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Healthcare Inspection

Veterans Crisis Line Caller Response and Quality Assurance Concerns Canandaigua, New York

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to complaints concerning the Veterans Crisis Line (VCL), Canandaigua, NY. The complainants alleged that:

- Calls to the VCL go unanswered or are answered by a voicemail system.
- Callers do not always receive immediate assistance.
- An ambulance, called to assist a veteran, did not arrive for 3 hours.
- Staff who answer calls are not properly trained to meet the needs of callers or to marshal resources needed to meet crises.
- Callers find the VCL phone number, 273-TALK, difficult to use during a crisis.

Additionally, we received complaints from the U.S. Office of Special Counsel involving two similar issues—VCL social service assistants were not properly trained, and, when all VCL staff are busy, callers are forwarded to volunteer backup call centers that lack the trained staff to properly coordinate immediate emergency services needed to prevent harm.

We substantiated allegations that some calls routed to backup crisis centers were answered by voicemail, and callers did not always receive immediate assistance from VCL and/or backup center staff.

We also substantiated that VCL management did not provide social service assistants with adequate orientation and ongoing training. The VCL program does not provide or monitor backup centers' staff training; therefore, we could not substantiate that backup center staff, including volunteers, did not receive adequate training. However, we did find evidence that raised concerns regarding backup center training adequacy.

We did not substantiate the allegations that staff who respond to callers did not receive proper training or that VCL staff were responsible for the 3-hour delay a veteran experienced while waiting for an ambulance. In addition, we did not substantiate that the VCL phone number was difficult to use during a crisis. We found that the VCL telephone number (1-800-273-8255, Press 1) currently excludes the lettering (1-800-273-TALK, Press 1) or includes the corresponding numbers on all printed media items such as business cards.

We identified gaps in the VCL quality assurance process. These gaps included an insufficient number of required staff supervision reviews, inconsistent tracking and resolution of VCL quality assurance issues, and a lack of collection and analysis of backup center data, including incomplete caller outcome or disposition information from backup center staff. We determined that a contributing factor for the lack of organized VCL quality assurance processes was the absence of a Veterans Health Administration

(VHA) directive or handbook to provide guidance for VCL quality assurance and other processes and procedures.

VCL management told us that they were aware of some gaps in VCL and backup center processes, including quality assurance and training, and were working to resolve those issues. This includes reviewing existing contracts with non-VHA vendors.

We made seven recommendations to the VHA Office of Mental Health Operations Executive Director. We recommended that the 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.
- Ensure that orientation and ongoing training for all VCL staff is completed and documented.
- Ensure that silent monitoring frequency meets the VCL and American Association of Suicidology requirements and that compliance is monitored.
- 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.
- Consider the development of a VHA directive or handbook for the VCL.
- 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.
- Consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.

Comments

The Office of Mental Health Services and Operations Director concurred with our recommendations and provided acceptable action plans. (See Appendix A, pages 19–23 for the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to complaints concerning the Veterans Crisis Line (VCL), Canandaigua, NY.

Background

Between 2006 and 2013, suicides in the United States increased each year from, 33,200 to 41,149.[1] According to data published by the Veterans Health Administration (VHA) in an August 2010 Suicide Prevention Fact Sheet,[2] approximately 20 percent of all suicides are veterans. In addition, the Fact Sheet reported that from October 1, 2008, through December 31, 2010, VHA suicide prevention coordinators reported approximately 5 suicide deaths per day and nearly 950 veteran suicide attempts per month among veterans receiving care through VHA.[3] Because of the rising number of suicides among veterans and the impact of those suicides on families and communities, VA strategized mental health and other services to address the needs of veterans who were at risk or actively contemplating suicide. The VCL is one of the strategies in VA's Suicide Prevention Program.[4]

The VCL program began operations in July 2007 as a telephone suicide crisis hotline for veterans, families of veterans, and military personnel. Since its launch in 2007, and as reported on the VCL website on August 27, 2015, VCL staff have answered more than 1.86 million calls and made more than 50,000 lifesaving rescues. In July 2009, the program added an online chat feature and, in November 2011, made text messaging available. According to the VCL website, as of August 27, 2015, VCL staff have engaged in more than 240,000 chats and responded to 39,000 text messages.[5] VCL staff provide services 24 hours a day, 7 days a week.

The VCL operates under VHA's Clinical Operations branch of the Office of Mental Health Operations (OMHO) and is physically located at the Canandaigua VA Medical Center. The medical center provides the VCL with administrative as well as human resource support.

[1] Centers for Disease Control and Prevention, *Fatal Injury Report: Suicide*, http://webappa.cdc.gov/sasweb/ncipc/mortrate10_us.html. Accessed July 30, 2015.
[2] This fact sheet was the only one available about suicide prevention on the VHA Mental Health Services and Operations website on August 28, 2015.
[3] Department of Veterans Affairs, *VA Suicide Prevention Program: Facts about Veteran Suicide,* August 2010, http://vaww.mentalhealth.va.gov/omhs-factsheets.asp. Accessed August 28, 2015.
[4] Department of Veterans Affairs Mental Health Services Suicide Prevention Program, *Suicide Data Report, 2012,* January 31, 2013.
[5] Veterans Crisis Line, http://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx. Accessed August 27, 2015.

The American Association of Suicidology[6] (AAS) accredits the VCL as a suicide crisis hotline and stipulates operational requirements for the management of nationwide telephone responses and web-based assistance for individuals in crisis and/or at risk for suicide. This accreditation includes specific requirements for services, staffing, and staff training.[7] In addition, the VCL is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). However, much of the CARF accreditation process does not pertain to VCL operations, as CARF requirements generally apply to facilities that provide direct inpatient and clinic patient care, such as medication disbursement and physical therapy, and are not specific to suicide intervention or crisis management.[8] The VCL must also follow VHA requirements such as mandatory training and quality assurance (QA) processes.[9]

VCL Operations. The nature of a suicide crisis hotline requires the availability of an easy to use toll free number and procedures to ensure callers have access to assistance. To ensure this availability on a nationwide basis, the Federal Communication Commission (FCC) assigned several toll free telephone numbers to the Substance Abuse and Mental Health Services Administration (SAMHSA), which is part of the U.S. Department of Health and Human Services, for the purpose of suicide crisis interventions. One of these toll free numbers is the National Suicide Prevention Lifeline or NSPL. When a caller uses the NSPL, the caller is routed to one of the crisis centers that is part of the SAMHSA National Suicide Prevention Lifeline Network. The Network suicide prevention crisis centers are staffed to answer calls and provide support on a 24-hour basis.

