



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420
2016 FEB 16 PM 12:06 February 12, 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW
Suite 300
Washington, DC 20036

RE: OSC File No. DI-15-1216

Dear Ms. Lerner:

I am responding to your letter of February 15, 2015, regarding allegations received from a whistleblower regarding the Department of Veterans Affairs, Canandaigua VA Medical Center, Veterans Crisis Line (VCL). The whistleblower alleged that:

- Social service assistants at the VCL are not properly trained; and
- When all phone lines at the VCL are busy, Veterans are transferred to volunteer call centers that lack the trained staff to properly coordinate rescues.

The enclosed report from the Office of Inspector General (OIG) responds to these allegations and to others that were received through the VA OIG Hotline. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The OIG substantiated that VCL management did not provide social service assistants (who do not answer calls) with adequate orientation and ongoing training. The OIG could not substantiate that backup center staff did not receive adequate training because the VCL program does not provide or monitor backup centers' staff training. Although, by contract, VCL management/supervisory staff assist in developing backup center staff training, VCL is not required to provide or monitor the training. The OIG made a number of recommendations to improve VCL operations and its ability to oversee backup call centers. Those recommendations included the following:

- Establishing a formal quality assurance process to identify system issues by collecting, analyzing, tracking, and trending data from the VCL routing system and backup centers and ensuring that subsequent actions are implemented and tracked to resolution.
- Ensuring 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.

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The OIG further asked VA to consider the development of algorithms or progressive situation-specific stepwise processes to provide guidance in the rescue process.

Regarding allegations received through the VA OIG hotline, the OIG also substantiated 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. The OIG identified gaps in the VCL quality assurance process, to include 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.

In summary, the attached report responds to five allegations received through the VA OIG hotline that concerned VCL operations, in addition to the two allegations outlined in your letter of February 15, 2015. The OIG made seven recommendations that address the issues identified during the course of their review.

Thank you for the opportunity to respond.

Sincerely,



Robert D. Snyder
Interim Chief of Staff

Enclosure