April 27, 2017

Preventing Veteran Suicide

Subcommittee Military Construction, Veterans Affairs, and Related Agencies, Committee on Appropriations, United States Senate, One Hundred Fifteenth Congress, First Session

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Chairman Jerry Moran Opening Statement
Committee on Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

Hearing titled "Preventing Veteran Suicide"

April 27, 2017

(*As prepared for delivery*)

Welcome to our second subcommittee hearing of 2017. The Subcommittee will come to order. Good morning. Thank you all for being here today to consider the important and tragic topic of veteran suicide. The latest data available suggests 20 veterans a day take their own life, and we all agree that even one is too many.

Today we have a large panel – but each member brings valuable expertise on how to help veterans in crisis. Today we will discuss the impact of the Department's efforts to combat veteran suicide as well as how community-based organizations and cutting-edge research are leading and supporting initiatives to eliminate veteran suicide. I do want to note that while headlines have brought attention to deficiencies in the VA's management of certain programs, the news does not tell the stories of lives that are saved. This hearing is about bringing awareness not only to the issues that may need work, but also to share the success that is occurring every day by mental health professionals across the VA who are saving the lives of veterans.

This subcommittee has responded with increases in funding for veteran suicide prevention programs, the Veterans Crisis Line, and mental healthcare. There have been increases in funding each year. Yet, since 2001, the rate of veterans using VA healthcare who were diagnosed with a mental health or substance abuse disorder rose "substantially" from 27 percent to more than 40 percent; and we have seen veteran suicide rates remain steady. I want to hear today from the Department on the plan to address this disconnect – if not an increase in funding then what? I do not see a connection between increased funding and better outcomes. I hope our community witnesses will speak to that disconnect, provide their perspective on resources, and share where they see the greatest need or opportunity for better investments to prevent suicide among our veterans.

What should we be doing differently; what are we not doing that should be done? Where appropriate, are there complementary and alternative treatments that should be embraced? How are job training and education incorporated into a treatment plan for veterans? What about family support – marriage and family counseling, caregiver support, providing mechanisms for connecting families caring for veterans in need?

We know, especially in our rural areas, access to mental healthcare can be extraordinarily difficult. We need to make certain no veteran feels abandoned by the country they served when they make the brave decision to seek mental healthcare services. I hope to hear today that the Department has a plan for increasing access to this crucial type of care in the places that need it the most.

Congress needs to know better how to support the Department, the Department needs to seek community partners and embrace the helpful findings of outside experts, and veteran-supporting groups need to be vocal about the needs of in-crisis veterans and their families. I hope this hearing helps bring us together to end veteran suicide.

I'd like to introduce our panel:

Dr. Carolyn Clancy, M.D., is the Deputy Undersecretary for Health for Organizational Excellence at the Veterans Health Administration. She is accompanied by Dr. Harold Kudler, M.D., Chief Consultant for Mental Health Services.

Dr. Stephanie Davis is a Suicide Prevention Coordinator and Staff Psychologist from the VA Eastern Kansas Healthcare System.

Mrs. Melissa Jarboe is the Chief Executive Officer and Founder of the Military Veteran Project located in Topeka, Kansas – but with a worldwide presence. Melissa is a Gold Star Wife, who has dedicated her life to support soldiers and veterans – a promise she made to her late husband, Staff Sergeant Jamie Jarboe.

The Honorable Michael Missal is the Inspector General at the Department of Veterans Affairs; and,

Mr. Rajeev Ramchand is a Senior Behavioral Scientist at the RAND Corporation who is an expert on the prevalence, prevention, and treatment of mental health in service members.

Welcome to all of you.