In 2007, VHA established an agreement with SAMHSA to specifically use and market the NSPL as a toll free number for veterans and military personnel to call the VCL. The decision by VHA to use the NSPL was based upon the fact that this number was already a recognized and well-publicized number. This agreement also allowed the veteran or military caller to access the VCL through any of the other SAMHSA suicide prevention toll free numbers by following the instructions in the greeting for veterans and military personnel.

Though a veteran may call the NSPL or other toll free numbers, the process to link the call to the VCL is not complete without a mechanism or process to forward or route the call. To accomplish this process, VA contracted with Link2Health Solutions, Inc. (L2HS), an incorporated subsidiary of the non-profit Mental Health Association of New York City, to provide the telephone routing system from the NSPL/SAMHSA numbers to VCL. In the event that the VCL telephone lines are in use or out of service, L2HS also provides an infrastructure to forward calls to the Network crisis backup centers. This system routes calls within seconds to ensure that callers are unaware of the process.

[6] AAS is a charitable non-profit organization dedicated to suicide prevention and intervention education including individual certification programs, research, public awareness, and crisis center accreditation (including hotlines).
[7] American Association of Suicidology, *Organization Accreditation Standards Manual*, January 2012.
[8] Commission on Accreditation of Rehabilitation Facilities, *Behavioral Health Standards Manual 2013*, July 1, 2013.
[9] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

The SAMHSA agreement with VHA also provided the VCL with access to over 150 backup centers through the Network; however, L2HS, with VCL management input, selected 6 centers to use for VCL backup.[10] VHA/VCL does not contract directly with these selected backup centers. The L2HS contract makes L2HS responsible for managing the routing of "Press 1" calls to the selected crisis center (VCL or backup) and ensuring that all callers receive access to help.

When VCL staff answer calls, an internal call management software system (Avaya CMS) tracks and manages the calls. VHA uses this system to ensure calls are not dropped due to VCL telephone equipment failure.

When a caller phones the NSPL number (the number specifically assigned to the VCL) or other SAMHSA numbers, he or she hears instructions to press 1 if they are a veteran, military member, or family member of a veteran or military member and wish to speak with VCL staff. According to VCL's routing process map, the greeting is about 22 seconds long. If the caller presses 1, the call is routed to the VCL and may ring up to 38 seconds before being answered by VCL staff or, if VCL staff do not answer, it is forwarded to a Network backup center. If routed to a backup center, calls are answered, placed in a call queue for backup center staff, or, if the backup center queue is full or staff are busy (not all backup centers have a queue system), forwarded to another backup center. A timeframe has not been defined for the backup centers to answer a call nor has a process been determined as to how many times the call is forwarded. However, the caller may end the call at any time during this process.

VCL Management. From 2010 to September of 2013, the VCL shared space, staff, and management with the National Call Center for Homeless Veterans, a VA telephone line dedicated to assisting homeless veterans. However, when the VCL began to experience a sharp rise in calls during fiscal years (FYs) 2011 and 2012,[11] program management separated the two lines' staff (September 2013) so that each program had its own specific staff to answer calls and address chats.

The VCL and National Call Center for Homeless Veterans are overseen by a Program Management Officer (manager) who organizes all administrative aspects of both operations. Responsibilities for the VCL program include quality assurance tasks and communication with backup centers and VHA leadership. On January 11, 2015, the manager resigned and was replaced by an acting manager.

Two Supervisory Program Specialists (SPS) report to the manager. They provide direct supervision of front-line supervisory staff; train, evaluate, and assist with hiring other VCL staff; gather workload data; handle personnel issues; manage resources; and assist with developing policies.

[10] As reported by the VCL program manager on April 6, 2015, only four backup centers are receiving calls as two are either no longer in business or participating. The backup centers have trained responders to interact with callers.
[11] Department of Veterans Affairs Mental Health Services: Suicide Prevention Program, *Suicide Data Report, 2012,* January 31, 2013.

Ten to 12 Supervisory Health Science Specialists (SHSS or supervisors) are directly responsible for supervising the approximately 250 front-line staff and assisting with performance improvement projects and policy development.

VCL Front-Line Staff. Crisis-trained Health Science Specialists (responders) speak directly with callers and perform caller lethality, emotional, functional, and/or psychological assessments. The number of responders has significantly grown in response to the increased number of calls to the crisis line. In 2013, 96 responders were hired, and, on April 6, 2015, VCL management reported that the VCL had approximately 255 full-time employees in this position. In addition to speaking with callers and assessing caller status, responders develop action and rescue plans, and contact callers with follow-up interviews as needed. They report to either the supervisory staff or the manager.

In 2012, VCL management began hiring for the position of Social Service Assistant (SSA) to assist responders with rescues. According to VCL management, as of April 6, 2015, the VCL employed 24 SSAs who provide coverage 24 hours per day, 7 days per week. The SSAs do not answer calls; they assist responders with rescues by communicating with 911 dispatchers, emergency responders, and mental health mobile units. In addition, they identify and utilize information resources during rescues, conduct follow-up assessments of electronic health record entries to ensure callers referred to a facility received services, follow up on consults,[12] follow up on emails from backup centers regarding caller disposition (disposition reports), and prepare and maintain case records.

Staff Training. VCL front line staff are in the unique position of intervening with individuals at different points during a suicidal crisis, including the moments or hours before an individual plans to commit suicide. Because of the sensitive nature of these interactions, staff must be knowledgeable about suicide interventions and rescues. In addition, because the VCL is devoted to veterans and military personnel, the staff should be familiar with unique issues such as military traumatic brain injury and/or post-traumatic stress disorder.[13] Thus, appropriate training becomes significant for all staff, including backup center call staff.

