And so we agree with you, Congressman, that that is something that needs to be part of the portfolio of the Veterans Crisis Line.

Mr. HIGGINS. One would hope so. Are the veterans service organizations counseled regarding hiring? There are many VSOs across the country that are dedicated veterans themselves that generally work for free in service of their fellow veterans across the country, male and female. Does the VAL. hiring process consult with VSOs in order to seek veterans that carry the qualifications that can fill these roles?

Mr. EITUTIS. That is an area that we can work more closely with them on.

Mr. HIGGINS. Ms. Keleher, did I pronounce your name right, ma'am?

Ms. KELEHER. Yes, sir.

Mr. HIGGINS. Thank you. Ms. Keleher, as a representative of the VFW, in your opinion, in your humble opinion, ma'am, would the VAL. be best able to address some of these problems that we are discussing today by filling the ranks with veterans themselves whereby when a veteran does call seeking help they are talking to a fellow veteran?

Ms. KELEHER. Sir, in my opinion and the VFW we have always supported peer to peer support and the expansion of it. VA has had great successes with it. Veterans who do use VA have responded with much positive feedback. The VFW has been advocating for more expansion of that, and increasing the employees at VAL who are veterans would, in my opinion, be a great benefit. But at the same time I do not think we can ask VAL. to strictly hire based off of veteran status. They need to look at the most qualified candidates and make sure that they are training the best while expanding peer to peer. Twenty-two million veterans is a lot and I think in a dream world we would be able to have that many filling the rolls at VAL. But we cannot guarantee every veteran in Canandaigua and Atlanta want that position. So, as long as VAL, is continuing to hire effectively with a focus on veterans, and VA continues focusing on peer to peer, other VSOs, and I know VFW, have been partnering with VA. We have our Mental Wellness Campaign. So we partnered with VA on suicide prevention and expanding and making sure that veterans know the signs of distress and then making sure VA has the resources available to provide to those veterans.

Mr. HIGGINS. Thank you for that answer, ma'am. That was a very thorough response. Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Sablan, you are recognized for five minutes.

Mr. SABLAN. Thank you very much, Mr. Chairman. Welcome, everyone. I truly apologize for not being here earlier. I have four things going on at the same time. But one, let me extend this welcome. But Ms. Keleher, I want to let you know that members of your organization in the Northern Marianas, I am from the Northern Marianas. They are some of my people I turn to on many issues of veterans. They are very helpful and I appreciate them.

Mr. Young, or Mr. Matthew, I come from a place, sir, where today we have been a part of the United States since 1978. But today someone would go to a post office in some rural place and try to mail something to my island, my district, and they would be told that it is international. Or there is no post office there. Or that the U.S. does not, it is not part of the United States. Sometimes people, telephone companies make mistakes, and the area code is 670. That happens to be the country code also for East Timor so they get charged.

So we are far out. And when you talk about territories, people hear about Puerto Rico and Guam. We tested the hotline. We have tested the texts. It works. Now let me ask you, if a veteran would

go to that hotline, place a call, how would you find someone there that would be able to provide immediate attention to a veteran who may be considering, who may be in a difficult situation and may be considering harming himself. And I am talking about three separate islands here now.

Mr. YOUNG. Thank you, Congressman. I think that is one of our more challenging areas.

Mr. SABLAN. Yes, sir.

Mr. YOUNG. We do have suicide prevention coordinators around America, including a suicide prevention coordinator in the Pacific Islands Healthcare System, that is able to engage by phone and to stay in contact with veterans that may be at risk. The suicide prevention coordinators, especially in areas like you are describing, and it is elsewhere in America, too. It is in some of our more rural areas as well. Where they have a responsibility to know of the resources that are available locally and be able to refer people appropriately for those resources. And so that is how we would approach it in that instance.

Mr. SABLAN. So the Crisis Line, if I was placing a call, the Crisis Line would be able to find someone for me to talk to if I was in a precarious situation?

Mr. YOUNG. The Crisis Line regularly refers veterans out to our suicide prevention coordinators around America and so in this instance they would, if there was an individual that they felt was at risk in your district, they would refer to the Pacific Islands suicide prevention coordinator, and then that person—

Mr. SABLAN. Where is that?

Mr. YOUNG. That is in Hawaii. Which obviously is a long ways away. But it is in the, it is the same circumstance that we have, as I said, in other parts of the Nation in terms of being familiar with local resources and being able to connect those veterans using telehealth technologies and other mechanisms to stay connected with them. So it is less than ideal but it is a mechanism—

Mr. SABLAN. It is very wanting. It is not, less than ideal is a perspective. I understand that we are so removed and but I appreciate what you guys do. I am, hopefully we could work something together where there is a more personal response. You know, I mean, if I am thinking of trying to end my life it is a serious situation. And but thank you very much for what you guys do. And again, to the Veterans of Foreign Wars, please know my gratitude for your members. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Dr. Wenstrup, you are recognized.

Mr. WENSTRUP. Thank you, Mr. Chairman. I thank you all for being here today and addressing this very challenging situation. And I am going to address this to you, Mr. Young. You know, I know that to the caller every call is a, situation is a crisis to them. I am curious if there is tracking of the numbers of types of calls that you are getting. For example, non-crisis type calls, whether they are harassment calls, or true crises. That, like I said, it is probably a crisis to whoever is calling. But do you categorize them? That is one of my questions. And I mean, do we define crisis for our veterans? Do they understand what crisis means? Are we defining it for them? Because or do we need a helpline, for example? I

mean, our offices are helplines, believe me. We get the harassment calls. We get people that are in need of help and guidance and direction. And that may be something that we need to expand on. Are we triaging the types of calls that we are getting? I guess my question is are we really achieving the intent of the hotline vis-a-vis crisis, if you will?

Mr. YOUNG. Thank you, Congressman. I think that the very fact that we have just since January done 4,600 interventions where we have dispatched people out to rescue, if you will, that is probably not the right term, but to intervene in individuals that are experiencing a crisis to such a degree that the responder thought it necessary to engage local responders, local EMS, to reach out to that veteran and bring them into health care. 4,600 times just since the beginning of this calendar year. I think that that says something very serious about the seriousness of the calls that we receive.

In addition to that over 25,000 times since the beginning of the year we have referred out to suicide prevention coordinators out across the country. Again, speaking to the seriousness of the calls that are coming in. Do we get some calls that are people harassing? Yeah. Do we get some that they are asking for information? Yeah. But the majority of the calls are those very serious, profound, important work that happens every day.

Mr. WENSTRUP. So it is not an overwhelming amount of having to really readdress where they need to be calling?

Mr. YOUNG. I would agree with the VFW's comments earlier, that we do need to redirect people to our patient advocates and be able to work with that mechanism that is already in place to try to reduce those calls that are really unnecessary to go to a crisis line so that we are able to focus on true crises.

Mr. WENSTRUP. Okay. I appreciate that. Thanks for the feedback and I yield back.

The CHAIRMAN. I thank the gentleman for yielding. Mr. Young, thank you. You have been very patient. You are now recognized for five minutes.

Mr. YOUNG of Iowa. Thank you, Mr. Chairman and Ranking Member Walz, and my colleagues, and Members of the panel here today. Thank you for your commitment to our veterans.

Under Secretary Young, the Veterans Crisis Line Handbook, what is the status of that?

Mr. YOUNG. If you are referring to the directive on the Veterans Crisis Line, it is in draft. It is going through concurrence.

Mr. YOUNG of Iowa. How long has it been being worked on?

Mr. YOUNG. We have, well I have been in the job three months. It has been in the works since I have been officially in the job, I know that much.

Mr. YOUNG of Iowa. Are you working with veterans service organizations on that? I mean, are you opening up that process and taking input from other, from veterans groups out there regarding this? And maybe the American Association of Suicidology, and those kind of folks?

Mr. YOUNG. Well we certainly work with in the Veterans Crisis Line, which is accredited by the American Association of Suicidology, and work to be in compliance with their standards. So

our directive absolutely will be in alignment with the requirements to be accredited by an outside entity.

Mr. YOUNG of Iowa. When were you accredited by the AAS?

Mr. YOUNG. I am going to defer to Matt on that. That was before my time.

Mr. EITUTIS. I believe that was in 2012, was the last date of our accreditation. It goes for five years. We are in—

Mr. YOUNG of Iowa. It goes for five years. Okay. So you are up here this year?

Mr. EITUTIS [continued]. This—

Mr. YOUNG of Iowa. Okay. So it is not a one-time process. It is once every five years. Do they accredit the whole program? Do they go and accredit the call, do they visit the call centers, backup call centers? How is the accreditation done?

Mr. EITUTIS [continued]. So individual call centers are accredited. So inside the National Suicide Prevention Lifeline what I have learned from our partnership with NSPL is that individual call centers can be accredited I think through seven different bodies of accreditation. We have chosen to remain with the American Association of Suicidology.

Mr. YOUNG of Iowa. I want to talk about silent monitoring. And you are increasing the frequency of that use?

Mr. EITUTIS. Well going back a year there was no silent monitoring, there was no quality assurance program.

Mr. YOUNG of Iowa. What percentage of the calls now do you think are monitored silently?

Mr. EITUTIS. I can get you the percentage on that. But what I will tell you is in a year we have reviewed 4,178 calls.

Mr. YOUNG of Iowa. What are you doing with the information and do you find it effective?

Mr. EITUTIS. We find it very effective. In fact, there is not a better way for us to be able to determine the success of a phone call in regards to establishing both non-critical and critical elements inside that veteran experience.

Mr. YOUNG of Iowa. Thank you. Ms. Bryant, you have strong feelings about organizational structure and making sure that clinicians need to be a stronger role there. How can they work together? How do you envision that?

Ms. BRYANT. Well we envision the clinicians being at the, first of all, a part of the leadership team and it should be an operations management and a clinical lead that work in tandem to establish protocols. And we would love to provide feedback if asked by the VA in order to demonstrate how we think that those best practices could be employed.

Mr. YOUNG of Iowa. You said if asked by the VA?

Ms. BRYANT. Well—

Mr. YOUNG of Iowa. I hope the VA will ask.

Ms. BRYANT [continued]. We do regularly consult with and they do call us for our best practices.

Mr. YOUNG of Iowa. Good. Good.

Ms. BRYANT. And so we are in close conversation with the VA. We could do more. And so we are happy to offer our services in doing that and in helping to provide that evaluation. But again, we strongly believe that there is a robust way in which you can si-

lently monitor calls, in which you could review calls, but then also manage the quality management and the clinical review as a part of that expansion of the current protocol. It simply just does not go far enough. And so what we envision is more of that clinical lead and that clinical aspect that individualized care being established into best practices that would need to go into that handbook.

Mr. YOUNG of Iowa. You mentioned something in your testimony that struck me. You mentioned compassion fatigue. Those, the veterans would call, those on the other line, the stories they hear. Tell me about compassion fatigue and is it real? And then how do you deal with that? How would the VA, the VAL. deal with that?

Mr. YOUNG. I am going to go ahead and defer to Matt for that.

Mr. EITUTIS. Again, that compassion fatigue, one of the first things we knew we needed to do was to establish the access. That simply meant hiring more qualified responders and SSAs. We have got an SSA, which is one of our employees that is the specialty inside the Veterans Crisis Line that is responsible for coordinating emergency dispatches for intervention for those veterans that are at the highest risk of suicide, to include having a plan and ready to carry that plan out. And so one of the first things that we knew that we needed to do was to establish the capacity to be able to defuse the amount of the workload. And so as I mentioned earlier to the previous Congressman in that discussion, we addressed that. We are now at near 100 percent access and establishing that employee readiness and resilience program is important. Adding those additional clinicians inside the organization so that we have those on board 24/7, 365. And again, make no mistake. Any employee involved in Veterans Crisis Line experiences they have the option, and they are in charge, of making sure that they take the time out in addition to the resources that exist inside VCL. And so they have got the opportunity to do that anytime they want.

Mr. YOUNG of Iowa. Mr. Chairman, my time is up. But I beg for maybe another minute or two.

The CHAIRMAN. That will be all right.

Mr. YOUNG of Iowa. Thank you. Thank you. Ms. Bryant, you talked about the importance of data and how can it help decrease in the end veteran suicides by driving, looking at that data, then driving it backwards to its impetus?

Ms. BRYANT. Right. Well we believe that the Veterans Crisis Line should fall under the purview of the Clay Hunt SAV Act as well as the Female Veterans Suicide Prevention Act. We ask for data reporting mechanisms just for that very reason, Congressman. To allow for us to utilize that data and figure out what we call in the Army TTPs, our techniques, tactics, and procedures, that are our best practices for evaluating calls, for providing the highest standard of care. But we need the data to see that.