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STATEMENT OF CAROLYN CLANCY, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH FOR ORGANIZATIONAL EXCELLENCE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES
APRIL 27, 2017

Good morning Chairman Moran, Ranking Member Schatz, and distinguished members of the Subcommittee. Thank you for the opportunity to discuss the important topic of suicide prevention among our Nation's Veterans. I am joined today by Dr. Harold Kudler, Chief Consultant for Mental Health Services for the Veterans Health Administration (VHA) and Dr. Stephanie Davis, Suicide Prevention Coordinator for the VA Eastern Kansas Health Care System.

Recent research suggests that 20 Veterans die by suicide each day, putting Veterans at even greater risk than the general public. VA is committed to ensuring the safety of our Veterans, especially when they are in crisis. Losing one Veteran to suicide shatters their family, loved ones and caregivers. Veterans who are at risk or reach out for help must receive assistance when and where they need it in terms that they value. Our commitment is to do everything possible to prevent suicide among the Veterans we serve and to reach all Veterans through partnerships and collaboration.

Suicide Prevention Overview

VA has developed the largest integrated suicide prevention program in the country. We have over 1,100 dedicated and passionate employees, including Suicide Prevention Coordinators, Mental Health providers, Veterans Crisis Line staff, epidemiologists, and researchers, who spend each and every day solely working on suicide prevention efforts and care for our Veterans. Screening and assessment processes have been set up throughout the system to assist in the identification of patients at risk for suicide. VA also developed a chart "flagging" system to ensure continuity of care and provide awareness among providers. Patients who have been identified as being at high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, weekly follow-up visits, and care plans that directly address their suicidality.

Reporting and tracking systems have been established in order to learn more about Veterans who may be at risk and help determine areas for intervention. We also have two centers devoted to research, education, and clinical practice in the area of suicide prevention. VA's Veterans Integrated Service Network (VISN) 2 Center of Excellence in Canandaigua, New York, develops and tests clinical and public health intervention strategies for suicide prevention. VA's VISN 19 Mental Illness Research Education and Clinical Center (MIRECC) in Denver, Colorado, focuses on: (1) clinical conditions and

neurobiological underpinnings that can lead to increased suicide risk; (2) the implementation of interventions aimed at decreasing negative outcomes; and (3) training future leaders in the area of VA suicide prevention.

Current Initiatives

Every Veteran suicide is a tragic outcome and regardless of the numbers or rates, one Veteran suicide is too many. We continue to spread the word throughout VA that "Suicide Prevention is Everyone's Business." The ultimate goal is to proactively eliminate suicide among Veterans via: strategic community partnerships, identification of risk, training, treatment engagement, effective treatment, lethal means education, research, and data science. Although we understand why some Veterans may be at increased risk, we continue to investigate and take proactive steps. The ultimate goal is eliminating suicide among Veterans. VA's basic strategy for suicide prevention requires ready access to high quality mental health services supplemented by programs designed to help individuals and families engage in care, and to address suicide prevention in high-risk patients.

REACH VET

Suicide prevention is VA's highest clinical priority. As part of VA's commitment to put resources, services, and all technology available to reduce Veteran suicide, Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) was initiated. This new program was launched by VA in November 2016 and was fully implemented in February 2017. REACH VET uses a new predictive model in order to analyze existing data from Veterans' health records to identify those who are at a statistically-elevated risk for suicide, hospitalization, illnesses, and other adverse outcomes. Not all Veterans who are identified have experienced suicidal ideation or behavior. However, REACH VET allows VA to provide support and pre-emptive enhanced care in order to lessen the likelihood that challenges Veterans face will become a crisis.

The VA REACH VET team and Army Study to Assess Risk and Reslience in Servicemembers (Army STARRS) teams have worked closely together, as both groups have developed predictive analytics capabilities. Because modeling risk is highly dependent on the available data, the approaches of both groups differ.