AAS and the VCL do not require specific licensure or education prerequisites, such as a college degree, for responders or SSAs. However, the majority of VCL responders have master's or bachelor's degrees and/or prior counseling experience. SSAs come from varied backgrounds including law enforcement, and many have associates or bachelor's degrees.

VCL has specific requirements under its AAS accreditation to provide 40 hours of training for new responder employees. This includes working 8 hours with a peer,

[12] Consult in this context means arranging for contact between the caller and a professional who can treat or address ongoing issues for the caller. This may include a referral to a mental health provider.
[13] Thomas Joiner, et al., *Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline,* The American Association of Suicidology, June 2007.

completing a post training competency test, and participating in supervised role-play or phone work prior to working independently. In addition, AAS requires ongoing job related training of 2 to 3 hours a year. Training topics include crisis intervention, suicide assessment, and use of community resources.[14] VCL responders, who have direct interactions with callers, must meet all training requirements, and VCL requires the same for SSA orientation and ongoing training. The only exception is that the SSA supervisor may decide whether supervised role-play or phone work with rescues is necessary, as SSAs are directed by responders and do not directly answer crisis line calls.

The Network requires that backup centers be certified/accredited/licensed by an external body but does not specify a particular organization.[15] VHA and the SAMHSA agreement with VHA do not require backup centers to be AAS accredited. As a result, backup center staff may not be required to have the same orientation and ongoing training as required in the AAS accreditation for the VCL staff. Neither VHA nor the SAMHSA agreement has specific requirements concerning backup center orientation or ongoing training. Since backup center call responders, who may be employees or volunteers, are supervised by their respective backup centers, they receive orientation and ongoing training from those backup centers and the contractor L2HS. VCL program management meets with backup center management to discuss specific training curriculums, which include both classroom work and on-the-job training, and works with L2HS to develop ongoing training sessions. However, VCL program management and supervisory staff have no direct control or formal process to provide or confirm that backup center staff have completed orientation and received ongoing training.

Quality Assurance. Crucial VHA and AAS quality assurance requirements to assess call management include collecting data and trending and analysis of internal and external system issues.[16] VCL, SAMHSA, L2HS, and Avaya all collect data concerning the number of internal and external calls answered and staffing utilization. VCL management collects additional data regarding staff supervision, customer complaints, and issues from callers and other stakeholders. In addition, VCL management discusses data and technical issues with VHA, NSPL, and backup center management at regularly scheduled meetings.

VCL and Backup Center Call Volume

When the VCL program started in 2007, management initially projected approximately 10 percent of calls would go to backup centers. Approximately 11 percent of calls in FY 2013 and 17 percent of calls in FY 2014 went to backup centers. As seen in the table below, the increase in call volume to the VCL and to backup centers had risen sharply between FY 2013 and FY 2014.

[14] American Association of Suicidology, *Organization Accreditation Standards Manual,* January 2012.
[15] NSPL network website: http://www.suicidepreventionlifeline.org/crisiscenters/joinnetwork.aspx. Accessed August 27, 2015.
[16] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value,* August 2, 2013.

Table 1. Calls to VCL answered by the VCL and by backup centers, FY 2013 and 2014

Fiscal Year	Calls Answered by VCL Staff	Calls Answered by Backup Center Staff
FY 2013	287,070	36,261
FY 2014	374,053	76,887
Percent Growth	30%	112%

Source: Department of Veterans Affairs

Allegations

On May 8, 2014, a complainant contacted the OIG hotline concerning the responsiveness and quality of the care provided by the VCL. Specifically the complainant alleged that:

- Calls to the VCL were directed to voicemail and/or went unanswered.
- Staff at the VCL did not provide immediate assistance to veterans calling the VCL and, at times, told veterans to contact a local VHA facility.
- Local resources, specifically an ambulance called to assist a veteran, did not arrive for 3 hours.
- Staff who answered calls to the VCL were not properly trained to meet the needs of callers or to marshal the resources needed to meet crises.
- Veterans who needed to call the VCL during a crisis could have difficulty locating the corresponding numbers to dial when utilizing the VCL telephone number displayed on business cards and other communication—273-TALK.

Subsequent to receiving the allegations above, on February 13, 2015, OIG received the following additional allegations from the U.S. Office of Special Counsel.

- SSAs at the VCL were not properly trained.
- When all VCL phone lines were busy, callers were forwarded to volunteer call centers that lacked trained staff to properly coordinate rescues.[17]

[17] Initiating the dispatch of emergency services was formally referred to as a "rescue."

Scope and Methodology

The period of our review was FY 2014 through the first quarter of FY 2015. We conducted a site visit on April 6, 2015.

We interviewed complainants, VCL and OMHO leadership, and nine responder and SSA staff members. We reviewed VCL policies and procedures, industry standards, healthcare literature related to crisis hotlines and suicide, VCL contracts, training records, VCL complaint logs, selected disposition forms, and other related documents. During our site visit, we observed the process by which VCL staff follow up on caller information and backup center emails. We also reviewed a VCL business card dated January 2014 and related pamphlets.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Issue 1: VCL Responsiveness

We substantiated the allegations that some calls routed to crisis backup centers went into a voicemail system and that the VCL and backup center staff did not always offer immediate assistance to callers. In addition, we found that callers could be placed on hold in a backup center queue or be passed through several backup centers for an unknown period of time, which could account for the perception that the calls were not answered.

VCL Calls Go to Voicemail or Are Unanswered. AAS, which accredits the VCL, mandates that crisis hotline/center responders must be available to answer a dedicated phone number 24 hours a day, 7 days a week. Though AAS does not strictly prohibit the use of voicemail or placing callers on hold, if a commercial call management system is used, such as for backup, AAS requirements state "most callers reach a trained crisis worker (VCL responder) within one minute of placing a call."[18] The basis for this response timeframe is to provide direct and immediate support to the individual caller with the goal of providing measures to ensure the caller's safety and coordinating emergency services if needed.[19] Routing to voicemail, instructing callers to call another party, or placing the caller on hold delays caller interaction with responders and could potentially affect caller access to needed crisis or emergency services.