I mentioned women veterans. I mentioned the fact that while 13 percent of your calls may be from women, that is all we know. We do not know anything beyond that and we certainly do not know an evaluation of those women veterans, of their experience during those calls. We would like to see that data recorded.

Mr. YOUNG of Iowa. Under Secretary Young, I hope that you hear her and the others who are calling for some great data mining on this. Ms. Keleher, how is the VA doing with the VAL. in your

assessment of connecting veterans with these emotional war wounds, these battle scars, to the local level where they can get some real help right at home?

Ms. KELEHER. VFW believes that overall VAL. has done great with improving, particularly after the report last year. And since the launching of the ATLVCL, the Atlanta one. And the resources, we firmly believe that the majority of responders do know. But unfortunately if even one does not know the resources available locally or the proper protocol, just like anything, it brings the whole thing down. You are only as strong as your weakest link.

So we do believe that with the monitoring capabilities that they do have now that that will help, you know, hold those individuals more accountable as well as show just how many people are not aware fully of the local resources. But we do believe that they are overall doing much better and improving.

Mr. YOUNG of Iowa. Just a final question. Ms. Bryant, you mentioned in your testimony about the invisible wounds of war and these emotional battle scars. It is one thing when the military leaves the Department of Defense and leaves their service, and they are told about their benefits and services available to them, and presumably the Veterans Crisis Line that could be available to them. I am wondering if going back even further than that upon leaving the Department of Defense, is there any kind of emotional or mental review or debriefing or checkup that the Department of Defense gives those who are leaving? And if not, should there be?

Ms. BRYANT. Thank you, Congressman, for that question. It is definitely something that can be improved upon. A lot of the time when we talk about veterans issues as a whole, we recognize that things should happen "left of the bang." Things should happen while you are still in uniform, transitioning from DoD, or under the purview of DoD. And you have that continuity of care as you move forward to the VA. You have Military OneSource, you have other mental health services that are provided while you are still in uniform and that is usually reported through reporting procedures through your chain and command and sometimes you do not even have to go through them to dial Military OneSource. So that would be what I understand the DoD's answer to giving that veteran care. But then you also have the transition and you have the evaluation that you go through at the time when you first separate from the military.

I can speak to my own experiences when I separated from the military to where I went through my physical evaluation at the VA. Yes, there was a screening for mental health but this was also 2009 when I separated and I will say that it was nowhere near what is probably provided today and it was probably insufficient for what I received when I separated from military service. I would love to see a robust battle handoff from uniform to when you come home.

Mr. YOUNG of Iowa. Well, thank you for that. And I want to thank all of you for coming here today and your love and care for our veterans, and your wanting to make the VAL. strong. And I want to thank our Chairman and Ranking Member for allowing me to be here today and your pressing on this issue to make sure we get it right, all of us.

The CHAIRMAN. Thank you. We now know what an Iowa minute is, don't we?

Mr. WALZ. I spent a lifetime in Iowa one day.

Mr. YOUNG of Iowa. Come on back.

The CHAIRMAN. Thank you, Mr. Young. And thank you all of you all for being here today. I think you can see by the participation in today's hearing how important it is to this Committee that this work and work right. I mean, you would not have seen this kind of questioning and Members who were on a lot of different Committees taking time to be here. And I guess the final thing I would like to do is just to yield to Mr. Walz and see if he has any closing comments.

Mr. WALZ. Yeah, just a moment. I would thank the Chairman on behalf of all of us. Mr. Young, thank you. You are carrying on a legacy that did begin with Mr. Boswell and I am appreciative. All of you, thank you. I am incredibly hopeful. And Mr. Eitutis, your professionalism and passion gives me great reason to be hopeful. I appreciate that.

I would just close with those two most important groups that we are talking about here. To any of those veterans in crisis listening, this Nation loves you. We are here to help. There is a better day. Make that call. Talk to the family. Do what needs to be done. Because all of us want to get that right. To those employees out there picking up the phone, the same thing. I do not want them to take anything away from this other than we are eternally grateful for them. We need to give them the training, the tools, everything necessary, and the leadership for them to do what they are doing, and that is saving lives. So thank you for that and I appreciate the time. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. And once again, the folks out there in the trenches are the ones that our hats are off to, that are answering the phone right now as we speak. While we are talking, they actually are intervening with somebody, who perhaps is saving a life. And I want to thank them for that. We want to be sure that they have the resources they need to do their job.

And I guess one of the final things I want to leave on the table is a year ago, over a year, about a year ago we were told that VA was going to have all these manuals and have all these recommendations carried out and nothing happened. And nothing happened adversely to anybody. So what I would want to see you do is are we going to have that policy manual by the end of the year so people will know? That is very important for people to have that come on the job, to know what are my responsibilities? What kind of resources do we need for this job? And I think we need to know that. And if the IG report and the GAO report and since you agreed to it and do not carry it out, then something ought to happen to somebody if again nothing happens.

So I hope by the end of this year we can have a follow up that says this has been done and somebody has been held responsible for getting this done. It does sound like things are improving. But remember, 500,000, all those numbers are just numbers. It is an individual that really matters. That one person that picks up the phone call, the phone at 10:00 tonight, desperate. And make sure

that we have a human being on the other end who is empathetic to their problem and can get their needs met. That is the whole purpose of this meeting.

I ask unanimous consent that all Members be given five legislative days to revise and extend their remarks. And without objection, so ordered. This hearing is adjourned.

[Whereupon, at 12:04 p.m., the Committee was adjourned.]

# A P P E N D I X

## Prepared Statement of Michael J. Missal

Mr. Chairman, Ranking Member Walz, and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent work on the operations of the Department of Veterans Affairs' (VA) Veterans Crisis Line (VCL). My statement will discuss two OIG reports, one from March 2017, Healthcare Inspection - Evaluation of the Veterans Health Administration Veterans Crisis Line, and one from February 2016, Healthcare Inspection - Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York.

**BACKGROUND**

The tragedy of veteran suicide is one of the Veterans Health Administration's (VHA) most significant issues. The rate of suicide among veterans is significantly higher than the rate of suicide among U.S. civilian adults. VA's most recent estimate calculates that 20 veterans commit suicide a day. Of those veterans, approximately 14 have not been seen in VHA.

In 2007, VHA established a telephone suicide crisis hotline located at the Canandaigua, New York, VA campus. Initially called the National Veterans Suicide Prevention Hotline, its name changed to the VCL in 2011.[1] VHA established the VCL through an agreement with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). This agreement provided for VHA's use of the already existing National Suicide Prevention Line (NSPL) toll-free number for crisis calls.[2] The VCL was managed by the VHA Office of Mental Health Operations at the time of the February 2016 OIG report. Subsequently the VCL was realigned under VHA Member Services (Member Services), an organization within the Chief Business Office that runs customer call centers for VHA.[3]

The VCL is part of an overall strategy to reach out to veterans in a time of crisis with the goal of reduction of veteran suicide.[4] The VCL's primary mission is "to provide 24/7, world class, suicide prevention and crisis intervention services to veterans, service members, and their family members."[5] Since its launch in 2007, VCL staff have answered nearly 2.8 million calls and initiated the dispatch of emergency services to callers in crisis over 74,000 times.[6] Currently, the VCL responds to over 500,000 calls per year, along with thousands of electronic chats and text messages. The VCL initiates rescue processes for callers judged at immediate risk of self-harm. The number of calls to the VCL has increased markedly since the VCL's first full year of operation in 2007, with a corresponding increase in VCL annual funding. The total number of calls answered by the VCL and backup centers was 9,379 in 2007 and grew to 510,173 in fiscal year (FY) 2016. In FY 2010, the VCL was funded at $9.4 million, increasing to $31.1 million in FY 2016.

A component of the VCL's long-term continuing operations plan was to expand beyond the Canandaigua Call Center to a second site, to ensure geographic redundancy and meet increasing VCL demands. The VCL and VHA Member Services leadership determined that the Canandaigua Call Center location did not have the

[1] Veterans Crisis Line 1-800-273-8255 Press 1, https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx. Accessed December 4, 2016.

[2] The toll-free number is (800) 273-8255.

[3] VHA Member Services Member Services is an operation and support office within the Chief Business Office and has two main ″front-end″ elements of interaction with VA's health care enrollee population, providing oversight, review, and direct service in the following areas: Eligibility and Enrollment Determination and Contact Management.

[4] https://www.va.gov/opa/publications/factsheets/Suicide—Prevention—FactSheet—New—VA—Stats—070616—1400.pdf

[5] VCL Mission Statement.

[6] https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx. Accessed on March 27, 2017.

necessary space or applicant pool to allow for the needed future growth. An expansion site was chosen in Atlanta, Georgia, because Member Services had a preexisting call center infrastructure at its Atlanta-based Health Eligibility Center (HEC).[7] Planning began in July 2016 with a phased rollout of responding to calls starting in October 2016 and continuing over the next two months.

In our February 2016 VCL report, we identified several problems including crisis calls going to voicemail, a lack of a published VHA directive to guide organizational structure, quality assurance gaps, and contract problems. The February 2016 report resulted in seven recommendations and VHA concurred with the findings and recommendations. VHA provided an action plan and timeframe to implement those recommendations by September 30, 2016.

## INSPECTION OF VETERANS HEALTH ADMINISTRATION VETERANS CRISIS LINE

In June 2016, we received an allegation related to the experience of a veteran with the VCL and its backup call centers. As a result of the complaint, and in light of the open recommendations from the OIG's February 2016 report, we expanded our scope to conduct an in-depth inspection of the VCL. During our inspection, in August of 2016, we received a request from the Office of Special Counsel (OSC) to investigate allegations regarding training and oversight deficiencies with staff that assist call responders (Social Service Assistants/SSAs). This inspection, in addition to our previous inspection, found organizational deficiencies and foundational problems in the VCL. We also identified key changes needed by VA in order to achieve VA goals of service for veterans in crisis.

Our inspection included the following objectives:

- To respond to a complaint alleging that the VCL did not respond adequately to a veteran's urgent needs.
- To perform a detailed review of the VCL's governance structure, operations, and quality assurance functions in order to assess whether the VCL was effectively serving the needs of veterans.
- To evaluate whether VHA completed planned actions in response to OIG recommendations for the VCL, published on February 11, 2016, in our report titled Healthcare Inspection-Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York.
- To address complaints received from the OSC alleging inadequate training of VCL SSAs resulting in deficiencies in coordinating immediate emergency rescue services needed to prevent harm.

### Veteran's Urgent Needs

Regarding the first objective, we substantiated that VCL staff did not respond adequately to a veteran's urgent needs during multiple calls to the VCL and its backup call centers. We also identified deficiencies in the internal review of the matter by the VCL staff. In the interest of privacy, information specific to this veteran is not included in the report. However, relevant information has been provided in detail to VHA.

### Governance, Operations, Quality Assurance Functions

Governance is defined as the establishment of policies, and the continuous monitoring of their proper implementation, by members of the governing body of an organization.[8] During the time of our review,[9] the leadership, governance, and committee structure was in an immature state of development. Examples include a governance structure without clear policies and unclear mandates to review clinical performance measures and make improvements. These structural problems led to operational and quality assurance gaps.

In our February 2016 report, we cited the absence of a VCL directive as a contributor to some of the quality assurance gaps identified in the review. VHA concurred with this recommendation and provided an initial target date for completion of June 1, 2016. As of the publication of our March 2017 report, this action was not complete. We found continuing deficiencies in governance and oversight of VCL operations.

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[7] The HEC provides information and customer service on key veteran issues such as benefits, eligibility, billing, and pharmacy. https://www.va.gov/CBO/memberservices.asp. Accessed December 1, 2016.

[8] Business Dictionary's definition of governance.

[9] Our review period was from June through December 2016.

During the August 2016 site visit to Canandaigua, the VCL's acting director told us that the VCL was using the Baldridge [10] framework for governance. For the VCL, the central leadership group in this model would be the Executive Leadership Council (ELC). [11] The ELC integrates the business and clinical aspects of operating the VCL. We requested all ELC draft policies to ensure that the ELC had a process for achieving its intended goals. We were informed that no current policies related to the ELC existed and that creation of such policies was in progress. The VCL and the services it provides have grown considerably since 2007, but VCL leadership did not develop a plan until 2016 that defined the strategic approach for the VCL to provide consistent, timely, and high quality suicide prevention services. For its Baldridge framework goals, VCL leadership was unable to provide policies, dashboards, or quality monitors for this governance initiative.