DoD and VA have integrated a public health approach to suicide prevention, intervention, and postvention using a range of medical and non-medical resources through:

- Data and Surveillance
- Messaging and Outreach
- Evidence-based Practices
- Workforce Development
- Federal and Non-government Organization Engagements

Once a Veteran is identified, his or her mental health or primary care provider will review their treatment plan and current condition(s) to determine if any enhanced care

options are indicated. The provider will then reach out to Veterans to check on their well-being and inform them that they have been identified as a patient who may benefit from enhanced care. This allows the Veteran to participate in a collaborative discussion about their health care, including specific clinical interventions to help reduce suicidal risk.

Veterans Crisis Line

Since 2007, VCL has answered over 2.8 million calls and dispatched emergency services to callers in crisis over 75,000 times. The VCL 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 more than 336,000 requests for chat.
- Expanding modalities to our Veteran population by adding text services in November 2011, resulting in nearly 69,000 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 ever been since its inception in 2007. VCL staff has forwarded over 463,000 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 2 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 facilities in Canandaigua and Atlanta 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.

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 rolled over only 58 phone calls. Since then, we continue to keep rollover calls well below 1 percent. This means that on average, we answer over **99 percent** of calls received on a daily basis by the Canandaigua and Atlanta call centers.

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 trained crisis hotline responder. 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.

Other Than Honorable Discharges

We know that 14 of the 20 Veterans who commit suicide on average each day do not receive care within VA. We need to find a way to provide care or assistance to all of these individuals. Therefore, VA intends to expand access to emergent mental health care for former Servicemembers with other than honorable (OTH) administrative discharges. This initiative specifically focuses on expanding access to assist former Servicemembers with OTH administrative discharges who are in mental health distress and may be at risk for suicide or other adverse behaviors. It is estimated that there are a little more than 500,000 former Servicemembers with OTH administrative discharges. As part of the initiative, former Servicemembers with OTH administrative discharges who present to VA seeking mental health care in emergency circumstances for a condition the former Servicemember asserts is related to military service would be eligible for evaluation and treatment for their mental health condition.

VA has authority to furnish care for service-connected conditions for former Servicemembers with OTH administrative discharges if those individuals are not legally barred from benefits. Such individuals may access the system for emergency mental health services by calling the Veteran Crisis Line, or visiting a VA Emergency Room, Outpatient Clinic, or Vet Center. Services may include: assessment, medication management/pharmacotherapy, lab work, case management, psycho-education, and psychotherapy. We may also provide services via telehealth.

Expanding Mental Health Services

While focusing on suicide prevention, we know that preventing suicide for the population we serve does not begin with an intervention as someone is about to take an action that could end his or her life. Just as we work to prevent fatal heart attacks, we must similarly focus on prevention, which includes addressing many factors that contribute to someone feeling suicidal. We are aware that access to mental health care is one significant part of preventing suicide. VA is determined to address systemic problems with access to care in general and to mental health care in particular. VA has recommitted to a culture that puts the Veteran first. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increased staff in mental health services. Between 2005 and 2016, the number of Veterans who received mental health care from VA grew by more than 80 percent. This rate of increase is more than three times that seen in the overall number of VA users. This reflects VA's concerted efforts to engage Veterans who are new to our system and stimulate better access to mental health services for Veterans within our system. In

addition, this reflects VA's efforts to eliminate barriers to receiving mental health care, including reducing the stigma associated with receiving mental health care.

Making it easier for Veterans to receive care from mental health providers also has allowed more Veterans to receive care. VA is leveraging telemental health care by establishing four regional telemental health hubs across the VA health care system. VA telemental health innovations provided more than 427,000 encounters to over 133,500 Veterans in 2016. Telemental health reaches Veterans where and when they are best served. VA is a leader across the United States and internationally in these efforts. VA's MaketheConnection.net, Suicide Prevention campaigns, and the Posttraumatic Stress Disorder (PTSD) mobile app (which has been downloaded over 280,000 times) contribute to increasing mental health access and utilization. VA has also created a suite of award-winning tools that can be utilized as self-help resources or as an adjunct to active mental health services.