The VA contract with L2HS, which provides VCL with access to the backup call centers, does not prohibit backup centers from using voicemail; however, VCL management told us that backup centers, though not prohibited by contract, should not use voicemail when answering calls for the VCL. Nevertheless, in addition to the complainant's allegations, we found 3 of the 41 complaints made to the VCL in FY 2014 were claims that calls were transferred to a voicemail system. Our review identified over 20 calls that were routed to voicemail at 1 of the backup centers. When VCL management investigated these complaints, they discovered that the backup center staff were not aware the voicemail system existed; thus, they did not return these calls. Although the dates of the calls were not in the messages, and VCL staff could not tell how old the messages were, responders still followed up on the voicemail messages that contained enough information to allow contact with the caller. The VCL manager, who investigated these complaints, discussed the issue with managers at all the backup centers. VCL management reported that they are working, along with VHA representatives, to change the current requirements in the VA contract with L2HS, once the existing contract expires, to include a restriction on the use of voicemail.

We reviewed five additional FY 2014 complaints from callers that included remaining "on hold" for at least 20 minutes or being repeatedly put on hold, listening to music

[18] American Association of Suicidology, *Organization Accreditation Standards Manual*, January 2012.
[19] *Department of Health and Human Services: Substance Abuse and Mental Health Administration, Crisis Services: Effectiveness, Cost – Effectiveness, and Funding Strategies,* HHS Publication No. (SMA)-14-4848, printed 2014.

when calling the VCL, and experiencing calls "not put through." "On hold" meant that the call would not reach a VCL responder or backup center staff member directly, but instead would be transferred to a backup center queue to wait for someone to answer the call. During this time, the caller would listen to music. Because neither the VCL program managers nor the backup center managers monitor information on how long calls were in the backup center queues, VCL management was unable to confirm or provide data as to whether callers were "on hold" for any extended time or if calls were dropped. The complaints about being "on hold" or "not put through" could account for the complainant's allegation that calls were not answered by the VCL staff. VCL management reported that these incidents would receive further investigation.

In addition to being uncertain as to how long callers were in backup center queues, VCL management told us that they were unsure if the backup centers thoroughly reported every call through direct contact or disposition emails to the VCL staff. Although VCL management had not confirmed this concern using call number data, they reported that calls had gone to backup center voicemail systems without any notification to the VCL that a call had been received.

Callers Do Not Receive Immediate Assistance. We identified that 11 of the 41 complaints made to the VCL in FY 2014 concerned incidents when responders did not give immediate assistance to callers; the complaints concerned both VCL and backup center staff. These incidents involved responders allegedly ending calls without providing assistance, inappropriately transferring calls, and telling callers to contact another organization. VCL management stated that, if they confirmed a complaint, the supervisory staff provided training and/or counseling to VCL responders. If the complaint concerned a backup center staff member, VCL management discussed the complaints with backup center management and requested that the involved staff receive training.

In April 2015, VCL management told us that they believed issues/complaints regarding responsiveness have increased due to an increase in calls to the backup centers. According to VCL management, calls forwarded to backup centers were initially intended to account for 10 percent of all answered calls; however, they now account for approximately 17 percent. VCL management stated that in the past, though they hired more responders to answer the increasing number of calls, they did not use a business management model for collecting and analyzing data to map and project staffing needs. However, in an effort to reorganize, they plan to use a proactive business approach that uses and analyzes aggregate data from all sources to assist with forecasting needs. This should make the VCL less reliant on backup centers.

Issue 2: Ambulance Response

We did not substantiate the allegation that a local ambulance requested by VCL took 3 hours to arrive, as we found no evidence that the VCL was involved with the ambulance request in this particular incident.

The issue involved a veteran for whom a community support person (not VCL) had requested from a VAMC a VHA ambulance to transport the veteran to the local VHA

facility. A staff member from the local VHA facility emergency room told the person who requested the ambulance that it would not be available for 3 hours. The VCL had no record of the incident, thus no patient outcome was documented.

Issue 3: VCL Responder Training

We did not substantiate that VCL responders did not have adequate orientation and ongoing training; however, we did find incomplete orientation documentation.

To meet AAS requirements and orientation requirements, VCL supervisors and front line staff use an orientation checklist to track and confirm orientation training. Responder orientation generally requires 40 hours of training, which includes classroom attendance for specific courses, supervisory monitoring such as observation and listening to calls, and on the job training with experienced staff. Responders must also take a pre and post-test.[20] The supervisor and orienting staff member are required to sign and date the completed checklist.

We requested the orientation checklists for responders hired in FY 2014. Of the 33 hired during that time, we found that 6 (18 percent) did not have orientation checklists. The 27 responders who had checklists had completed training modules related to call center rescues and consult resources. However, 24 of the 27 (89 percent) orientation checklists did not have all of the checklist items marked as completed and/or were not signed or dated by the responders' supervisors. We also found no evidence that 18 of the 33 (55 percent) responders had taken a post-orientation test. When we interviewed responders, they told us that the training, including both classroom time and several weeks of observation, was adequate.

To meet AAS ongoing training requirements for 2–3 hours, VCL management developed crisis line specific training programs and tracked attendance using VHA's Tempo Track System.[21] We reviewed the tracking system records as well as sign-in records for FY 2014 and found that 212 responders, who were no longer orienting and had worked for 12 months or more, had completed at least 1 VCL specific training class. During an interview, one responder expressed the belief that additional ongoing training would be beneficial.

Issue 4: Veterans Crisis Line Telephone Number

We did not substantiate the allegation that the VCL number on the crisis line business card or other marketing venues was difficult to use in a crisis.

VHA developed the VCL business card, brochures, and other communication information as tools to assist veteran callers to reach the crisis line when needed. When initially developed, the business card and other items used the word TALK as

[20] American Association of Suicidology, *Organization Accreditation Standards Manual*, January 2012.
[21] Nationwide educational tracking system used by some VHA facilities to track staff training requirements and hours.

part of the number without explaining or showing the actual numbers. VHA re-designed the business card, and since January 2014, the lettering (TALK) is now either excluded or includes the corresponding numbers. We observed the same change on the VCL and other suicide prevention web sites and in brochures.