Shortly after the publication of the 2016 OIG report, the VCL was realigned under VHA Member Services, although VA leadership stated that the VCL would remain closely tethered to VHA's clinical operations. VHA's Office of Suicide Prevention [12] leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention. However, we found a disconnect between the VHA Office of Suicide Prevention and Member Services in communicating about suicide prevention and the VCL. While the expectation was that Member Services and subject matter experts on suicide prevention would work closely together, we found substantial disagreement about key decisions and oversight between the two groups.

The lack of effective utilization of clinical decision makers at the highest level of VCL governance resulted in the failure to include fully clinical perspectives impacting the operations of the VCL. Administrative staff made decisions that had clinical implications. Examples include disagreements about the scope of services associated with core versus non-core calls [13] and the selection of training staff who did not have clinical backgrounds. Clinical leaders stated concerns about staff morale, decisions impacting VCL capacity of responders to assist callers in crisis promptly, and effective training of new responders.

Another example of deficient governance was a lack of permanent VCL leadership. During most of 2015, the VCL was without a permanent director. At the end of 2015, a permanent director was chosen. However, the new permanent director resigned his position in June 2016. As of December 2016, the VCL continued to operate without a permanent director.

**Operations**

The VCL was undergoing changes throughout our review. For example, there were three versions of the VCL organizational chart between June 2016 and September 2016. The evolving VCL staffing model was based on a service level of zero percent rollover, answering all calls within 5 seconds, and forecasting call volume based on historical interval data.

*Calls to VCL and Contracted Backup Centers*

To reach the VCL (Canandaigua or Atlanta) through its toll-free number, a caller is instructed to press 1 (for veterans) on the telephone keypad. If the caller does not press 1, the caller is routed to a National Suicide Prevention Line center. The caller still speaks with a responder. However, this route will take the caller to a non-VCL and non-VA contracted backup call center. If the caller presses 1, as instructed for veterans, and the call cannot be answered within 30 seconds by the VCL, it rolls over to a VA contracted backup center.

During our review, VHA leadership was in the process of implementing an automatic transfer function, which directly connected veterans who call their local VA

[10] The Malcolm Baldrige National Quality Award is the highest level of national recognition for performance excellence that a U.S. organization can receive. The award focuses on performance in five key areas: product and process outcomes, customer outcomes, workforce outcomes, leadership and governance outcomes, financial and market outcomes. https://www.nist.gov/baldrige/baldrige-award. Accessed December 23, 2016.

[11] ELC membership includes VCL Director, Chairperson, VCL Deputy Director, Business Operations Lead, Veteran Experience Lead, Employee Experience Lead, Partnerships Lead, Clinical Quality Lead, AFGE Leadership Member, Union Leadership Member, Clinical Psychologist, and CAC.

[12] The Office of Suicide Prevention leads suicide prevention efforts for VHA and coordinates and disseminates evidence-based findings related to suicide prevention.

[13] Core calls are calls defined as calls resulting in referral to the Suicide Prevention Coordinator and/or calls requiring the application of crisis management skills (example: a suicidal caller). Non-core calls are defined as those that do not require specific crisis intervention skills (example: a caller inquiring about benefits).

Medical Centers to the VCL by pressing 7 during the initial automated phone greeting. Member Services leadership determined that the implementation of various communication enhancements that increased VCL access, including Press 7, voice recognition technology, vets.gov, and MyVA311,[14] created increased demand for services.

When a call is answered by VCL staff, a trained crisis responder answers the call, and after engaging with the caller and building rapport, the responder asks about suicidal ideation.[15] Depending upon the caller's answer, the responder may conduct a more detailed assessment of lethality, which addresses a range of both suicide risk factors as well as protective factors. Callers may choose to remain anonymous and the responder may only be able to identify the caller by phone number.

We identified a deficiency in the VCL's processes for managing incoming telephone calls. Callers may decide to remain anonymous, but in every case responders document the incoming telephone number. However, responders must manually enter the number into the electronic documentation system, increasing the risk of human error. While reviewing responders' call documentation, we found that the documentation was often lacking in sufficient detail to facilitate retrospective assessment of the interaction between the caller and responder.

VCL call complaint data included callers' complaints about being on hold. We found that some contracted backup call centers used a queuing (waiting) process that callers may perceive as being on hold. During the queue time, or wait time, the caller waits for a responder to answer. The caller's only option is to abandon the call (hang up) and call back, or continue to wait for a responder to pick up. The backup centers had processes to record wait times and abandonment rates. We found that VCL leadership had not established expectations or targets for queued call times, or thresholds for taking action on queue times, resulting in a systems deficiency for addressing these types of complaints. At the time of our review, there were four contracted backup centers. Two of the backup centers queued calls and two did not queue calls.

VHA contracted with an external vendor[16] to manage backup center performance and report back to the VCL, with administrative and clinical oversight of the contract terms by VCL managers. We found that the VHA contracting staff and Member Services and VCL leaders responsible for verifying and enforcing terms of the contract did not provide the necessary oversight and did not validate that the contracted vendor provided the required services before authorizing payment.

*Atlanta Call Center*

On July 21, 2016, planning for the new Atlanta-based call center started. By November 21, 2016, Member Services anticipated that staffing at the Atlanta Call Center would be sufficient to allow for zero rollover calls to backup call centers.[17] Member Services leaders planned to have the Atlanta facility fully staffed and telephonically operational by December 31, 2016. Text and chat services would begin in June 2017.[18]

Member Services leaders made the decision to roll out the Atlanta Call Center without first establishing on-site leadership, a critical piece to ensuring proficient execution of call center function. The September 2016 VCL organizational chart called for Atlanta to have its own Deputy Director and Director for Team Operations. However as of September 20, 2016, even though the leadership positions had not even been advertised much less filled, the Atlanta office held its inaugural responder training class with plans to begin operations on October 10, 2016. As of November 8, 2016, this iteration of the organizational chart had been rescinded. VCL leadership structure reverted to that outlined in the July 2016 organizational chart, which does not include either a Deputy Director, a Director of Team Operations for Atlanta, or other leadership positions specific to the Atlanta Call Center.

Bringing the Atlanta Call Center online in a three-month period entailed the rapid hiring and training of new staff. The training content is the same for responders at both the Atlanta and Canandaigua sites, but with notable differences in trainer-to-learner ratios. For instance, in order to accommodate the sizable number of trainees, class sizes were larger at the Atlanta Call Center, ranging from 44 to 62

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[14] VA is introducing 1-844-MyVA311 (1-844-698-2311) as a go-to source for veterans and their families who do not know what number to call.

[15] Suicidal ideation is thinking about, considering, or planning suicide. Centers for Disease Control and Prevention, http://www.cdc.gov/violenceprevention/suicide/definitions.html. Accessed December 2, 2016.

[16] Link2Health Solutions, Inc.

[17] Backup centers will be used on a contingent basis.

[18] Responders are required to have 6 months of VCL telephone experience, prior to engaging in training for text and chat services.

trainees, versus 20 trainees per class at the Canandaigua Call Center. Once the responders completed classroom training and passed a proficiency test, they were assigned to work with a preceptor for one to three weeks. The preceptor-to-responder ratio at the Canandaigua Call Center is 1:1. The original plan for the Atlanta Call Center called for a 1:2 or 1:3 preceptor to responder ratio. However, due to limited preceptor availability and large class sizes, the ratios were as high as 1:16.

The supervisors hired to work at the Atlanta Call Center did not have the same skill set as those at the Canandaigua Call Center. Canandaigua Call Center supervisors first served in a responder role, while most Atlanta Call Center supervisors had not. Because of this, we were told that Atlanta Call Center supervisors would be required to complete responder training prior to supervisor training. One VCL supervisor told us that inexperience might detrimentally affect practice at the Atlanta Call Center because new responders, particularly linked with new supervisors, may be too quick to call rescues whereas more experienced responders may be able to de-escalate the situation. Despite the experiential and training differences between sites and the potential for variances in practice, with the exception of silent monitoring, we found no documentation of plans to compare metrics between sites, including rescue rates.

The rapid establishment of the Atlanta Call Center required that a substantial number of staff from the Canandaigua Call Center be detailed to the Atlanta Call Center to train staff as well as assist with workload. The diversion of Canandaigua Call Center staff to Atlanta in order to achieve VCL programmatic milestones also contributed to a delay in the development and implementation of policies, programs, and procedures for the VCL. Examples of delays cited by staff include the deferral of annual lethality assessment training for responders, the delayed rollout of chat and text monitoring at the Canandaigua Call Center, and delayed implementation and utilization of wellness programs.

Prior to the end of our review in December 2016, the VCL implemented audio call recording capability for incoming and outgoing calls for quality assurance purposes, but had yet to provide procedures, protocols, or policies that provided guidance for listening to or using recorded call information. VCL Quality Management (QM) program leaders could enhance performance improvement evaluations by using call recording to monitor the quality of interactions between responders and callers and by collecting and analyzing performance data from the new Atlanta Call Center separately from the Canandaigua Call Center. The new call center in Atlanta could have QM concerns that are no different from its Canandaigua partner, but the ability to recognize site-specific issues, especially in a new program, is facilitated by separating quality data elements by site.

**Quality Assurance**

Systematic collection of relevant and actionable data for analysis is crucial when making decisions that will prevent problems. To be effective, VCL's QM data collection and analysis should be accurate and inform VHA and VCL leadership and staff whether their actions effectively serve veterans and others who use VCL services. In our February 2016 report, we recommended that VHA establish a formal quality assurance process and develop a VHA directive or VHA handbook for the VCL. We reviewed the VCL QM program structure and processes, the VCL QM program manual, and the draft VCL directive and identified systems deficiencies in QM program processes. We further found that neither the VCL QM program manual nor the draft VCL directive provided a framework for a QM program structure.

*Quality Management Leadership*

VHA does have a directive that outlines leadership responsibilities for program integration and communication, and the designation of individuals with appropriate background and skills to provide leadership to promote quality and safety of care.[19] In order to implement the foundational principles of QM, leaders within a program must be able to promote, provide, and recognize QM practices that will lead to better outcomes. After reviewing the number and types of QM roles in the VCL, as well as QM staff experience and background, we determined that the challenges likely stemmed from the QM staff's lack of training in QM principles. Member Services leadership tasked QM staff with multiple responsibilities and competing priorities that included VCL QM program and policy development, data collection and analysis, data presentation for evaluation and action planning, and identification of outcomes measures. However, the QM staff had not been provided with training in the

[19] VHA Directive 1028, VHA Enterprise for Framework for Quality, Safety, and Value, August 2, 2013.

skills needed to provide leadership to promote quality and safety of care, leading to deficiencies in the QM program.

*Quality Management Data Analysis*

We found that while VCL staff collect data on clinical quality performance measures, the QM program lacked defined processes for analyzing and presenting data and for developing a committee structure for reporting the analysis, making recommendations and following up.

*Quality Management Committees and Planning*

VHA requires a standing committee to review data, information and risk intelligence, and to ensure that key quality, safety and value functions are discussed and integrated on a regular basis. This committee should be comprised of a multidisciplinary group, should meet quarterly, and should be chaired by the Director. We did not identify a VCL standing committee that met the intent of VHA requirements outlined in Directive 1026.

*Policies, Procedures, and Handbooks*

VHA Directive 6330 (1), Controlled National Policy/Directive Management System, established policy and responsibilities for managing, distributing, and communicating VHA directives. VCL policies have been created in response to external reviews and internal processes but a controlling directive has not yet been published. A draft directive was in development, dated April 4, 2016; however, it lacked defined roles and responsibilities for VCL leaders, such as the VCL Director. We found that VCL policies, procedures, or handbooks were not readily accessible for staff reference.

VCL leaders developed a QM Program Manual which was updated in July 2016 (no initial publication date was available). The program manual did not outline a framework for the QM program that is consistent with relevant existing VHA directives providing guidance for QM programs.

*Outcome Measures for Quality Improvement*

We found that while the VCL measured internal performance of its staff (silent monitors, End of Call Satisfaction question, and complaints), its QM data analysis did not include measures of clinical outcomes for callers. During interviews, we inquired about outcome measures to evaluate the success of a veteran's transition from the VCL to other dispositions. We identified deficiencies in the VCL QM program including data analysis and presentation of clinical quality performance measures, lack of development of a directive consistent with established VHA guidance, lack of a reporting structure for regular review of performance measures, and frequent changes in the organizational structure of the QM program. We found that deficiencies in the QM program were related to VHA leadership failing to provide a developmental plan, appointing staff into positions without formal QM training, and assigning staff multiple competing priorities. [20]

*Measurement of Program Success with Adverse Outcomes Reviews*

We found that the VCL had no process in place for routinely obtaining or reviewing data on serious adverse outcomes, such as attempted or completed suicides by veterans who made contact with the VCL prior to the event. We learned that adverse outcomes were not aggregated for review by VCL leadership in order to measure performance improvement for achieving more successful outcomes. The Acting Director and Acting Quality Assurance Clinical Officer confirmed that debriefings or other reviews were not conducted after known suicide attempts or completions. By not reviewing serious adverse outcomes, VCL QM managers missed opportunities for quality improvement.