Additionally, in 2007, VA began national implementation of integrated mental health services in primary care clinics. Primary Care-Mental Health Integration (PC-MHI) services include co-located collaborative functions and evidence-based care management, as well as a telephone-based modality of care. By co-locating mental health providers within primary care clinics, VA is able to introduce Veterans on the same day to their primary care team and a mental health provider in the clinic, thereby reducing wait times and no show rates for mental health services. Additionally, integration of mental health providers within primary care has been shown to improve the identification of mental health disorders and increase the rates of treatment. Several studies of the program have also shown that treatment within PC-MHI increases the likelihood of attending future mental health appointments and engaging in specialty mental health treatment. Finally, the integration of primary care and mental health has shown consistent improvement of quality of care and outcomes, including patient satisfaction. The PC-MHI program continues to expand, and through January 2017, VA has provided over 6.8 million PC-MHI clinic encounters, serving over 1.5 million individuals since October 1, 2007.

Hiring Practices

At VA, we have the opportunity, and the responsibility, to anticipate the needs of returning Veterans. As they reintegrate into their communities, we must ensure that all Veterans have access to quality mental health care. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from over 900,000 in fiscal year (FY) 2006 to more than 1.65 million in FY 2016.

We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA has taken aggressive action to recruit, hire, and retain mental health professionals in order to improve Veterans' access to mental health care. As part of our ongoing

comprehensive review of mental health operations, VA has considered a number of factors to determine additional staffing levels distributed across the system, including the following: Veteran population in the service area; the mental health needs of Veterans in that population; and the range and complexity of mental health services provided in the service area.

Since there are no industry standards defining accurate mental health staffing ratios, VA is setting the standard, as we have for other dimensions of mental health care. VHA has developed a prototype staffing model for general mental health and is expanding the model to include specialty mental health. VHA will build upon the successes of the primary care staffing model and apply these principles to mental health practices. VHA has developed and implemented an aggressive recruitment and marketing effort to fill specialty mental health care occupations. Key initiatives include targeted advertising and outreach, aggressive recruitment of qualified trainees/residents to leverage against mission critical mental health vacancies, and providing consultative services to VISN and VA stakeholders.

VA is committed to working with public and private partners across the country to support full hiring to ensure that no matter where a Veteran lives, he or she can access quality, timely mental health care. For example, multiple professional organizations, including the American Psychiatric Association and American Psychological Association, have offered support in getting announcements to their members about fulfilling career opportunities with VA.

Conclusion

Mr. Chairman, all of us at VA are saddened by the crisis of suicide among Veterans. We remain focused on providing the highest quality care our Veterans have earned and deserve and which our Nation trusts us to provide. Our work to effectively treat Veterans who desire or need mental health care continues to be a top priority. We emphasize that we remain committed to preventing Veteran suicide, aware that prevention requires our system-wide support and intervention in preventing precursors of suicide. We appreciate the support of Congress and look forward to responding to any questions you may have.

Military Veteran Project Founder, Melissa Jarboe, delivered the following testimony today at the House Veterans Affairs Committee hearing titled, *Veteran Suicide Prevention.*

Thank you Chairman and Ranking Member(s) for the opportunity to appear before this committee to discuss the topic of Veteran Suicide.