Issue 5: QA Program

We found that the VCL did not meet the intent and goals of QA procedures and processes. Specifically, VCL supervisory staff did not complete the required number of supervision tasks associated with the quality of call responses by VCL responders; QA issues were not tracked to resolution; and VCL management did not collect, analyze, track, and trend backup center and other available data to ascertain whether QA system issues existed.

VCL Responder Supervision. AAS requires accredited crisis centers to review and measure staff skills and the quality of their practices or techniques with callers. To accomplish this, AAS requires crisis centers to perform direct supervision of a responder's crisis work including encounters with callers.[22] According to VCL management, supervisors use a process called silent monitoring to assess the quality of responder practices and techniques and provide QA measurement data. In performing silent monitoring, supervisors evaluate chat documentation by VCL responders and monitor both sides of crisis telephone calls or encounters.

We found that the number of VCL silent monitoring supervision reviews performed during FY 2014 did not meet VCL requirements. During FY 2014, the VCL employed approximately 10 FTE supervisors and, according to VCL management, each supervisor needed to evaluate 4 chat transcripts and 8 responder/caller encounters per month to provide direct supervision of the responders crisis work. The total number of silent monitors per month for 10 supervisors would be 40 chats reviews and 80 responder/caller encounters. However, VCL data shows that for FY 2014, the average number of chat reviews per month was 34 and the average number of caller encounters per month was 52, which is below the amount established by the VCL to assist in meeting the AAS requirements to review the quality of responder practice. Although VCL management acknowledged that they did not perform the required number of silent monitoring supervision reviews, they believed that an increase in caller volume affected the supervisors' ability to perform silent monitoring, as they were likely answering calls or assisting responders.

As a quality of care concern, VCL has identified tracking and trending aggregate data collected on silent monitoring reviews as a means to identify system issues, such as training or staffing needs. However, VCL management reported that they have not formalized the process and that they would like to improve this aspect of measurement to identify quality indicators.

[22] American Association of Suicidology, *Organization Accreditation Standards Manual,* January 2012.

VCL QA Program. AAS does not specifically identify procedures or processes for crisis lines to manage QA activities other than staff supervision; however, it does require leadership to support processes that implement program and outcome evaluations and recommendations.[23] VHA requires specific procedures to include a standing QA committee that meets at least quarterly; collects, analyzes, and reviews aggregate data; develops recommendations; and tracks identified issues to resolution.[24]

VCL management identified one activity in addition to silent monitoring to ensure compliance with QA tasks. They instituted a QA process that organizes complaints to the VCL by date, allows VCL management to track and trend items, and identifies possible actions. Although the VCL program does not have a specific QA standing committee, two internal, supervisory leadership committees performed QA activities including discussion of aggregated data and organizational issues. We reviewed the complaint trends and actions identified by VCL management in FY 2014 as well as the available FY 2014 meeting minutes of the two committees.

Complaint Trends. In FY 2014, the VCL received 41 complaints from callers concerning both the VCL and backup center staff and operations. In general, the management or supervisory staff resolved individual complaints by contacting the complainant, responder, and/or organization involved in the complaint. To address and resolve possible system issues, VCL management grouped the complaints into themes or trends and assessed those trends for system issues. However, although the assessments or briefs usually included action plans with analyses, they did not consistently include timeframes for completion, designate a responsible party, or track identified issues to resolution.

Committee QA Activities. The Supervisory or VCL Leadership Committee and the Advisory Board are internal committees that each performs some QA activities. The Supervisory Committee meets regularly every 1 to 2 weeks and membership includes program management and supervisory staff. Minutes reflected that program management presented VCL aggregate performance data, such as staff hiring and utilization, and committee members discussed day-to-day concerns, such as complaints. However, when we traced several identified issues in the FY 2014 minutes, we found that, other than the initial issue discussion and follow-up staff assignment, the minutes lacked consistent documentation of actions, plans, or issue resolution.

The Advisory Board meets monthly and includes representatives from VCL and VHA leadership. This committee reviews aggregated VCL data and issues that affect staffing and general operations, including VCL call volume, policy revisions, and accreditation. We reviewed the committee's activities throughout FY 2014 and found that the Advisory Board met monthly except for June and July 2014. Meeting agendas were provided for participants; however, meeting minutes were only documented in November 2013 and from February through April 2014. We traced several projects documented in the minutes and found that the committee developed action plans for the issues and

[23] American Association of Suicidology, *Organization Accreditation Standards Manual*, January 2012.
[24] VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

projects on the agenda. In some instances, the projects were followed to a rollout, but because the action plans usually had no dates it was difficult to understand when the rollout would occur. We also found very little documentation of discussion other than a statement of the plan, without responsible parties identified to follow up with the progress of the plan. Because we had so few minutes, we were unable to ascertain if issues were tracked to resolution.

Contract Partners and Backup Center QA. SAMHSA and L2HS provide specific quality assurance data related to the telephone and other communication operations, but not on patient outcomes or other quality indicators. In addition to collecting data, VCL management also meets with VHA leadership, backup center management, and NSPL representatives to discuss system issues.

SAMHSA Inter-Agency Agreement. The SAMHSA Inter-Agency Agreement stipulated that SAMHSA would monitor the ongoing use of the toll free number as the first contact for the veteran calling the VCL, analyze trends, and provide a quarterly report to VHA program officials with recommendations concerning projected call needs and technical modifications required to meet those projected needs. Data is specifically focused on the number of calls going to the VCL and backup centers and whether the system is able to handle the call volume.

L2HS Contract. Specific quality targets designated by the L2HS contract included the 100 percent successful routing of calls and chats to the VCL or, if VCL staff were unavailable, to the backup centers. The contract required that the VCL manager and the VHA contracting officer discuss and review these monitors weekly. However, according to VCL management, due to the lack of QA staff, they did not hold weekly discussions and did not consistently review the data for call routing issues.

Backup Centers. According to VCL management, backup centers do not provide QA data. When issues arise, the Network provides incident reports and memos to the VCL. In an interview on April 6, 2015, VCL management reported that they would like to change the contract to ensure that the Network provides QA data.

