What was the opportunity, issue or challenge you were trying to address and in what setting?

A patient contacted one of VA’s telephone contact centers for assistance. He began to express concerns about the care and services he was being provided along with his perceptions of inaccurate judgement and mistreatment. In the process of explaining his multiple and complex concerns, the call center operator documented additional statements made by the patient about having access to a weapon along with a statement to defend oneself in addition to requesting follow-up and resolution. The patient also shared he and his family were in the process of relocating and wanted to make sure he would remain eligible for services and care throughout the nation.

There can be some challenges in ensuring staff are safe while remaining committed to resolving complex multi-faceted complaints requiring coordination of numerous processes and staff (i.e., access to care, benefit eligibility, staff courtesy). This is especially challenging when working with patient populations that may have acute, chronic, and severe physical and mental health illnesses. However, due to the staff person’s astute judgement when reading documentation, questions about safety mechanisms and actions for potentially suicidal or homicidal patients were raised.

What process did you use to develop a solution?

To address the questions and ensure the safety of staff and patients at the initial point of service, as well as any future points of service, a multi-disciplinary team of subject matter experts and stakeholders was assembled to develop a plan of action. The team included representation of experts from the following disciplines: patient advocacy, contact center operations, complaint management and safety systems, disruptive behavior committee, and process improvement.

What outcomes were you looking to achieve?

The group was looking to:

- Prioritize, assess, and evaluate if appropriate and timely actions were taken to mitigate immediate risk of harm.
- Assess and evaluate if there were any future potential safety concerns for staff, patients, or the public.
- Uphold the patient’s rights, advocate and work towards resolution of his concerns in a fair and non-discriminatory manner as outlined by policy and law.
- Educate the patient of his responsibilities related to the treatment plan, services or benefits he may be eligible to receive.

What specific steps did you take to address the problem?

The actions we took included:

- Quickly assembling a multi-disciplinary group of subject matter experts and stakeholders.
- Reviewing and communicating the definitions of “a threat” and ensuring there were current associated procedures and protocols.
- Reviewing the technological and systems’ capabilities to support sharing of safety information and alerts across multiple sites and staff.
- Developing a plan of action to address staff workplace safety concerns.
- Developing a plan of action to assess and prioritize patient complaints for language that may signal potential threats to others.
- Activating established protocols to include patient specific instructions, resolutions, and points of contact for continuity of care and communications.
What resources, if any, did you engage to address the problem?
Technological resources necessary to provide the infrastructure to address patient complaint, safety, and health information challenges in real-time at an enterprise-wide level included:

• Electronic complaint management systems
• Electronic health record
• Electronic disruptive behavior incident management system
• Electronic safety alerts system with capacity for cross-system integration and visibility
  • Disruptive Behavior Flags
  • Suicide Prevention Flags

In addition to the technological resources, financial and human resources were needed to purchase, install, support, maintain, and update systems, processes and procedures for sustained success.

What measures did you establish to determine the success of this effort?
The measures we used to determine if outcomes were achieved included:

• Frequency and volume of incidents and escalations
• Key performance indicators
• Workplace safety survey of staff

While volume of incident reports might be a monitoring measure, this data would be more reflective of culture of safety reporting and should not be used to measure effectiveness of communication and safety reporting.

What was the ultimate outcome of your effort?
The results we achieved include:

• Patient specific instructions were added to this individual’s complaint management record.
• The instructions included safety measures for staff to be aware of and to alert the appropriate safety and or law enforcement professionals.

• After safety had been established for all involved, we provided access to information to a single point of contact to whom the patient could receive clinical care and work with to address his multiple complaints for resolution.

What lessons did you learn to share with others as they consider addressing a similar issue?
Some lessons learned include:

• Understanding how workplace safety can have impacts on the broader human experience including the patient, staff and community.
• Definitions, policy and training are the first levels of error-proofing and cultural change management.
• Validation of the importance of maintaining real-time and cross-cutting information technology systems which provide transparency leading to safety, intervention, and complaint resolution mechanisms at and beyond the initial point of care.

About The Veterans Health Administration
The Veterans Health Administration is America’s largest integrated health care system, providing care at 1,293 health care facilities, including 171 medical centers and 1,112 outpatient sites of care of varying complexity (VHA outpatient clinics), serving 9 million enrolled Veterans each year.

The Office of Patient Advocacy was established on June 12, 2017 as directed by the Comprehensive Addiction and Recovery Act (CARA), Public Law 114-198. The office’s role at the national level is to establish national policy and processes that ensure patient advocacy occurs when Veterans have concerns with the health care they have sought and received; provide training with reporting on patient advocacy processes and practices; and carry out the responsibilities detailed in the legislation (CARA, Sections 922, 923, and 924).

About The Beryl Institute
The Beryl Institute is a global community of healthcare professionals and experience champions committed to transforming the human experience in healthcare. As a pioneer and leader of the experience movement and patient experience profession for more than a decade, the Institute offers unparalleled access to unbiased research and proven practices, networking and professional development opportunities and a safe, neutral space to exchange ideas and learn from others.

We define the patient experience as the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care. We believe human experience is grounded in the experiences of patients & families, members of the healthcare workforce and the communities they serve.