Six years ago, on April 10, 2011, as I was driving to work, I received a phone call informing me that my husband, Staff Sergeant Jamie Jarboe, was shot by a sniper while on patrol in the Zhari District of Afghanistan. The sniper's bullet entered the left side of my husband's neck, and exited through the lower part of his right shoulder blade instantly paralyzing him from the chest down. Forty-eight hours later, I was standing at his bedside at Walter Reed Hospital. Jamie was able to open his eyes just long enough for me to tell him, “I love you. Continue to fight because your family needs you”. My husband did just that. Over an 11-month period, Jamie endured over 100 surgical procedures in an effort to heal him physically; however, it was during this fight for survival that I noticed dramatic changes in my husband mentally. The hospital staff would come in, administer medications, day after day, hour after hour. At one point, he was on 59 different doses of medication in a single day. There would be entire days when Jamie would not even be able to open his eyes, and when I asked why my husband was so over-medicated, lethargic, the hospital staff would respond "How would you like us to care for your husband?" That is when I began to do my own research on symptoms, medications, and brain patterns. With the assistance of doctors from the Mayo Clinic, John Hopkins and Kennedy Krieger, I was able to educate myself, and those around me, on how to adequately care for Jamie. We began by tapering down his medications, starting with Elixir, Valium, Roxycotin, Oxycontin, Percocet, and Klonopin, just to name a few. We then introduced sensory deprivation treatments. This treatment is where one basically works on resetting the brain by allowing it to shut down in a soundproof barrier for 60 to 90 minutes at a time. The characteristics of post-traumatic stress my husband displayed was manifested each morning at 7:34 a.m., when he would gear up, put on his helmet, his vest, pick up his machine gun and then mime as if he was marching, ending when his head would suddenly jolt back violently. It took me weeks to figure out that my husband was reliving the fateful day when he was shot, over, and over, and over, in his mind. I was

determined to find a way to help Jamie mentally, while Walter Reed continued to help him physically. That is when I came across a man by the name of Dr. Daniel Amen, who has researched the brain using SPECT imaging. From Dr. Amen, I learned that post-traumatic stress is indicated by an increased relative blood flow of the upper extremity of the brain. I further learned that ongoing usage of sensory deprivation as an alternative to narcotic medication has been proven successful. Dr. Amen also explained that a traumatic brain injury is indicated by the decreased relative blood flow in the lower extremity of the brain, and when combined with PTS, can have devastating affects on the brain, if not treated in a timely manner. We continued our efforts to taper down Jamie's narcotic dosages under the direct care of his primary doctors and pain management team, and introduced hyperbaric chamber treatments to Jamie's regimen. This assisted with the cerebral hypoxia his brain had sustained due to a lack of oxygen at the time of his injury. By January of 2012, Jamie was able to carry on a somewhat normal daily schedule: where he woke up at 7:30am, did daily activities for agility, and was able to finally sleep at night due to the fatiguing of his body both physically & mentally. Each day for the 11 months Jamie was in the hospital, we both did everything we could to get back home to our children and family waiting for us in Kansas. All we wanted to do was live our own American dream, have a home with a white picket fence, raise our children, and love one another forever. On March 10, 2012 that dream was shattered when we were told that Jamie would not be coming home. Jamie's tracheal and esophageal area detached and it was only a matter of time before my husband would suffocate. I remember looking at my husband, in complete shock,after we got the news. With his crooked smile, he looked back at me and said, "It figures that would happen. Honey, I want to get a pen and paper, so we can use the remaining moments of my life to help you plan the rest of yours." That day, my husband asked three wishes of me. One, never to re-enter the corporate world. Two, to care for his fellow service members, and three to never become bitter or tainted by this tragedy, so that I might find love again. The second wish of my husband, Staff Sergeant Jamie Jarboe, is why I address you today. To help me carry out Jamie's second wish, I created the Military Veteran Project, a 501c3 military non-profit, with a mission of military suicide prevention through research and alternative treatments.

In the last five years, I have personally met with veterans in crisis, veterans contemplating suicide, widows and family members who have lost their veteran loved one to suicide, and organizations assisting those affected by these all too frequent tragedies. The bottom line is our men and women are returning home from war to fight a new battle on their home soil, and each day the casualties are increasing. It is estimated that anywhere from 14 to 22 veterans and active duty service members take their own lives every day. That would mean since September 11, 2001, using the conservative estimate of 14 veteran suicides a day, we have lost 76,930 heroes. So where does that leave us? Well, a few statistical questions remain unanswered. It is unclear the number of veterans that were combat-experienced versus non-combat, and the number of veterans that were enrolled in the Veterans Administration or not enrolled in the V.A. What is clear is that we have an information gap between the Department of Defense and the V.A. Currently, the computer systems, or databases, between these two government agencies are not compatible. The V.A. is currently relying only on documents veterans hand carry in, to render benefits and/or determine care. If these documents do not reflect a pattern of medical issues, services will not be provided. The disconnect is further evidenced by the discrepancy in Department of Defense discharges and registrations with the V.A. If the DOD releases 1,000 service members this year for retirement or service contract completion, only 37% will register with the Veterans Administration within the allotted time frame.