VCL management participates in a monthly meeting called VA Backup Conference Calls with representatives from the backup centers, VHA leadership, and NSPL to discuss data and other issues such as call volume, complaints, or technical problems. Meeting minutes did not reflect that members analyzed aggregated data or addressed QA issues on a system level. According to VCL management, only the September, October, and November 2014 meeting minutes were available.

We identified an additional data source that the VCL has not utilized for QA purposes. This data source is related to backup center communications with VCL responders and SSAs but is not part of the monthly meetings with the backup centers. When the backup center staff take a call from someone trying to reach the VCL, they send an email to the VCL with the caller's demographic information, the circumstances surrounding the call, and any actions or rescue efforts taken to resolve the crisis. VCL staff copy this information onto a disposition form and follow up on any actions or rescues performed by the backup center staff. For QA purposes, the disposition form

could identify information that may be relevant for future rescues as well as system issues regarding the completeness of information provided by specific backup centers. However, according to VCL management, the VCL keeps the forms for 3 months and then destroys them. Information from the form may be entered into the caller's electronic health record, but is not used to evaluate the backup center processes of collecting or conveying caller information to the VCL.

We determined that VCL procedures and policies are not guided by a VHA Directive or Handbook specific to the VCL. In contrast, VHA does have a directive for the National Call Center for Homeless Veterans.[25] We consider this lack of a VCL-specific directive or handbook as a contributing factor for the absence of an organized QA process (and other processes). Specific directions and guidelines would assist VCL management to identify and address system issues.

Issue 6: SSA Training

We substantiated allegations that SSAs did not receive orientation and ongoing training that met VCL training requirements. In addition, we could not find documentation that the majority of SSAs had received training on rescues and the use of potential resources.

SSAs, like the responders, use an orientation checklist to track and confirm orientation training. Orientation generally requires 40 hours of training, which includes classroom attendance for specific courses and on the job training with experienced staff.[26] Observation of an SSA performing rescue functions is optional and decided on by the SSA's supervisor. The supervisor and orienting SSA are required to sign and date the completed checklist.

We requested the orientation checklists for the 24 currently employed SSA staff (hired between August 12, 2012, and September 7, 2014). VCL supervisors could only find two checklists and an email stating that one SSA had completed the orientation. Similar to the responder checklist, the SSA checklist includes information on whether the SSA completed training on rescues and training on consult resources. During interviews, SSA staff reported that orientation consisted mostly of sitting with another SSA who may or may not have been experienced and access to a handbook that did not instruct them on specific SSA procedures or processes. Some SSAs stated that they did not feel they had adequate training and had received erroneous or inadequate information from other SSAs, including information regarding rescue procedures and consult resources.

SSAs who are no longer orienting and have worked 12 months or more have the same VCL requirements for ongoing training and may attend the same training as responders. After reviewing the tracking system, we found that 10 of the 24 currently employed SSAs were no longer orienting and had worked at the VCL for 12 months or more.

[25] VHA Directive 2010-043, *Operation of the National Call Center for Homeless Veterans,* September 28, 2010.
[26] American Association of Suicidology, *Organization Accreditation Standards Manual,* January 2012.

Three of the 10 SSAs had no evidence of VCL specific training during FY 2014. During interviews, SSAs reported that after completing orientation they received little or no ongoing training.

In addition to training, SSAs may benefit from situational related guidance such as a process algorithm[27] with systematic instructions to efficiently and effectively perform the tasks related to the challenging rescue function. The sequential instructions should be based upon available information at specific decision points and include what progressive steps need to be taken if one step fails or if a situation changes.[28] VHA uses this type of guidance for many clinical practice processes including assessments and referrals for the visually impaired, women's health, anticoagulation therapy, and rehabilitation continuum of care. There is no specific VHA suicide rescue algorithm; however, algorithms are commonly used in emergency medical situations, such as triaging and dispatching appropriate services for a patient with stroke symptoms.[29]

SSAs at the VCL have a procedure handbook available. However, they describe the handbook procedures as broad with no specific details to guide the rescue process in a progressive systematic or situation specific fashion. Experienced staff may be available but may also be busy with other tasks or rescues.

Issue 7: Backup Center Staff Training

We could not substantiate that the backup center staff and volunteers lacked training, as the VCL does not monitor individual backup center personnel training. However, the VCL does monitor caller complaints regarding the backup centers, and we were able to identify several issues from the FY 2014 complaints concerning backup center actions and responses, which raised concerns regarding training adequacy.

According to VCL program management, backup center staff and volunteers receive specific training on suicide crisis interventions through the backup centers and in conjunction with the L2HS contract. Although, by contract, VCL management/supervisory staff assist in developing backup center staff training, VCL is not required to provide or monitor the training. However, as part of the QA process, VCL management monitors caller complaints regarding backup centers. Upon review of FY 2014 complaints, we identified several issues concerning backup center staff actions and responses, which in turn raised concerns about training adequacy. VCL management reported that for each caller complaint involving backup center staff, the backup center management received information from the VCL about the complaint and a request to provide training. VCL did not monitor whether the training occurred.

[27] An algorithm is a systematic process consisting of an ordered sequence of steps, each depending on the previous step. The process is used to solve a problem.
[28] Medilexicon, http://www.medilexicon.com/medicaldictionary.php?t=2189, accessed on October 27, 2015.
[29] Prasanthi Govindarajan, et al., Comparative Evaluation of Stroke Triage Algorithms for Emergency Dispatchers (MeDS: Prospective Cohort Study Protocol, *BioMed Central Neurology*, 2011, 11:14 http://www.biomedcentral.com/1471-2377/11/14, accessed October 27, 2015.