We reported systems deficiencies in the VCL Quality Management program in our 2016 and 2017 reports. VHA provides a framework for QM program structure and leadership to ensure delivery of safe and effective care; however, we found multiple program deficiencies remained during our second review.

**Status of Recommendations from OIG's February 2016 Report**

In our report from February 2016, we made seven recommendations. VA concurred with the recommendations and at the time provided action plans and a time frame for implementation of all recommendations by September 2016. We reviewed VHA documents submitted as evidence to support the completion of the planned ac-

[20] VHA Directive 1026, VHA Enterprise for Framework for Quality, Safety, and Value, August 2, 2013.

tions. However, VHA has not completed the planned actions and we consider those recommendations as open. We would note that VHA established the time frame for implementation and not the OIG.

**Inadequate Training Allegations Received from OSC**

We found that VCL managers developed a process for monitoring the quality of crisis intervention services provided by responders; however, VCL lacked a process for monitoring the quality of performance by SSAs. We identified deficiencies in SSA training and substantiated complaints referred to us by the OSC in regard to SSA training and performance. Specifically, we substantiated that SSAs were allowed to coordinate emergency rescue responses independently after the end of a 2-week training period, without supervision and regardless of performance or final evaluation; that in mid-2016, a newly trained SSA contacted a caller in crisis by telephone to solicit the veteran's location, although we found that no harm resulted from the interaction; and we substantiated a lack of documentation by an SSA when closing out a veteran's case in mid-2016. We could not substantiate an allegation that documentation by an SSA resulted in conflicting information about a veteran being contacted within 24 hours. The complainant (who remained anonymous) was not interviewed by us, and we did not have identifiers for the veteran caller.

**Report Recommendations**

The OIG recommendations from 2016 and 2017 fall into the categories of governance/leadership, operations, and quality assurance. It is noteworthy that many of these recommendations cut across all three categories.

- *Governance* - Governance recommendations include the establishment of a VCL directive that guides structure, roles, and responsibilities. Additional recommendations include that the governance structure ensures cooperation between clinical and administrative leadership. We also recommended that lines of authority delineate that clinical leadership make clinical policy decisions.
- *Operations* - Operations recommendations include that SSAs are certified by supervisors before engaging in independent assistance with rescues. Other recommendations involve information technology infrastructure including an automated process for transcription of telephone numbers, and audio call recording with related policies and procedures. We recommended improved control of policy and document management so that updated policies and procedures and related staff training can be tracked. We issued recommendations related to backup center and contractor performance, including an enforceable quality assurance surveillance plan for contracted backup centers, and establishing targets for rollovers and call queuing. We recommended that contractors are held to the same standards as the VCL, and contract performance is monitored to assure that the terms of the contract are met. We also recommended that contractor performance is verified prior to payment.
- *Quality Assurance* - Quality assurance recommendations include establishing a formal quality assurance process that incorporates policies and procedures consistent with the VHA framework. Other recommendations include QA leadership being fully trained in QA principles, evaluating negative clinical outcomes in order to improve, and ensuring that VCL silent monitoring frequency meets established VCL standards. We also recommended that VCL develop structured oversight processes for tracking and trending of clinical quality performance measures. We recommended that quality data be used to enhance performance, that call recording be used for quality assurance, and that Canandaigua and Atlanta are analyzed separately with performance measures. We recommended consistent quality assurance and monitoring policies are established for responder staff and SSAs.

A complete listing of the individual recommendations from both reports is attached in Appendix A and Appendix B.

**CONCLUSION**

Our 2016 and 2017 VCL inspections identified various challenges facing the VCL in their mission to provide "suicide prevention and crisis intervention services to veterans, service members, and their family members." We found numerous deficiencies and made seven recommendations in the 2016 inspection and sixteen additional recommendations in the 2017 inspection. All recommendations remain open today. Until VHA implements fully these recommendations, they will continue to have challenges meeting the VCL's critically important mission.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or members of the Committee may have.

**Recommendations from Healthcare Inspection - Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York (February 11, 2016)**

**Recommendation 1.** We recommended that the OMHO (now VHA Member Services)[21] Executive Director ensure that issues regarding response hold times when callers are routed to backup crisis centers are addressed and that data is collected, analyzed, tracked, and trended on an ongoing basis to identify system issues.

**Recommendation 2.** We recommended that the Member Services Executive Director ensure that orientation and ongoing training for all VCL staff is completed and documented.

**Recommendation 3.** We recommended that the Member Services Executive Director ensure that silent monitoring frequency meets the VCL and American Association of Suicidology requirements and that compliance is monitored.

**Recommendation 4.** We recommended that the Member Services Executive Director establish a formal quality assurance process, as required by VHA, to identify system issues by collecting, analyzing, tracking, and trending data from the VCL routing system and backup centers, and that subsequent actions are implemented and tracked to resolution.

**Recommendation 5.** We recommended that the Member Services Executive Director consider the development of a VHA directive or handbook for the VCL.

**Recommendation 6.** We recommended that the Member Services Executive Director ensure that contractual arrangements concerning the VCL include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.

**Recommendation 7.** We recommended that the Member Services Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.[22]

**Recommendations from Healthcare Inspection - Evaluation of the Veterans Health Administration Veterans Crisis Line (March 20, 2017)**

**Recommendation 1.** We recommended that the Under Secretary for Health implement an automated transcription function for callers' phone numbers in the Veterans Crisis Line call documentation recording system.

**Recommendation 2.** We recommended that the Under Secretary for Health ensure that Veterans Crisis Line policies and procedures, staff education, Information Technology support, and monitoring are in place for audio call recording.

**Recommendation 3.** We recommended that the Under Secretary for Health implement a Veterans Crisis Line governance structure that ensures cooperation and collaboration between VHA Member Services and the Office of Suicide Prevention.

**Recommendation 4.** We recommended that the Under Secretary for Health develop clear guidelines that delineate clinical and administrative decision-making, assuring that clinical staff make decisions directly affecting clinical care of veterans in accordance with sound clinical practice.

**Recommendation 5.** We recommended that the Under Secretary for Health ensure processes are in place for routine reviewing of backup call center data, establish wait-time targets for call queuing and rollover, and ensure plans are in place for corrective action when wait-time targets are exceeded.

**Recommendation 6.** We recommended that the Under Secretary for Health ensure processes are in place to require contracted backup centers to have the same standards as the Veterans Crisis Line related to call queuing and wait-time targets.

**Recommendation 7.** We recommended that the Under Secretary for Health ensure that VHA Member Services leadership, Veterans Crisis Line leadership, VHA Contracting Officers, and Contracting Officer Representatives implement the quality control plan and conduct ongoing oversight to ensure contractor accountability in accordance with their roles as specified in the contract with backup call centers.

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[21] The VCL was realigned under VHA Member Services in the spring of 2016. At the time the February 2016 OIG report regarding the VCL was published, the Office of Mental Health Operations was responsible for the VCL.

[22] VCL staff consider rescues, welfare checks, and dispatch of emergency services to be equivalent terms.

**Recommendation 8.** We recommended that the Under Secretary for Health ensure that training is provided to Veterans Crisis Line quality management staff in the skills needed to provide leadership to promote quality and safety of care.

**Recommendation 9.** We recommended that the Under Secretary for Health ensure the development of structured oversight processes for tracking, trending, and reporting of clinical quality performance measures.

**Recommendation 10.** We recommended that the Under Secretary for Health ensure processes for Veterans Crisis Line quality management staff to collect and review adverse outcomes so that established cohorts of severe adverse outcomes are analyzed.

**Recommendation 11.** We recommended that the Under Secretary for Health direct the Veterans Health Administration Assistant Deputy Under Secretary for Health for Quality, Safety, and Value to review existing Veterans Crisis Line policies and determine whether the policies incorporate the appropriate Veterans Health Administration policies for veteran safety and risk management, and if not, establish appropriate action plans.

**Recommendation 12.** We recommended that the Under Secretary for Health ensure that Veterans Crisis Line quality management staff incorporate call audio recording into quality management data analysis.

**Recommendation 13.** We recommended that the Under Secretary for Health ensure that processes are in place to analyze performance and quality data from the Atlanta Call Center separately from the Canandaigua Call Center data.

**Recommendation 14.** We recommended that the Under Secretary for Health ensure that quality assurance monitoring policies and procedures are in place and consistent for both Social Service Assistants and responders.

**Recommendation 15.** We recommended that the Under Secretary for Health ensure that supervisors certify Social Service Assistant training prior to engaging in independent assistance with rescues.

**Recommendation 16.** We recommended that the Under Secretary for Health ensure a process is in place to establish, maintain, distribute, and educate staff on all Veterans Crisis Line policies and directives that includes verifying the use of current versions when policies and directives are modified.

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**Prepared Statement of Kayda Keleher**

Chairman Roe, Ranking Member Walz and members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, I want to thank you for the opportunity to present the VFW's views on the Department of Veterans Affairs (VA) Office of the Inspector General's (OIG) report on the Veterans Crisis Line (VCL).

In 2007, Department of Veterans Affairs Health Administration (VHA) established a suicide hotline. The hotline, which later became known as the VCL, was established to provide 24/7, suicide prevention and crisis intervention to veterans, service members and their families. This was necessary as a means of constant availability to individuals in need of crisis intervention. The VCL provides crisis intervention services to veterans in urgent need, and helps them begin their path toward improving their mental wellness. The VCL plays a critical role in VA's initiative of suicide prevention, and ongoing efforts to decrease the estimated 20 veterans who die by suicide each day. The VCL answers more than 2.5 million calls, responds to more than 62,000 text messages and initiates the dispatch of emergency services more than 66,000 times each year. Yet, there is still more work that must be done to improve the VCL.

The VA OIG released a report March 20, 2017. This report came after the United States Government Accountability Office (GAO) release of another VCL report in May 2016. Of the four objectives highlighted by VA OIG, there are 16 recommendations. The VFW applauds the VCL for the progress it has made since the reports were released. To continue improvements the VCL must improve quality control, implement clinical oversight and increase collaboration.

**Quality Control**

From January 1 - March 11, 2017 the VCL received a total of 133,694 calls between their two locations in Canandaigua, N.Y., and Atlanta, Ga. Of those calls, 552

were rolled over to a backup call center. It is also worth noting VA does not have the capability of monitoring any calls which are sent to their Substance Abuse and Mental Health Services approved backup call centers. While 552 unanswered VCL phone calls may seem high, the VFW believes rollover calls cannot be completely eradicated. We believe the goal of VCL responders should be quality of crisis intervention, not quantity of calls answered. Though it should still be a priority for responders to answer as many calls as possible, the number one goal must be successful crisis intervention. Yet, without being able to promise every veteran it is completely practical for the employees in New York and Georgia to always have somebody available to answer the call, it is imperative VCL continue contracting backup call centers with oversight and monitoring of the quality of those calls. Since the mark of the New Year, VCL roll overs have decreased from 1.99 percent of calls to anywhere from .02 to .47 percent of calls. This is a huge improvement since November 2016, when 31.34 percent of calls were being sent to backup centers and throughout much of the time VA OIG was doing its investigation. The consistent and dramatic decreases in amount of calls being sent to backup centers can be directly correlated with the second VCL location opening in Atlanta, Ga., on Oct. 1. Each individual employee at the VCL is answering an average of nine calls per day, and those calls are being answered quicker than 911 and the National Emergency Number Association standards. While these improvements compared to the past are commendable, the VCL must focus on quality of crisis intervention provided- not strictly on quantity of calls answered. The VFW believes with the right adjustments, VCL staff can maintain this quantity of service while also improving the quality.

Precise numbers of non-veterans and veterans not in a mental health crisis calling VCL are unknown. Last year it was publicized that four callers were calling and harassing VCL employees thousands of times, estimates of four percent of incoming calls were to harass VCL responders. Other veterans admit to calling VCL when not in mental health crisis because it is the first phone number they see publicly available. They have called in hopes of being able to schedule appointments or to complain about unsatisfactory care they received. Completely screening these calls and assuring only individuals in crisis are calling the VCL is not practical, and most callers are in need of some level of intervention. Crisis is defined individually, and everyone in crisis deserves support. Yet the VFW is concerned some of the calls not being answered by VCL responders may be due to non-crisis callers clogging the system.