The VA is further hampered by changes to recruitment quotas initiated after September 11th. Post 9/11, there was a steady increase in enlistment quotas recruiters were required to fill in order to prepare for the war on terrorism. The requirements to join the military were lowered to combat the attrition, and as a result, an increased number of service members with pre-existing conditions were deemed “fit for service,whereas before they would have been classified “not fit for duty.” For example John Doe, who suffered prior mental diagnosis, or psychological symptoms, was passed and allowed to join the Armed Services after 9/11, while prior John Doe would have been dismissed. The need for the Department of Defense to bolster numbers 16 years ago has put a tremendous strain on our Veterans’ Administration today. By allowing these men and women, who may be in

physically and/or mentally fragile states, to serve, we have caused them further harm.

There is also the very real fact that non-combat veterans make up a large percentage of those being served by our V.A. This can directly impact the wait times and availability of services for combat veterans who may be suffering.

In reviewing the numerous cases we have received at the Military Veteran Project, and in consultation with medical and research teams across the nation, we find that the best approach to assisting with veteran suicide prevention is starting where the problem first manifests, in the brain. We know, without question, that our men and women, who are placed in the combat environment, are exposed to a myriad of traumatic events. Add in the direct impact of shock, trauma, sleep deprivation, and malnourishment during the average combat tour, and the resulting damage to the brain is nearly inevitable. If we can properly diagnose our veterans using brain scans or SPECT imaging to identify the harmful effects of combat service, and track them through the entirety of their military career, then we could apply the information gained to adequately diagnose and treat our heroes throughout and immediately following their service.

The suffering of the men and women sent to protect us can no longer be considered status quo. We must take responsibility for providing the care that is necessary to protect them. To achieve this, we need to allocate a budget that allows the VA to properly diagnose our veterans. We need to adequately fund alternative treatment programs, which will empower our veterans to better understand their diagnosis, and result in more effective care plans for them. Have no delusions, this is only the first step in our mission to vanquish veteran suicide, and this is a battle our veterans should not have to fight alone. As a country, we can choose to stand up and unite as one and help our VA system succeed in the treatment of our veterans. We can show every veteran we have their six. The bottom line is this, if we continue to fight against our Veterans Administration we, as a country, will abandon our veterans, and each of us will be responsible for not helping to save a life.

In closing, I ask you to remember the men and women of our military, not only while they hold a rifle and travel to distant lands to fight, but to

remember them when they come home. I ask that you honor them by not merely thanking them for their service, but by taking care of them in their time of need, by fighting for them as they have for us. I ask that you fulfill my husband's dying wish, "take care of my fellow soldiers."

Thank you for the invitation to join you this evening and for your leadership on this critical matter. I'm confident in our ability to unite for this bipartisan issue, together we can prevent military suicide. Thank you.

STATEMENT OF
MICHAEL J. MISSAL
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON MILITARY CONSTRUCTION,
VETERANS AFFAIRS, AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
HEARING ON
"PREVENTING VETERAN SUICIDE"

APRIL 27, 2017

Mr. Chairman, Ranking Member Schatz, and Members of the Subcommittee, 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]

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[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.

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 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

[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.

[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.

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.

[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.

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[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).

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 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

[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.

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.

[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.

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 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 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

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

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.

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

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

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. 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 Subcommittee 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]

[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.

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.