In addition to reviewing the complaints, we interviewed VCL responders and SSA staff who had direct contact with the backup centers. Direct contact means that the VCL staff member received caller disposition emails from the backup center responders describing demographic information and their interactions with callers. VCL staff reported issues with the backup center staff emails to the VCL and told us that while most backup center staff sent disposition emails within a few hours, on occasion, emails were not received for several hours or days. Additionally, VCL staff told us that emails from backup center staff were frequently not comprehensive and lacked basic or sufficient information for SSAs to confirm the outcome of the call or the veteran's disposition without having to call the backup center, search for additional information using VCL resources, or essentially duplicate the caller interaction. To complete the interaction with the backup centers, SSAs and responders enter information into relevant fields of a template in the VCL's software program. The VCL does not provide backup centers with an email template that correlates with the VCL template, and contracts do not specify relevant template information fields for backup center staff to document and send to the VCL.

VCL management did not express concern about backup center staff training and believed that they had sufficient communication with the backup centers about complaints and training. Backup center managers had assured VCL management during monthly conference calls and with other forms of communication that complaints were addressed and staff was compliant with training. In recent monthly meetings with backup center staff, VCL management requested detailed explanations of the centers' training programs, which they provided. However, VCL management has no formal process to confirm whether backup center staff complete the training discussed during the meetings.

Conclusions

We substantiated allegations that backup crisis centers routed some VCL calls to voicemail, callers did not always receive immediate assistance from VCL and/or backup center staff, and the VCL did not provide social service assistants with adequate orientation and ongoing training. In addition, we found that orientation checklists, though considered complete, often had missing items or lacked the signature of the staff member and/or the supervisor. The VCL program does not provide or monitor backup centers' staff training; therefore, we could not substantiate that backup center staff, including volunteers, did not receive adequate training. However, we found evidence that raised concerns regarding backup center training adequacy.

We found that VCL management addressed issues regarding voicemail and offering immediate assistance to callers. Management retrained VCL staff; however, training for backup center responders was not confirmed because the VCL has no formal process to verify that training at backup centers was initiated or completed.

We also found that callers had made numerous complaints of long wait times for responders, being put "on hold," or calls "not being put through" to a responder. This could account for the issue of calls not being answered by the VCL staff or backup

center staff. However, VCL management had no data to ascertain whether the issues were valid, thus we could not substantiate that VCL and backup center staff did not answer calls.

VCL management had identified specific quality assurance issues as trends, and although they often identified actions, they did not consistently document the implementation of actions and track issues to resolution. We also identified gaps in other QA activities including an insufficient number of silent monitoring reviews and the lack of quality assurance data from contract partners. We determined that a contributing factor of the VCL QA process gaps was the lack of a VCL-specific VHA directive or handbook to provide guidance for VCL QA and other procedures and policies.

We did not substantiate the allegation that the ambulance requested by the VCL took 3 hours to arrive, as we found no evidence that the VCL was involved with the request for this particular ambulance. In addition, we did not substantiate that the VCL phone number was difficult to use during a crisis. Since 2014, either the lettering (TALK) in the VCL 1-800 number was omitted or corresponding numbers for the letters (TALK) were included. We observed this on all printed media, including web based sites.

VHA leadership and VCL management acknowledged some gaps in the VCL and backup center training and QA processes. They reported that systems were being reviewed to resolve issues. This includes reviewing existing contracts with non-VHA vendors.

Recommendations

1. We recommended that the Office of Mental Health Operations 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.

2. We recommended that the Office of Mental Health Operations Executive Director ensure that orientation and ongoing training for all Veterans Crisis Line staff is completed and documented.

3. We recommended that the Office of Mental Health Operations Executive Director ensure that silent monitoring frequency meets the Veterans Crisis Line and American Association of Suicidology requirements and that compliance is monitored.

4. We recommended that the Office of Mental Health Operations Executive Director establish a formal quality assurance process, as required by the Veterans Health Administration, to identify system issues by collecting, analyzing, tracking, and trending data from the Veterans Crisis Line routing system and backup centers and that subsequent actions are implemented and tracked to resolution.

5. We recommended that the Office of Mental Health Operations Executive Director consider the development of a Veterans Health Administration directive or handbook for the Veterans Crisis Line.

6. We recommended that the Office of Mental Health Operations Executive Director ensure that contractual arrangements concerning the Veterans Crisis Line include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.

7. We recommended that the Office of Mental Health Operations Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.

Appendix A

Office of Mental Health Services and Operations Comment

Department of Veterans Affairs

Memorandum

Date: December 28, 2015

From: Executive Director, VHA Office of Mental Health Services and Operations (10NC5)

Subj: Healthcare Inspection—Veterans Crisis Line Caller Response and Quality Assurance Concerns, Canandaigua, New York

To: Director, (Bedford Regional Office) Office of Healthcare Inspections (54BN)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

David Carroll, Ph.D.
Executive Director, Mental Health Operations (10NC5)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Office of Mental Health Operations 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.

Concur

Target date for completion: April 1, 2016

Program response: Requirements for recurring reports (daily, weekly, monthly, etc.) are outlined in both the FY16 six month contract extension (10/1/15–3/31/16) and the FY16 Back-Up Center Contract Performance Work Statement (PWS; 4/1/16 onward). Reports are provided and analyzed by OMHO and VCL staff to track, trend, and identify system issues related to back-up center service quality and technical performance. VCL leadership and OMHO management work with the contracting officer to notify the contractor of issues and follow-up through issue resolution. The FY16 Back-up center contract contains a Quality Assurance Surveillance Plan (QASP) that will be used to require contractor adherence to system performance and service quality standards. Example back-up center metrics for analysis, tracking, and trending include: total offered and total answered calls, abandonment rate, average speed to abandonment, average speed of service, and average wait time in queue.

Hold Times: It is currently against VCL policy for back-up centers to put VCL callers on hold ("hold" is defined as an answered call where the caller waits before being receiving any service or assessed for risk). This requirement was added to the FY15 PWS once this issue was identified. This prohibition is clearly stated in the current FY16 back-up center contract six month extension and is contained in the new PWS for the FY16 Back-up Center contract to be in effect 4/1/16.

Timely Access: The PWS for the FY16 Back-Up Center contract requires that the contractor manage the routing of "rollover" calls, ensuring callers receive timely access to services, where timely access is defined as 90% of calls answered within 30 seconds of rollover, where no caller waits more than 2 minutes. A FY15 PWS amendment prohibited back-up centers from using voice answering systems (i.e., answering machines, voice mailboxes).