The VFW believes expanding VA's Office of Patient Advocacy would greatly benefit the VCL. By improving and expanding the patient advocacy offices throughout VA, employees of these offices would have better visibility and means to assist non-crisis patients. If veterans become more aware of the patient advocate mission and capabilities, non-crisis callers to the VCL would decrease. The VFW has been working to expand and improve patient advocacy within VA and we will continue to monitor progress. The VFW urges this Committee to conduct extensive oversight of the VA Patient Advocate Program to ensure veterans are able to have their non-emergent concerns addressed without having to call the VCL.

Employees at VCL undergo extensive training before being allowed to answer calls, and it takes at least six months before they may begin training to also answer chat and text conversations with veterans in crisis. Yet it was not until late December 2016 that the VCL had the capability to record and monitor their calls. Without this crucial technological capability, there was no way for calls to be truly monitored for quality control. Now that this capability is available the technology must be properly utilized. Staff at VHA and the VCL monitor some ongoing calls for quality assurance, but a better, constant, process must be implemented to ensure these recordings are being used to improve the training and capabilities of VCL responders. This would not only improve crisis intervention, but would assist with ending allegations of responders not understanding or following protocol, instructions and resources.

Over the last six months, turnover rate for employees at both VCL locations have been far below the national average. Canandaigua currently has 361 employees, they have lost 15 employees since October 2016, with a turnover rate of 4.1 percent. In Atlanta, there are currently 275 employees. The Atlanta call center has lost 10 employees since October 2016, with a turnover rate of 3.6 percent. According to a 2015 study published by Nursing Solutions, Inc., the average turnover rate for health care employers was 19.2 percent. This may in part be due to increased morale thanks to the VCL employee wellness program. Leadership at VCL took notice in the past to low morale amongst employees, which is completely reasonable given the nature of responders' jobs. The employee wellness program provides responders at VCL 15 minutes to prepare themselves mentally before and after their shifts. This allows them time to enter the mindset necessary for their emotionally demand-

ing job, as well as time to decompress and adjust their mindset or talk amongst others before leaving their workplace. The employee wellness program also improved the supervisor to responder ratio. Prior to the program, there were 20 employees for every supervisor. The ratio was decreased to ensure the needs of employees are not overseen so that now there are 11 employees to every one supervisor.

**Clinical Oversight**

There is no doubt clinical oversight at VCL is a necessity. Clinical decision making must be made by clinicians and not by operations and administrative staff. Leadership running the VCL must also have clinical background. This would ensure veterans in crisis who call the VCL receive the best clinical judgement and assistance possible. Clear guidelines must be established for the VCL so non-clinicians are not forcing a clinically based crisis line to operate as a business. This has a clear link to quality control as well. The VFW believes that while the number of calls going to backup centers decreasing at such a rapid rate is a positive, it is not a sign of the quality of work being provided. Veterans, service members and their families deserve the best clinical care available, and VA is known for outperforming the private sector in many areas of health care. In fact, of the estimated 20 veterans who commit suicide every day, only six of them are enrolled in VHA. This shows that clinicians within VA know what they are doing, and they do it well.

The VFW believes VHA must establish both clinical and operational policies specific to the VCL. This would allow for easier protocol standards to be understood and met on a regular basis, while establishing guidance and regulations to continue being followed by employees without clinicians stepping on the toes of operations, or operations stepping on the toes of clinicians.

In March 2016, VCL established a Clinical Advisory Board at the request of VHA Member Services. This board was intended to assist and work with VHA Member Services, to assure no clinical necessities were being dismissed after VCL operations were moved to the non-clinical office within VHA. This group was intended to assist VHA Member Services in collective expertise of clinicians to improve the veteran experience, efficiencies of employees and increase access to the VCL. The charter for the advisory board was later changed by different leadership within VHA Member Services. The board now has one meeting per month where they call in for one hour. Call data is presented to the board members, but a monthly hour long meeting does not provide them with the means to effectively obtain clinical input for policy decisions to improve the VCL.

**Collaboration**

The VFW firmly believes VCL has improved and will continue to improve. Though that improvement will continue to be slow, frustrating and life-endangering if VCL does not begin collaborating with others. Aside from working with patient advocacy offices to cut down on non-crisis calls and VHA Member Services to re-adjust the advisory board and increase clinicians- VCL must also work more closely with the Office of Suicide Prevention (OSP).Member Services has undoubtingly assisted VCL in quantity control, but OSP can also assist VCL in quality control. If the goal of the VCL is to intervene on veterans in need of immediate assistance while they are in the middle of a mental health crisis - the VCL should be working with the subject matter experts and leaders in suicide prevention and outreach for VA. If all three offices could collaborate together, with better guidelines, Member Services must be able to continue improving VCL call center expertise and business, while OSP can make sure the VCL is up-to-date with the most current clinical expertise on suicide prevention and outreach.

**Prepared Statement of Melissa Bryant**

Chairman Roe, Ranking Member Walz, and Distinguished Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, thank you for your time last week as IAVA introduced our She Who Borne the Battle Campaign. We look forward to working with you and your staff to fully recognize and improve services for women veterans. We also thank you for the opportunity to share our assessment of ongoing concerns with the Veterans Crisis Line (VCL) today. Mental health and suicide prevention remains one of the top concerns of our members, where an overwhelming 75% of respondents to our latest survey (to be published later this spring) still believe troops and veterans are not getting the care they need for mental health injuries.

I am here today not only as IAVA's Director of Intergovernmental Affairs, but also as a former Army Captain and a combat veteran of Operation Iraqi Freedom. I was a military intelligence officer, a leader of men and women in combat, and I bore witness to the trauma and anguish several of my soldiers and friends endured when dealing with suicidal ideations or attempts. I bore the battle with these brave men and women, with two soldiers in particular—one male and one female— who were under my direct charge and I felt a special duty to protect and care for. And while I am eternally grateful these two soldiers were saved by mental health interventions, I mourn the loss of my sisters and brothers in arms who lost their battle and died by suicide. I am giving voice to all of us who served and the invisible wounds of war as I speak today.

In 2007, IAVA fought for and celebrated the passage of the Joshua Omvig Suicide Prevention Act, which among other things required the establishment of a hotline to provide information on and referrals to mental health services. This established the VCL. IAVA signed an Memorandum of Agreement with the VCL in 2012, and continues to partner with them today to both ensure our members are aware of the critical services the Crisis Line offers, as well as to provide crisis support to clients who are seeking support from IAVA's Rapid Response Referral Program (RRRP). To date, our RRRP Veteran Transition Managers (VTMs) have referred nearly 200 clients to the VCL. These clients share both positive and negative stories of their experiences with the VCL. IAVA wants to get to a place where all of the feedback we get about the VCL is positive.

The Veterans Crisis Line provides a critical service to veterans and their loved ones. Since its inception, the crisis line has provided around the clock support to 2.8 million calls, engaged in 332,000 chats and answered 67,000 texts. IAVA recognizes the life-saving services the VCL offers every day. It is a vital resource for our community, and we are committed to ensuring that it continues to fulfill its mission to provide 24/7, world class suicide prevention and crisis intervention services to veterans, service members, and their family members.

Media reports covering the recent Department of Veterans Affairs Office of the Inspector General Report, Evaluation of the Veterans Health Administration Veterans Crisis Line focused on the finding that the Veterans Crisis Line could not handle call volume and had to rely on a back-up call center to field these calls. The VA has addressed this specific piece in their press release and data that they've shared with the community. But they haven't addressed the additional findings of the IG report that point to larger, more systemic issues. These findings point to institutional challenges with the VCL: its governance structure, operations, and quality assurance protocols. These are the deficiencies that still need to be addressed.

IAVA strongly urges the VA to reconsider its management structure of the Veterans Crisis Line. There must be a dual leadership structure in which an operations lead can oversee the functional aspects of the call line while a clinical lead oversees the clinical aspects. These roles must be complementary and cooperative to ensure the success and safety of the those both clients of the VCL and the responders who are answering their calls. Finally, the Office of Suicide Prevention must be heavily engaged with the operations, quality assessment, and oversight of the VCL.

IAVA already brought some of these concerns before the committee last year, particularly regarding the governance structure and quality control measures. In 2016, the VA moved the VCL from the directorship of the VA Suicide Prevention Office to VA Member Services. While VA Member Services oversees all of the call lines at VA, what makes the VCL different is it inherently requires a strong clinical component. We worried that the restructuring was discounting the clinical piece that is so critical to the success of the Crisis Line. Specifically, we raised the following questions:

- Understanding that there are existing quality standards in place at VCL, are these standards being enforced?
- Are they being met?
- Do these standards apply to contracted call centers, as well?
- Are the existing standards strict enough to ensure no call goes unanswered?

We recommended in 2016 the VA consider shifting management back to the Suicide Prevention Office, with consultation on operations from Member Services of another appropriate entity, to ensure appropriate operational management of the call line.

The IG report confirmed our concern that not enough is being done to manage quality across the VCL calls or more broadly, define through data how the VCL accomplishes its mission. Some of our questions were answered in conversations with the VA. The VA shared with IAVA a quality management matrix that is being used to assess call quality. We feel this matrix does a decent job of setting baseline stand-

ards for each phone call, but does not go far enough to assess broader program effectiveness or implement a higher standard of clinical care for callers. The delay in implementing this in Atlanta is a real issue, but the VA assures us that delay has been remedied. We encourage the VA to share those data with the veteran community and Congress on a regular basis, as we all have skin in the game when it comes to ensuring the VCL is running efficiently and effectively. The IG report also highlights concern that the Atlanta call center was opened too quickly and the staff were ill prepared to handle the case load placed on them. IAVA agrees and hopes the VA will be transparent in sharing solutions to address these challenges. Finally, we understand that the VA continues to work to define expectation for the contracted call centers to ensure no call goes unanswered and to refine expectations for these centers, an absolutely critical aspect of this conversation.

IAVA implores the VA to also consider whether the level of clinical support provided to each call responder is appropriate, how the VCL is addressing self-care among responders, and what mechanisms are in place to prevent staff burnout and experienced responders from moving on. Appropriate and continued training is critical to ensure call quality, but training cannot be replaced with experience, and the VA must ensure that it has protocols in place to support its staff. Compassion fatigue is real. The employees answering the calls of veterans, service members, and families are dedicated and tireless advocates. We, and the VA, owe it to them to ensure they are being cared for and supported both emotionally and professionally. We strongly believe there is a robust way to silently monitor and review calls, both for quality management and clinical review, which would require an expansion of the current quality assurance protocol. Given the challenges the IG report highlights with training, particularly at the opening of the Atlanta call center, IAVA believes this is critical for both continued staff training and staff support.

We also believe that a strong clinical program will allow a ratio of one clinician to ten responders and will encourage weekly reviews of calls with rigorous review and critique of call responses. The current emphasis on business process and optimized workflow over individualized, clinical service to a veteran in crisis places already vulnerable veterans in peril. And applying a sterilized quality assurance protocol that could also be templated for determining a customer service rating for your home cable installer is woefully insufficient for our veterans.

While quality control is an important aspect of assessing the VCL, again, application of a larger program evaluation is critical. We would expect that the Veterans Crisis Line would fall under the purview of two bills championed by IAVA: the Clay Hunt SAV Act, which requires annual evaluation of VA's mental health and suicide prevention program; and the Female Veterans Suicide Prevention Act, which goes a step further to require analysis of these programs by gender. IAVA's She Who Borne the Battle Campaign is anchored in the fact that women veterans are the fastest growing veteran population, yet often go unrecognized. We do not know how many women veterans use VCL, nor how effective VCL is at providing support for women, or even how they are welcomed by a responder that is answering their call. As part of our She Who Borne the Battle Campaign, we recognize that the motto of the VA functions as a symbolic barrier perceived by many women veterans like myself, emblematic of our lack of parity in care compared to our male counterparts; perhaps this culture is trickling down to the VCL, but a holistic program evaluation including gender-specific data should be conducted to know for certain.

We point to IAVA's own best-in-class case management and referral program, the Rapid Response Referral Program, as a model. This high-tech, high-touch program provides one-on-one support, connecting veterans, service members and their families to a highly skilled and trained Veteran Transition Manager with a Masters in Social Work. It is supported without government funding by generous foundations like the Wonderful Foundation, The Annenberg Foundation, The Goldhirsh Foundation, the New York State Health Foundation, the Robin Hood Foundation, the May and Stanley Smith Charitable Trust, and the Schultz Family Foundation, among others. Since its inception in 2012, we have served over 7,800 clients, 20% of them women, connecting them quality resources and benefits. We have put a strong emphasis on client follow-up and customer satisfaction at RRRP. Programs like RRRP can help complement the VCL and be valuable partners by supporting veterans and their families who are not in immediate crisis, but are at risk if these types of services are not provided; support for these programs is critical.