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.

Testimony

Preventing Veteran Suicide

The Critical Role of Community-Based Prevention

Rajeev Ramchand

CT-474

Testimony submitted to the Senate Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies on April 27, 2017.

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Preventing Veteran Suicide: The Critical Role of Community-Based Prevention

Testimony of Rajeev Ramchand[1]
The RAND Corporation[2]

Before the Committee on Appropriations
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
United States Senate

April 27, 2017

Thank you, Chairman Moran, Ranking Member Schatz, and members of the subcommittee, for inviting me to testify today. My name is Rajeev Ramchand, and I am a senior behavioral scientist at RAND. For nearly ten years, I have studied suicide and the best ways to prevent people from taking their own lives. I have interviewed hundreds of people preventing suicide at crisis lines and prevention programs. I also have spoken with the spouses, parents, siblings, children, and battle buddies affected by the death of a loved one. Today, I will summarize areas where our research shows efforts to prevent veteran suicide are working, as well as areas where more effort is needed.

The Department of Veterans Affairs (VA) is the largest integrated health care system in the United States, and it provides the care, offers the programs, and conducts the research that make it a national leader in suicide prevention. The VA sees over six million patients each year, most of whom are middle-aged white men.[3] This is the group at highest risk of suicide nationally. Many VA patients have also been exposed to atrocities in war zones from Vietnam to Afghanistan. As a result, a sizeable number have both visible and invisible wounds.[4] RAND research shows that the VA is serving these veterans with the high-quality care that they deserve. Our analyses reveal that the mental health care delivered at the VA generally exceeds the care

[1] The opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of the RAND Corporation or any of the sponsors of its research.

[2] The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

[3] RAND Health, *Current and Projected Characteristics and Unique Health Care Needs of the Patient Population Served by the Department of Veterans Affairs*, Santa Monica, Calif.: RAND Corporation, RR-1165/1-VA, 2015.

[4] Rajeev Ramchand, Terry L. Schell, Benjamin R. Karney, Karen Chan Osilla, Rachel M. Burns, and Leah Barnes Calderone, "Disparate Prevalence Estimates of PTSD Among Service Members Who Served in Iraq and Afghanistan: Possible Explanations," *Journal of Traumatic Stress*, Vol. 23, No. 1, 2010, pp. 59–68.

offered in other health systems,[5] and that the services provided by the Veterans Crisis Line surpass most crisis lines operating in the United States today.[6] As a member of a panel that reviews and scores VA research proposals, I can attest firsthand to the high-quality research proposed and funded by the VA that will continue to promote it as a national leader in suicide prevention.

This is why the biggest challenge the VA currently faces is preventing suicide among those not enrolled in VA care. In 2015, we learned that veterans with other-than-honorable discharges had double the risk of suicide relative to those who separated honorably. Last month, Secretary Shulkin announced plans to extend services to these veterans who were traditionally ineligible for VA care.[7] We also need to focus on women veterans: The rate of suicide among the youngest cohort of women veterans was 35 per 100,000, a rate seven times that of their civilian counterparts.[8] In collaboration with the VA, RAND interviewed responders working at the Veterans Crisis Line to investigate why women callers might be unreceptive to VA care. The women these responders talk to on the phones refer to a "male-oriented" culture at the VA that begins as early as check in, when receptionists presume a woman is supporting her husband and is not a veteran herself. Women most satisfied with their care tend to have received services specifically for female veterans or have developed strong therapeutic relationships with their health care providers.[9] Women and those with other-than-honorable discharges are only two groups at risk: We must continue to figure out what other groups of veterans are at high risk of suicide, understand why they are not accessing care, and address those barriers as well.