Monitoring and Quality Assurance: FY16 PWS requires the contractor to provide detailed daily and monthly reporting to ensure these performance metrics are met and to maintain a 24/7/365 emergency support line (ESL) to enable real-time notification of system issues (all of which will be monitored as outlined in the QASP).

Recommendation 2. We recommended that the Office of Mental Health Operations Executive Director ensure that orientation and ongoing training for all Veterans Crisis Line staff is completed and documented.

Concur

Target date for completion: September 30, 2016

Program response: New employee orientation (NEO) occurs in conjunction with new VA employee human resources orientation or federal employee job transfer procedures. New staff orientation is delivered and monitored by the VCL staff. VCL management monitors completion and post-test achievement data on a weekly basis to identify staff (responders and social service assistants) needing training and potential gaps in training. Remediation or re-training is coordinated through the VCL supervisory team, clinical care coordinators, and/or VCL leadership. As an interim solution, VCL established a training database in July 2015 to track completion and achievement on VCL-specific trainings to supplement the existing VA Talent Management System (TMS) tracking method and created a shared "Training Calendar." As a long-term solution, VCL management plans to input internal trainings into TMS for assignment, tracking, and reporting.

VCL management is developing one integrated tracking system for VA, facility, and VCL-specific NEO training and ongoing training requirements to enable reporting of individual and organizational training status. The tracking system will include a revised NEO and ongoing training requirements checklist including supervisor/leadership sign-off to ensure completion and accountability. Full implementation of updated NEO and ongoing training curriculum, instruction, tracking, and reporting is contingent on hiring training, quality management, and analytics staff (in process).

Recommendation 3. We recommended that the Office of Mental Health Operations Executive Director ensure that silent monitoring frequency meets the Veterans Crisis Line and American Association of Suicidology requirements and that compliance is monitored.

Concur

Target date for completion: September 30, 2016

Program response: Complete implementation of an updated call monitoring (silent monitoring) program with adjusted frequencies to meet appropriate sampling will occur after the onboarding of quality management staff designated to perform call monitors for quality assurance and continuous quality improvement.

Recruitment for the Quality Management Officer (QMO) is in process, and the QMO will be responsible for developing a formal quality assurance plan/program that includes silent monitoring and meets the American Association of Suicidology (AAS) requirement

of “a written plan for assuring that the quality of crisis worker intervention is monitored, recorded and corrected.”

Recommendation 4. We recommended that the Office of Mental Health Operations Executive Director establish a formal quality assurance process, as required by the Veterans Health Administration, to identify system issues by collecting, analyzing, tracking, and trending data from the Veterans Crisis Line routing system and backup centers and that subsequent actions are implemented and tracked to resolution.

Concur

Target date for completion: Back-Up Centers- April 1, 2016; VCL- September 30, 2016

Program response: **Back-up Centers:** Monitoring of contracted back-up centers will be achieved through reports provided by the contractor and adherence to metrics defined in the QASP and through VCL’s internal complaint tracking system. Currently back-up center service quality is addressed through the complaint/compliment tracking process, contractor oversight of back-up center operations, and VCL analysis of contractor provided reports. Back-up center operational processes and expectations are outlined in the PWS and will be monitored through the FY16 Back-Up Center Contract QASP.

VCL: VCL is developing a formal quality assurance program and implementation plan that includes call monitoring, complaint and compliment tracking, end-of-call satisfaction measurement, and a formal coaching plan. The quality management plan includes a comprehensive database for tracking, trending and reporting on quality improvement data from issue identification to actions and resolution. Data will be used to inform training initiatives through a continuous quality improvement cycle that includes data collection, analysis and feedback, standard work review/updates, training, and implementation.

Recommendation 5. We recommended that the Office of Mental Health Operations Executive Director consider the development of a Veterans Health Administration directive or handbook for the Veterans Crisis Line.

Concur

Target date for completion: June 1, 2016

Program response: Development of a draft VCL Veterans Health Administration (VHA) Directive and associated education and communication plan is part of the VCL’s current Performance Improvement Plan. This draft VHA Directive will define roles, responsibilities, and relationships with other VA and non-VA entities to promote appropriate access, quality, and follow-up of crisis intervention/suicide prevention services.

The VCL Employee Handbook, an internal guide for VCL employees, was updated in October 2015. New VCL leadership is currently preparing a draft revision of the

Handbook to more closely align with the Health Resource Center (HRC) Employee Handbook which will state VCL's mission, vision, and values; explain overall context of VCL within VA; highlight key employee conduct and performance expectations consistent with a high volume call center environment; and share important employee resources and organizational initiatives.

Recommendation 6. We recommended that the Office of Mental Health Operations Executive Director ensure that contractual arrangements concerning the Veterans Crisis Line include specific language regarding training compliance, supervision, comprehensiveness of information provided in contact and disposition emails, and quality assurance tasks.

Concur

Target date for completion: April 1, 2016

Program response: The FY16 PWS states that the contractor must ensure back-up center responders have access to all needed materials and resources to successfully perform crisis intervention work 24/7/365 according to National Suicide Prevention Lifeline standards (including supervision), are trained according to the training specifications in the QASP, and provide call documentation on the standardized VCL template for all answered calls.

The FY16 PWS states that there will be monthly clinical calls facilitated by VCL Subject Matter Experts that include contractor and back-up center representatives and the Substance Abuse and Mental Health Services Administration (SAMHSA) grantee, to ensure contracted back-up centers provide clinically sound support to Veterans Crisis Line callers. The contractor will be responsible for submitting the agenda and meeting minutes to the VCL Director.

Recommendation 7. We recommended that the Office of Mental Health Operations Executive Director consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.

Concur

Target date for completion: May 1, 2016

Program response: VCL management is currently developing standard work, or algorithms, to ensure standardization of work processes for all caller types and the emergency dispatch process (formally referred to as a "rescue"). This standard work will provide clear, specific guidance regarding decision points, roles, and responsibilities during the emergency dispatch process, particularly for Social Service Assistants.

Appendix B

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix C

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