RRRP's VTMs engage in rigorous follow-up with clients prior to closing their case to ensure their needs have been met and referrals made are providing quality level of services and support. They also regularly follow-up with referral partners to ensure that they are connecting with RRRP clients and continuing to provide the standard of service that our program advertises. We believe the VCL could benefit from our model. To truly understand the impact of the VCL, the metrics must go

beyond the number of calls or the number of emergency services dispatched. The VCL must conduct routine follow-up calls with clients and referral partners and regularly review VA data sources to ensure service delivery and better quantify the impact of the VCL.

In closing, I cannot emphasize enough on behalf of IAVA the gratitude that we have for those who staff the VCL call lines and are there to support the tens of thousands of calls received each year. In our 7th Annual Member Survey, nearly 20% of respondents had reached out to the VCL on their own behalf or on behalf of someone they loved. It continues to be a resource well known and highly recommended by IAVA members for mental health support. This is a critical, often lifesaving resource for our community. 65% of respondents to our latest survey personally know a post-9/11 veteran who attempted suicide, while 58% of respondents to our survey personally know a veteran who died by suicide. And as one of those respondents to our survey who personally knows veterans who have either attempted or died by suicide, this issue is deeply personal to me, and one we must resolve swiftly.

It's important to emphasize that these reports and conversations should not deter our community from reaching out, but rather reinvigorate Congress, the VA and the VSO community to work together to continue improving this critical program. I think this is best captured by a statement made by the VA OIG report in its opening pages, which highlights the inherent challenges facing the VCL and other programs like it, but also the critical benefit:

The VCL faces two major challenges. First is to meet the operational and business demands of responding to over 500,000 calls per year, along with thousands of electronic chats and text messages, and initiating rescue processes when indicated. Second is to train staff to respond to veterans and their family members in individual encounters. These complex and difficult challenges are not unique to the VCL as we observed other crisis hotlines that face similar issues. Although we made findings and recommendations concerning the VCL, we note an unwavering and impressive commitment by VCL staff who compassionately assist veterans in crisis.

Members of the Committee, thank you again for the opportunity to share IAVA's assessment of the Veterans Crisis Line with you here today. We look forward to working with each of you and the VA in the months to continue to improve this essential resource. I look forward to answering any questions you may have.

**Prepared Statement of Steve Young**

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

**Introduction**

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

**Positive Actions Taken to Date**

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

- Launching "Veterans Chat" in 2009, an online, one-to-one chat service for Veterans who prefer reaching out for assistance using the Internet. Since its inception, we have answered nearly 314,000 requests for chat.
- Expanding modalities to our Veteran population by adding text services in November 2011, resulting in nearly 62,000 requests for text services.
- Opening a second VCL site in Atlanta in October 2016, with over 200 crisis responders and support staff.

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

VCL is the strongest it has been since its inception in 2007. VCL staff has forwarded over 416,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with their local VA providers. Initially housed in 2007 at the Canandaigua VA Medical Center in New York, it began with 14 responders and two health care technicians answering four phone lines. In the past 6 months, VCL has nearly doubled the capacity to ensure appropriate access to Veterans. Today, the combined facilities employ more than 500 professionals, and VA is hiring more to handle the growing volume of calls. Atlanta offers 200 call responders and 25 social service assistants and support staff, while Canandaigua houses 310 and 43, respectively. Despite all this, there still is more that we can do.

**VA Office of Inspector General (OIG) Report**

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

**Response**

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

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

**Progress**

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

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

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

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

**Weekly VCL Access Table**

| Week for 2016–2017 | Total Number of Calls | Total Rollovers | Rollover % |
|---|---|---|---|
| **10/30 - 11/5** | 10558 | 3309 | 31.34% |
| **11/6 - 11/12** | 10485 | 2274 | 21.69% |
| **11/13 - 11/19** | 11344 | 2484 | 21.90% |
| **11/20 - 11/26** | 9508 | 1363 | 14.34% |
| **11/27 - 12/3** | 12477 | 2097 | 16.81% |
| **12/4 - 12/10** | 12,380 | 1,488 | 12.02% |
| **12/11–12/17** | 12,613 | 1,396 | 11.07% |
| **12/18 - 12/24** | 12,257 | 640 | 5.22% |
| **12/25 -12/31** | 12,852 | 507 | 3.94% |
| **1/1 - 1/7** | 14,768 | 294 | 1.99% |
| **1/8 - 1/14** | 12,233 | 58 | 0.47% |
| **1/15 - 1/21** | 14,117 | 58 | 0.41% |
| **1/22 - 1/28** | 12,768 | 16 | 0.13% |
| **1/29 - 2/4** | 13,309 | 11 | 0.08% |
| **2/5 - 2/11** | 13,925 | 3 | 0.02% |
| **2/12 - 2/18** | 12,690 | 10 | 0.08% |
| **2/19 - 2/25** | 12,956 | 12 | 0.09% |
| **2/26 - 3/4** | 13,193 | 28 | 0.21% |
| **3/5 - 3/11** | 13,735 | 62 | 0.45% |
| **3/12 - 3/18** | 13,711 | 16 | 0.12% |
| **3/19 - 3/25** | 13,966 | 16 | 0.11% |

The No Veterans Crisis Line Call Should Go Unanswered Act (Public Law 114–247) directed VA to develop a quality assurance document to use in carrying out VCL. It also required VA to develop a plan to ensure that each telephone call, text message, and other communication to VCL, including at a backup call center, is answered in a timely manner by a person. This is consistent with the guidance established by the American Association of Suicidology. In addition to adhering to the requirements of the law, VCL has enhanced the workforce with qualified responders to eliminate routine rollover of calls to the contracted backup center. We also implemented a quality management system, to monitor the effectiveness of the services provided by VCL. This also will enable us to identify opportunities for continued improvement. As required by law, VA will submit a report containing this document and the required plan to the House and Senate Veterans Affairs Committees by May 27, 2017.

**Conclusion**

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

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

## Statements For The Record

### The Government Accountability Office (GAO)

Chairman Roe, Ranking Member Walz, and Members of the Committee:

We are pleased to submit this statement on our May 2016 report regarding the Department of Veterans Affairs' (VA) Veterans Crisis Line (VCL).[1] Upon returning home from deployments in Afghanistan, Iraq, Vietnam, and other locations, many servicemembers struggle with mental health issues, including post-traumatic stress disorder, depression, and substance abuse. Several of these mental health issues have been identified as risk factors for suicide among veterans. As part of the continuum of mental health services it provides, VA established the VCL in July 2007.[2]

The VCL supports veterans in emotional crisis and helps implement VA's goal of improving mental health outcomes for servicemembers, veterans, and their families through a number of actions-including reducing barriers to seeking mental health treatment and expanding access to VA services. During the time of our review for the May 2016 report, the VCL operated through a VA-operated primary center staffed with VA-employed responders and five backup call centers that provided additional responders and other services through a backup call coverage contract.[3] Veterans can access the VCL by calling a national toll-free number-1-800-273-TALK (8255). The VCL and the National Suicide Prevention Lifeline (Lifeline) share this national number through an interagency agreement between the VA and the Substance Abuse and Mental Health Services Administration (SAMHSA).[4] In addition to responding to calls, the VCL can also be accessed via online chat and text message.

Since it was established, demand for the VCL's services has exceeded VA's expectations. The VCL received about 534,000 calls in fiscal year 2015, an almost 700 percent increase from the about 67,000 calls it received in fiscal year 2008, its first full year of operation. In response, VA steadily increased the VCL's spending from about $3 million to $30 million from fiscal year 2008 through fiscal year 2015, devoting additional staff and resources to the VCL over time. As VA endeavored to address increasing numbers of requests for assistance, reports of dissatisfaction with VCL service periodically appeared in the media, and the VA Office of Inspector General was asked to investigate complaints about the VCL's lack of timely response to callers.[5] The Inspector General identified gaps in the VCL quality-assurance process, including challenges associated with supervisory review, tracking of issues, and collection and analysis of data from VCL backup call centers. In addition, the Inspector General found that in some cases callers did not receive immediate assistance from responders.

Our statement discusses (1) the extent to which VA met response-time goals for calls, online chats, and text messages received through the VCL; (2) how VA monitored the performance of the VCL primary center responders and call center operations; and (3) how VA worked with VCL service partners-backup call centers and SAMHSA-to help ensure veterans receive high-quality service from responders. This statement is based on our May 2016 report on VA's oversight of the VCL as well as updates from VA and SAMHSA about efforts to address the report's recommendations.

For the May 2016 report, we made covert test telephone calls, text messages, and online chats to assess the extent to which VA met its response-time goals through the VCL. The test calls included a generalizable sample of 119 calls that could be used to describe all callers' wait times when calling the VCL during July and August of 2015. We also sent a nongeneralizable sample of 15 test online chats to the VCL and 14 test text messages during the same time period. In addition, we examined telephone call, online chat, and text message data and summary reports from

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[1] GAO, Veterans Crisis Line: Additional Testing, Monitoring, and Information Needed to Ensure Better Quality Service, GAO-16-373 (Washington, D.C.: May 26, 2016).

[2] VA established its crisis line at the VA medical center located in Canandaigua, New York. The original name of VA's crisis line was the National Veterans Suicide Prevention Hotline until it was rebranded as the VCL in 2011.

[3] For the purposes of this statement, the term ″VCL service partners″ includes the Substance Abuse and Mental Health Services Administration (SAMHSA), the VCL backup call coverage contractor, and the backup call centers that this contractor used to provide coverage to the VCL at the time of our 2016 review. VA has since opened an additional call center in Atlanta.

[4] The VCL is distinct from Lifeline, which operates through a network of private, nonprofit providers working independently of one another while maintaining agreed-upon clinical standards. SAMHSA is an agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA funds a cooperative agreement grant to administer Lifeline with the same entity that VA contracts with to provide VCL backup call coverage. Through this interagency agreement, VA and SAMHSA set out to establish a seamless crisis management system through a collaborative and cooperative relationship between the agencies that provides consistent suicide prevention techniques to callers

[5] Department of Veterans Affairs, Office of Inspector General, Veterans Crisis Line Caller Response and Quality Assurance Concerns (Washington, D.C.: 2016).

January 2013 through December 2015 that VA maintained related to the timeliness of the VCL's operations. [6]

We reviewed VCL policies, procedures, and monitoring data and interviewed VA officials. We also compared VA's use of key performance indicators to the Office of Management and Budget's guidance on performance goals, which are consistent with the Government Performance and Results Modernization Act of 2010. [7] We observed call centers' operations and interviewed officials and representatives of the VCL primary center and two of the five VCL backup call centers to examine the extent to which VA coordinates with the VCL's service partners in ensuring that veterans receive high-quality service from responders. Further, we reviewed VA's contract that provides backup call coverage and VA's interagency agreement with SAMHSA. We also made 34 covert calls in which we mimicked the experience of veterans who did not follow the instructions of a voice prompt to press ″1″ to reach the VCL. Finally, to examine the extent to which VA had plans to improve VCL operations, we reviewed VA's improvement plans and interviewed VA officials responsible for planning and implementing those improvements. More detailed information on our objectives, scope, and methodology for this work can be found in our 2016 report.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. In addition, the related investigative work was performed in accordance with the standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

**Background**

In 2007, VA established the VCL, a 24-hour crisis line staffed by responders trained to assist veterans in emotional crisis. Through an interagency agreement, VA collaborated with SAMHSA to use a single, national toll-free number for crisis calls that serves both Lifeline and the VCL. [8] Through this interagency agreement, VA and SAMHSA set up a cooperative relationship between the agencies that would provide consistent suicide-prevention techniques to callers.

The national toll-free number presents callers with choices. Callers are greeted by a recorded message that explains the function of the crisis line and prompts individuals to press ″1″ to reach the VCL. Callers who do not press ″1″ by the end of the message are routed to one of Lifeline's 164 local crisis centers. [9] All callers who press ″1″ are routed first to the VCL primary center. Calls that are not answered at the VCL primary center within 30 seconds of the time that the caller presses ″1″ during the Lifeline greeting are automatically routed to one of five VCL backup call centers. If a call is not answered by the VCL backup call center that initially receives it, the call may be sent to another VCL backup call center. [10] VA entered into a contract with a firm to oversee the operations of the VCL backup call centers.

At the time of our 2016 report, there were a total of 164 Lifeline local crisis centers, 5 of which also serve the VCL. [11]

VA added online chat and text message capabilities to the VCL in fiscal years 2009 and 2012, respectively. The number of online chats and text messages handled by the VCL generally increased every year, though the number of online chats decreased in fiscal year 2015.

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[6] We reviewed telephone call data to determine how many calls were answered at the VCL primary center; we reviewed online chat data to determine how many online chat requests received by the VCL received a response within 1 minute; and we reviewed text message data to determine how many text messages sent to the VCL received a response within 2 minutes.

