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November 6, 2023

The Honorable Gene Dodaro
Comptroller General of the United States
441 G Street, NW
Washington, D.C. 20548

Dear Mr. Dodaro,

On September 14, 2023, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) published a report regarding insufficient Veterans Crisis Line (VCL) staff management of a patient who died by suicide. VCL staff failed to take appropriate action with a veteran who died by suicide the same night the veteran contacted the VCL. Beyond that tragedy, the OIG uncovered systemic issues at the VCL, a lack of standard operating procedures and policies, and overall inadequate oversight. Additionally, the OIG discovered that VCL leadership provided advice and incorrect information to VCL staff prior to interviews with the OIG, finding that it may "compromise the accuracy and integrity of information provided."

At a Senate Veterans' Affairs Committee hearing examining the OIG report on September 20, 2023, VA's program leaders left us with more questions than answers. Following the hearing, my Committee staff met with current and former employees of the VCL and found substantial evidence of mismanagement creating a danger to the health and safety of veterans nationwide. Among the most concerning issues raised was a credible allegation that VCL staff are currently transferring veterans who present with complex needs to a special unit within VCL, a unit which is severely understaffed by an undertrained workforce. Further, a break in record retention is reportedly resulting in a complete loss of communication with veterans whose health and safety are at a heightened risk, unless they follow up again with the VCL after the transfer has been made.

VA's history with secret waiting lists of veterans in desperate need for care is deplorable. If the Veterans Crisis Line is letting veterans who reach out in moments of desperation slip through the cracks, as alleged, it needs to be known and it needs to be stopped. With nearly 900,000 contacts made to the VCL in 2022 alone, a 15% increase from 2020, any breakdowns in this lifesaving resource for veterans must be found and corrected immediately. Any program leaders who are aware of gaps in the service and preventing transparency should be held accountable and replaced.

I request a thorough audit of the Veterans Crisis Line, to include the following non-exclusive elements:

1. VCL Operations, specifically of the Call Center, Silent Monitoring, and Complex Needs units.

    a. How does VA determine and address workforce needs for the VCL?

    b. Is the overall operational staffing plan appropriately organized in accordance with contact demand and administrative requirements?

    c. What information does VCL management maintain regarding vacancies, turnover rates, training of new staff, and continuing education/training for all staff members, including those in specialized units of the VCL?

2. Information Technology and Record Retention.

    a. How are prior communications with veterans stored and secured? For what purposes are the records used? Is the record retention policy sufficient?

    b. Are management and information security controls adequate to preclude crisis contacts from being left on indefinite hold when transferred to the Complex Needs unit?

    c. Are information security controls adequate to prevent unauthorized access to the systems?

3. Oversight and Quality Assurance.

    a. What is VA's management structure for the VCL, and what type of routine oversight is provided?

    b. How does VA ensure that VCL staff follow-up with veterans who need additional contact?

    c. Is the Quality Assurance program for VCL reliable? Please examine Complaints, Silent Monitoring, Critical Incidents, Sentinel Events, and Root Cause/Aggregated Analyses.

    d. How does VA ensure that all Sentinel event and Disclosure decisions are made in accordance with VA policy?

    e. Are the results of the quality assurance program used to develop and shape continuing education for VCL staff?

It is stated that ending veteran suicide is VA's top clinical priority. A thorough Government Accountability Office review of the Veterans Crisis Line would help VA and Congress to address this program's flaws and move us closer to that goal. The Veterans Crisis Line is on the front line to support veterans whose health and safety are at heightened risk. Any mismanagement of this critical program unduly increases that risk and is completely unacceptable.

Thank you for your attention to this request. If you have any questions, please contact my staff at the Senate Committee on Veterans' Affairs.

Sincerely,

Jerry Moran
Ranking Member
Senate Committee on Veterans' Affairs