But not all veterans will ultimately access VA care, which is why community-based suicide prevention is a necessary part of preventing veteran suicide. This requires support and leadership outside the VA. Gun sellers, shooting ranges, and advocacy groups are playing a role, with new

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[5] Rajeev Ramchan, *Resources and Capabilities of the Department of Veterans Affairs to Provide Timely and Accessible Care to Veterans*, Santa Monica, Calif: RAND Corporation, RR-1165/2-VA, 2015; Katherine E. Watkins, Harold Alan Pincus, Brad Smith, Susan M. Paddock, Thomas E. Mannie, Jr., Abigail Woodroffe, Jake Solomon, Melony E. Sorbero, Carrie M. Farmer, Kimberly A. Hepner, David M. Adamson, Lanna Forrest, and Catherine Call, *Veterans Health Administration Mental Health Program Evaluation: Capstone Report*, Santa Monica, Calif.: RAND Corporation, TR-956-VA, 2011.

[6] Rajeev Ramchand, "Is America's Crisis 'System' in Crisis?" *US News and World Report,* July 17, 2016.

[7] Mark A. Reger, Derek J. Smolenski, and Nancy A. Skopp, "Risk of Suicide Among US Military Service Members Following Operation Enduring Freedom or Operation Iraqi Freedom Deployment and Separation From the US Military," *JAMA Psychiatry*, Vol. 72, No. 6, pp. 561–569, 2015; Office of Public and Intergovernmental Affairs, Department of Veterans Affairs, "VA Secretary Announces Intention to Expand Mental Health Care to Former Service Members with Other-Than-Honorable Discharges and in Crisis," press release, March 8, 2017.

[8] Office of Suicide Prevention, Department of Veterans Affairs, *Suicide Among Veterans and Other Americans: 2002–2014*, Washington, D.C., 2016.

[9] R. Ramchand, L. Ayer, V. Kotzias, C. Engel, Z. Predmore, P. Ebner, J. E. Kemp, E. Karnas, and G. Haas, "Suicide Risk Among Female Veterans in Distress: Perspectives of Responders on the Veterans Crisis Line," *Women's Health Issues*, Vol. 26, No. 6, 2016, pp. 667–673; Charles Engel, Virginia Kotzias, Rajeev Ramchand, Lynsay Ayer, Zachary Predmore, Patricia Ebner, Elizabeth Karras, Janet E. Kemp, and Gretchen Haas, "Mental Health Service Preferences and Utilization Among Women Veterans in Crisis: Perspectives of Veterans Crisis Line Responders," presented at the American Association of Suicidology 50th Annual Conference, April 27, 2016.

campaigns that raise awareness and promote safe firearm storage.[10] Veterans involved with the justice system likely represent another group at high risk. They can be enrolled in veterans' treatment, mental health, or drug courts, in which the goal is to rehabilitate, not to punish. But only some veterans can access these programs, and such programs need to be evaluated so that we can determine whether there is a social business case to justify their continued expansion.

Suicide is not just a veterans' issue. It is a national public health threat. Suicide is increasing nationwide, among young and old, men and women, white, black, and Hispanic.[11] Strengthening community-based programs would not only help prevent veteran suicide, but could help turn back the rising tide of suicides nationally. The VA could play a role in stemming this tide as well: Evidence-based suicide prevention strategies within the VA should be promoted and adopted by communities, many of which are facing acute suicide threats and are in dire need of support. It's only when we come together in a spirit of *support and collaboration* that we will begin to make a real dent in the public health threat that suicide poses to America today.

Thank you again for inviting me to testify. I will be happy to answer your questions.

[10] M. Vriniotis, C. Barber, E. Frank, R. Demicco, and the New Hampshire Firearm Safety Coalition, "A Suicide Prevention Campaign for Firearm Dealers in New Hampshire," *Suicide and Life Threatening Behavior*, Vol. 45, No. 2, 2015, pp. 157–163.

[11] Sally C. Curtin, Margaret Warner, and Holly Hedegaard, *Increase in Suicide in the United States, 1999-2014*, data brief No. 241, Hyattsville, Md.: National Center for Health Statistics, 2016.