[7] See Office of Management and Budget, Preparation, Submission, and Execution of the Budget-Strategic Plans, Annual Performance Plans, Performance Reviews, and Annual Program Performance Reports, Circular No. A-11, pt. 6 (Washington, D.C.: June 2015).

[8] SAMHSA and the Mental Health Association of New York City launched Lifeline on January 1, 2005. Lifeline provides free and confidential emotional support to people in suicidal crisis or emotional distress, 24 hours a day, 7 days a week.

[9] The automated greeting also prompts Spanish speakers to press ″2″ for assistance in Spanish.

[10] Some VCL backup call centers do not allow calls to be rerouted to another VCL backup call center and instead hold the call in a queue awaiting response by that backup call center's responders.

[11] VA does not directly contract with any of the VCL backup call centers.

### Extended Call Wait Times Were Uncommon in July and August 2015, but VA Did Not Meet Its Call Response Time Goals and Some Text Messages Did Not Receive Responses

### VA Responded to Most Calls within 30 Seconds in July and August 2015, but Did Not Meet Its Goal to Answer 90 Percent of Calls within 30 Seconds at the VCL Primary Center

In our covert testing of the VCL's call response time in July and August 2015, we found that it was uncommon for VCL callers to wait an extended period before reaching a responder since all of our calls that reached the VCL were answered in less than 4 minutes. However, we also found VA did not meet its goal of answering 90 percent of calls to the VCL within 30 seconds for test calls that we made. Our test calls included a generalizable sample of 119 test calls that could be used to describe all callers' wait times when calling the VCL during this period.[12] On the basis of our test calls, we estimated that during July and August 2015 about 73 percent of all VCL calls were answered at the VCL primary center within 30 seconds.[13] VA officials told us that, during fiscal year 2015, about 65 to 75 percent of VCL calls were answered at the VCL primary center and about 25 to 35 percent of VCL calls were answered at the backup call centers. These VA-reported results indicate that about 65 to 75 percent of VCL calls were answered within either 30 or 60 seconds.[14] These results are consistent with our test results for July and August 2015.

During our 2016 review, VA officials told us that VA attempts to maximize the percentage of calls answered at the VCL primary center because these responders have additional resources-including access to veterans' VA electronic medical records-that are unavailable to VCL backup call center responders. All responders-whether at primary or backup centers-receive specialized training to assist callers in crisis.[15]

### To Help Achieve Response-Time Goals, VA Implemented Changes at the VCL Primary Center

To improve its performance toward meeting the goal of answering 90 percent of calls at the VCL primary center within 30 seconds, VA implemented two changes in fiscal year 2015-namely, staggered work shifts for responders and new call-handling procedures.

**Staggered work shifts.** VA implemented staggered shifts for responders at the VCL primary center on September 6, 2015. Staggered shifts are work schedules that allow employees to start and stop their shifts at different times as a way to ensure better coverage during peak calling periods. Specifically, it helps schedule more employees to work when call volume is highest and fewer employees to work when call volume is lowest.[16] Additionally, staggered shifts help limit disruptions in service as responders begin and end their shifts.

By comparing VCL telephone call data from September through December of 2014 to that of September through December of 2015, we found that VA's implementation of staggered shifts at the VCL primarycenter had mixed results.[17] For example, the average percentage of calls answered per hour at the VCL primary center from Sep-

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[12] For these test calls, callers' wait times refer to the length of time that elapses between when callers press ″1″ and when responders at either the VCL primary center or backup call centers answer the calls.

[13] In addition, we estimated that during July and August of 2015, 99 percent of all VCL calls were answered within 120 seconds and the median call response time was 17 seconds. These percentage estimates have a margin of error of within plus or minus 9 percentage points, and the median response times estimates have a relative margin of error that is less than 9 percent at the 95 percent confidence level.

[14] For approximately 5 months of fiscal year 2015, VA allowed calls to ring at the VCL primary center for 60 seconds before routing the calls to VCL backup call centers. VA then returned to the standard that calls not answered at the VCL primary center within 30 seconds are then routed to VCL backup call centers.

[15] All VCL primary and backup call center responders are required to complete Applied Suicide Intervention Skills Training in which they learn to use a suicide intervention model to identify persons with thoughts of suicide, seek a shared understanding of reasons for dying and living, develop a safe plan based on a review of risk, be prepared to do follow-up, and become involved in suicide-safer community networks.

[16] The International Customer Management Institute includes staggered shifts as a best practice among call centers.

[17] Our analysis compared VCL call data from September 6, 2015, through December 31, 2015, to VCL call data from September 1, 2014, through December 31, 2014. The percentage of calls answered was likely affected by several factors, such as call volume, staffing levels, and complexity of calls. Our analysis controlled for day of the week, time of day, and holidays, but did not control for all factors that may affect the percentage of calls answered.

tember through December 2015-after staggered shifts were implemented-was 75 percent, slightly less than the average of 79 percent answered during the corresponding period in 2014 before staggered shifts were implemented. However, the VCL received an average of about 1.3 more calls per hour during this period in 2015 than it received during the corresponding period in 2014 and, according to VA officials, the VCL primary center employed fewer responder staff in 2015 than 2014.

**New call-handling procedures.** VA implemented new call handling procedures at the VCL primary center beginning in June 2015 that provided responders with specific guidance to more efficiently handle ″noncore″ callers-those callers who were not seeking crisis assistance but rather seeking help with other issues, such as help with veterans' benefits questions. For example, if a caller reached the VCL with a question about VA disability benefits, the VCL primary center responder would verify that the caller was not in crisis and transfer the caller to the Veterans Benefits Administration to address the question.

VCL telephone call data provided by VA suggest that the average time VCL primary center responders spent handling noncore calls decreased by approximately 30 percent over a 5-month period after responder training began on these new call-handling procedures.[18] We would expect that as the average time VCL primary center responders spent handling noncore calls decreased, these responders would have more time available to answer additional incoming calls.

### In July and August 2015, Most of Our Test Online Chats Were Answered Within 30 Seconds, but VA Did Not Ensure That Veterans Received Responses through Its Text Messaging Service

To determine the timeliness of the VCL's responses to online chats and text messages, we conducted a covert test in July and August 2015 using nongeneralizable samples of 15 online chats and 14 text messages. All 15 of our test online chats received responses within 60 seconds, 13 of which were within 30 seconds. This result was consistent with VA data that indicated VCL responders sent responses to over 99 percent of online chat requests within 1 minute in fiscal years 2014 and 2015. During our 2016 review, VA officials told us that all online chats are expected to be answered immediately. Although this was an expectation, we found in 2016 that VA did not have formal performance standards for how quickly responders should answer online chat requests and expected to develop them before the end of fiscal year 2016.

However, our tests of text messages revealed a potential area of concern. Four of our 14 test text messages did not receive a response from the VCL. Of the remaining 10 test text messages, 8 received responses within 2 minutes, and 2 received responses within 5 minutes.

As we reported in May 2016, VA officials stated that text messages are expected to be answered immediately, but, as with online chats, VA had not developed formal performance standards for how quickly responders should answer text messages. VA data indicated that VCL responders sent responses to 87 percent of text messages within 2 minutes of initiation of the conversation in both fiscal years 2014 and 2015. During our 2016 review, VA officials said that VA planned to establish performance standards for answering text messages before the end of fiscal year 2016. VA officials noted and we observed during a site visit that some incoming texts were abusive in nature or were not related to a crisis situation.[19] According to VA officials, in these situations, if this is the only text message waiting for a response, a VCL responder will send a response immediately. However, if other text messages are awaiting responses, VA will triage these text messages and reply to those with indications of crisis first. This triage process may have contributed to the number of our test texts that did not receive responses within 2 minutes.

The VCL's text messaging service provider offered several reasons for the possible nonresponses that we encountered in our test results. These included: (1) incompatibilities between some devices used to send text messages to the VCL and the software VA used to process the textmessages, (2) occasional software malfunctions that freeze the text messaging interface at the VCL primary center, (3) inaudible audio prompts used to alert VCL primary center responders of incoming text messages, (4) attempts by people with bad intentions to disrupt the VCL's text messaging service by overloading the system with a large number of texts, and (5) incompatibilities between the web browsers used by the VCL primary center and the text messaging software.

At the time of our 2016 review, VA officials told us that they did not monitor and test the timeliness and performance of the VCL text messaging system, but rather

[18] We did not test this aspect of VCL operations with covert test calls.

[19] Our test text messages consisted of a simple greeting, such as ″Hi″ or ″Hello.″

relied solely on the VCL's text messaging service provider for such monitoring and testing. They said that the provider had not reported any issues with this system. According to the provider, no routine testing of the VCL's text messaging system was conducted. Standards for internal control in the federal government state that ongoing monitoring should occur in the course of normal operations, be performed continually, and be ingrained in the agency's operations.[20] We concluded that without routinely testing its text messaging system, or ensuring that its provider tests the system, VA cannot ensure that it is identifying limitations with its text messaging service and resolving them to provide consistent, reliable service to veterans.

We recommended that VA regularly test the VCL's text messaging system to identify issues and correct them promptly. In response, VA developed and implemented procedures to regularly test the VCL's text messaging system, as well as its telephone and online chat systems. We believe this change will allow VA to more reliably and quickly identify and correct errors in the text messaging system and therefore help veterans reach VCL responders in a timelier manner.

### VA Had Taken Steps to Improve Its Monitoring of VCL Primary Center Performance but Had Not Established Targets and Time Frames for VCL Key Performance Indicators

### VA Established a Call Center Evaluation Team, Implemented Revised Responder Performance Standards, and Analyzed VCL Caller Complaints

As we reported in May 2016, VA had sought to enhance its capabilities for overseeing VCL primary center operations through a number of activities-including establishing a call center evaluation team, implementing revised performance standards for VCL primary center responders, implementing silent monitoring of VCL primary center responders, and analyzing VCL caller complaints.[21]

**Establishment of a call center evaluation team.** In October 2013, VA established a permanent VCL call center evaluation team that is responsible for monitoring the performance of the VCL primary center.[22] As we reported in May 2016, the call center evaluation team analyzes VCL data, including information on the number of calls received and the number of calls routed to backup call centers from the primary center. VA officials told us that they use these data to inform management decisions about VCL operations.

**Implementation of revised performance standards for VCL primary center responders.** In October 2015, VA implemented new performance standards for all VCL primary center responders that will be used to assess their performance in fiscal year 2016. According to VA officials,these performance standards include several measures of responder performance-such as demonstrating crisis-intervention skills, identifying callers' needs, and addressing those needs in an appropriate manner using VA approved resources.

**Silent monitoring of VCL primary center responders.** In February 2016, VA officials reported that they were beginning silent monitoring of all VCL responders using recently developed standard operating procedures, standard data collection forms, and standard feedback protocols.

**Analysis of VCL caller complaints.** In October 2014, VA created a mechanism for tracking complaints it receives from VCL callers and external parties, such as members of Congress and veterans, about the performance of the VCL primary and backup call centers. According to VA officials, each complaint is investigated to validate its legitimacy and determine the cause of any confirmed performance concerns. The results and disposition of each complaint are documented in VA's complaint tracking database.

### VCL Key Performance Indicators Lacked Measureable Targets and Time Frames

In 2011, VA established key performance indicators to evaluate VCL primary center operations; however, in our May 2016 review, we found these indicators did not have established measureable targets or time frames for their completion.

**VCL key performance indicators lacked measurable targets.** We found that VA's list of VCL key performance indicators did not include information on the targets the department had established to indicate their successful achievement. For

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[20] See GAO, Standards for Internal Control in the Federal Government, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[21] VCL also tracks and analyzes complaints about the services of VCL backup call centers as a part of this effort.

[22] According to VA officials, this team was initially staffed with VA employees detailed from other areas of the department in December 2012. Permanent staff for call center evaluation were hired in October 2013.

example, VA included a key performance indicator for the percentage of calls answered by the VCL in this list but did not include information on what results would indicate success for (1) the VCL as a whole, (2) the VCL primary center, or (3) the VCL backup call centers. As another example, VA had not established targets for the percentage of calls abandoned by callers prior to speaking with VCL responders. Measureable targets should include a clearly stated minimum performance target and a clearly stated ideal performance target.[23] These targets should be quantifiable or otherwise measurable and indicate howwell or at what level an agency or one of its components aspires to perform.[24] Such measurable targets are important for ensuring that the VCL call center evaluation team can effectively measure VCL performance.

**VCL key performance indicators lack time frames for their completion.** We found that VA's list of VCL key performance indicators did not include information on when the department expected the VCL to complete or meet the action covered by each key performance indicator. For example, for VA's key performance indicator for the percentage of calls answered by the VCL, the department had not included a date by which it would expect the VCL to complete this action. As another example, VA had not established dates by which it would meet targets yet to be established for the percentage of calls abandoned by callers prior to speaking with VCL responders. Time frames for action are a required element of performance indicators and are important to ensure that agencies can track their progress and prioritize goals.[25]

Guidance provided by the Office of Management and Budget states that performance goals-similar to VA's key performance indicators for the VCL-should include three elements: (1) a performance indicator, which is how the agency will track progress; (2) a target; and (3) a period.[26] Without establishing targets and time frames for the successful completion of its key performance indicators for the VCL, we concluded that VA could not effectively track and publicly report progress or results for its key performance indicators for accountability purposes.

We recommended that VA document clearly stated and measurable targets and time frames for key performance indicators needed to assess VCL performance. While VA officials have informed us that they have created scorecards that track information related to calls answered, staffing, and average handle times, as of March 2017, clearly stated and measurable targets and time frames have not yet been developed.

### VA Was Strengthening Requirements for VCL Backup Call Centers, but VA and SAMHSA Did Not Collect Information to Assess How Often and Why Callers Were Not Reaching the VCL

### VA Was Enhancing Performance Requirements for Its Backup Call Coverage Contractor

As we reported in May 2016, VA's backup call coverage contract, awarded in October 2012 and in place at the time of our review, did not include detailed performance requirements in several key areas for the VCL backup call centers. Clear performance requirements for VCL backup call centers are important for defining VA's expectations of these service partners. However, VA had taken steps to strengthen the performance requirements of this contract by modifying it in March 2015 and was beginning the process of replacing it with a new contract. According to VA officials, the new contract was awarded in April 2016.

**October 2012 backup call coverage contract.** This contract provided a network of Lifeline local crisis centers that could serve as VCL backup call centers

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[23] See GAO, VA Health Care: Additional Guidance, Training, and Oversight Needed to Improve Clinical Contract Monitoring, GAO-14-54 (Washington, D.C.: Oct. 2013).

[24] Consistent with the Government Performance and Results Modernization Act of 2010, the Office of Management and Budget states that a performance goal should include a tangible, measurable objective or a quantifiable standard, value, or rate. See Office of Management and Budget, Preparation, Submission, and Execution of the Budget-Strategic Plans, Annual Performance Plans, Performance Reviews, and Annual Program Performance Reports.

[25] Consistent with the Government Performance and Results Modernization Act of 2010, the Office of Management and Budget defines a performance goal as a statement of the level of performance to be accomplished within a time frame. See Office of Management and Budget, Preparation, Submission, and Execution of the Budget-Strategic Plans, Annual Performance Plans, Performance Reviews, and Annual Program Performance Reports.

[26] See Office of Management and Budget, Preparation, Submission, and Execution of the Budget-Strategic Plans, Annual Performance Plans, Performance Reviews, and Annual Program Performance Reports.

managed by a contractor.[27] This contractor was responsible for overseeing and coordinating the services of VCL backup call centers that answer overflow calls from the VCL primary center. This contract as initially awarded included few details on the performance requirements for VCL backup call centers. For example, the contract did not include any information on the percentage of VCL calls routed to each VCL backup call center that should be answered. Detailed performance requirements on these key aspects of VCL backup call center performance are necessary for VA to effectively oversee the performance of the contractor and the VCL backup call centers. By not specifying performance requirements for the contractor on these key performance issues, we believe that VA missed the opportunity to validate contractor and VCL backup call center performance and mitigate weaknesses in VCL call response.

As we reported in May 2016, VA officials told us about several concerns with the performance of the backup call centers operating under the October 2012 contract based on their own observations and complaints reported to the VCL. These concerns included the inconsistency and incompleteness of VCL backup call centers' responses to VCL callers, limited or missing documentation from records of VCL calls answered by VCL backup call center responders, limited information provided to VA that could be used to track VCL backup call center performance, and the use of voice answering systems or extended queues for VCL callers reaching some VCL backup call centers. For example, VA officials reported that some veterans did not receive complete suicide assessments when their calls were answered at VCL backup call centers. In addition, VA officials noted that they had observed some VCL backup call centers failing to follow VCL procedures, such as not calling a veteran who may be in crisis when a third-party caller requested that the responder contact the veteran. According to VA officials, these issues led to additional work for the VCL primary center, including staffing one to two responders per shift to review the call records submitted to the VCL primary center by backup call centers and to determine whether these calls required additional follow-up from the VCL primary center. Theseofficials estimated that 25 to 30 percent of backup call center call records warranted additional follow-up to the caller from a VCL primary center responder, including approximately 5 percent of backup call center call records that needed to be completely reworked by a VCL primary center responder.

**March 2015 backup call coverage contract modification.** Given these concerns, in March 2015, VA modified the October 2012 backup call coverage contract to add more explicit performance requirements for its backup call coverage contractor, which likely took effect more quickly than if the department had waited for a new contract to be awarded. These modified requirements included (1) the establishment of a 24-hours-a-day, 7-days-a-week contractor-staffed emergency support line that VCL backup call centers could use to report problems, (2) a prohibition on VCL backup call centers' use of voice answering systems, (3) a prohibition on VCL backup call centers placing VCL callers on hold before a responder conducted a risk assessment, (4) documentation of each VCL caller's suicide risk assessment results, and (5) transmission of records for all VCL calls to the VCL primary center within 30 minutes of the call's conclusion.

**Development of new backup call coverage contract.** In July 2015, VA began the process of replacing its backup call coverage contract by publishing a notice to solicit information from prospective contractors on their capability to satisfy the draft contract terms for the new contract; this new backup call coverage contract was awarded in April 2016.[28] We found that these new proposed contract terms included the same performance requirement modifications that were made in March 2015, as well as additional performance requirements and better data reporting from the contractor that could be used to improve VA's oversight of the VCL backup call centers. Specifically, the proposed contract terms added performance requirements to address VCL backup call center performance-including a requirement for 90 percent of VCL calls received by a VCL backup call center to be answered by a backup call center responder within 30 seconds and 100 percent to be answered by a backup call center responder within 2 minutes. In addition, the proposed contract terms included numerous data reporting requirements that could allow VA to

[27] The backup call coverage contract in place at the time of our review was awarded in October 2012 with a 1-year base and two 1-year option periods (for a total of 3 years of coverage) and was set to expire in September 2015. However, according to VA officials, the contract was extended through May 2016 while the department was finalizing a new contract. VA officials reported that the new backup call coverage contract was awarded in April 2016.

[28] This notice-referred to as a sources sought notice-included a draft performance work statement. In April 2016, VA officials reported that this contract was awarded to the previous backup call coverage contractor.

routinely assess the performance of its VCL backup call centers and identify patterns of noncompliance with the contract's performance requirements more efficiently and effectively than under the prior contract. The proposed terms for the new contract also state that VA will initially provide and approve all changes to training documentation and supporting materials provided to VCL backup call centers in order to promote the contractor's ability to provide the same level of service that is being provided by the VCL primary center.

**VA and SAMHSA Did Not Collect Information Needed to Assess How Often and Why Callers Were Not Reaching the VCL**

In May 2016, we found that when callers did not press ″1″ during the initial Lifeline greeting, their calls may take longer to answer than if the caller had pressed ″1″ and been routed to either the VCL primary center or a VCL backup call center.[29] As previously discussed, VA and SAMHSA collaborated to link the toll-free numbers for both Lifeline and the VCL through an interagency agreement. The greeting instructs callers to press ″1″ to be connected to the VCL; if callers do not press ″1,″ they will be routed to one of SAMHSA's 164 Lifeline local crisis centers. To mimic the experience of callers who did not press ″1″ to reach the VCL when prompted, we made 34 covert nongeneralizable test calls to the national toll-free number that connects callers to both Lifeline and the VCL during August 2015 and we did not press ″1″ to be directed to the VCL.[30] For 23 of these 34 calls, our call was answered in 30 seconds or less. For 11 of these calls, we waited more than 30 seconds for a responder to answer-including 3 calls with wait times of 8, 9, and 18 minutes. Additionally, one of our test calls did not go through, and during another test call we were asked if we were safe and able to hold.[31] VA's policy prohibits VCL responders from placing callers on hold prior to completing a suicide assessment; Lifeline has its own policies and procedures.[32]

According to officials and representatives from VA, SAMHSA, and the VCL backup call centers, as well as our experience making test calls where we did not press ″1,″ there are several reasons why a veteran may not press ″1″ to be routed to the VCL, including

- an intentional desire to not connect with VA,
- failure to recognize the prompt to press ″1″ to be directed to the VCL,
- waiting too long to respond to the prompt to press ″1″ to be directed to the VCL, or
- calling from a rotary telephone that does not allow the caller to press ″1″ when prompted.

As we found in May 2016, VA officials had not estimated the extent to which veterans intending to reach the VCL did not press ″1″ during the Lifeline greeting.[33] These officials explained that their focus had been on ensuring that veterans who did reach the VCL received appropriate service from the VCL primary center and backup call centers. In addition, SAMHSA officials said that they also did not collect this information.[34] These officials reported that SAMHSA did not require the collection of demographic information, including veteran status, for a local crisis center to participate in the Lifeline network. However, they noted that SAMHSA could request through its grantee that administers the Lifeline network that local crisis centers conduct a one-time collection of information to help determine how often and why veterans reach Lifeline local crisis centers. SAMHSA officials explained that

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[29] At the time of our tests, the initial greeting was about 30 seconds long and prompted the caller to press ″1″ to be connected to the VCL at the end of the greeting. If callers did not press″1,″ the call was routed to one of SAMHSA's 164 Lifeline local crisis centers based on the area code of the callers' telephone numbers.

[30] These 34 calls were a random but nongeneralizable sample.

[31] When asked if we were safe and could hold, we terminated this test call.

[32] We did not review Lifeline's policies and procedures as a part of our May 2016 report due to our focus on the VCL. We focused our review of Lifeline on those elements of their operations that interacted with the VCL or VA, such as the interagency agreement between VA and SAMHSA that governs the shared use of a single national toll-free number between the VCL and Lifeline.

[33] According to SAMHSA officials, in 2014, about 383,000 callers abandoned their calls to Lifeline during the initial greeting used to direct callers to either Lifeline local crisis centers or the VCL. We did not assess the reasons these calls were abandoned.

[34] According to SAMHSA officials, the SAMHSA grantee responsible for administering Lifeline conducted a survey in 2014 that captured veteran-related data. However, SAMHSA had no involvement with this survey or the data collection activities of the Lifeline local crisis centers that provided the information because it was outside the scope of SAMHSA's grant to the organization. Further, HHS stated that the SAMHSA grantee did not share the results of the survey with SAMHSA. We did not evaluate the results of this survey.

they could work with the Lifeline grantee to explore optimal ways of collecting this information that would be (1) clinically appropriate, (2) a minimal burden to callers and Lifeline's local crisis centers, and (3) in compliance with the Office of Management and Budget's paperwork reduction and information collection policies. The interagency agreement between VA and SAMHSA assigns SAMHSA responsibilities for monitoring the use of the national toll-free number that is used to direct callers to both the VCL and Lifeline. These responsibilities include monitoring the use of the line, analyzing trends, and providing recommendations about projected needs and technical modifications needed to meet these projected needs. Using the information collected from the Lifeline local crisis centers on how often and why veterans reach Lifeline, as opposed to the VCL, VA and SAMHSA officials could then assess whether the extent to which this occurs merits further review and action.

Although the results of our test were not generalizable, substantial wait times for a few of our covert calls suggested that some callers may experience longer wait times to speak with a responder in the Lifeline network than they would in the VCL's network. We concluded that without collecting information to examine how often and why veterans do not press ″1″ when prompted to reach the VCL, VA and SAMHSA could not determine the extent veterans reach the Lifeline network when intending to reach the VCL and may experience longer wait times as a result. In addition, limitations in information on how often and why this occurs did not allow VA and SAMHSA to determine whether or not they should collaborate on plans to address the underlying causes of veterans not reaching the VCL. Standards for internal control in the federal government state that information should be communicated both internally and externally to enable the agency to carry out its responsibilities.[35] For external communications, management should ensure there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency achieving its goals.

We recommended VA and SAMHSA collaborate in taking the following two actions: (1) collect information on how often and why callers intending to reach the VCL instead reach Lifeline local crisis centers and (2) review the information collected and, if necessary, develop plans to address the underlying causes. We understand that VA and SAMHSA have been coordinating on these issues. However, as of March 2017, both of these recommendations remain open.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes our statement for the record.

**GAO Contact and Staff Acknowledgments**

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