

Veterans Crisis Line Update

The following is an update regarding transformation at the Veterans Crisis Line (VCL) to ensure that Veterans, Servicemembers, and their families receive the timely, high-quality, world-class crisis intervention services they have earned and deserve.

The VCL, located at the Canandaigua, New York VA Medical Center, is exclusively dedicated to the needs of Veterans experiencing a crisis, their families, and their friends. VA continues to expand and improve the VCL, which has answered nearly 2.2 million calls since its launch in 2007. Nearly 490,000 calls, or a quarter of these 2.2 million calls, were answered during the last fiscal year. VCL responders dispatched emergency responders to callers in crisis over 11,000 times last year – over 57,000 times since 2007.

The VCL has worked diligently to ensure that Veterans' calls can be answered in a timely manner. Our experience has shown that delays beyond a few minutes most likely occur because the caller did not "press 1." When this occurs, the call is not directly routed to VCL or a contracted back-up center, but instead, to a local suicide prevention line, unaffiliated with VA. Unfortunately, recent media reports, in which a Veteran waited approximately 30 minutes, was due to a technological programming error at a contracted back-up center following an information technology (IT) upgrade. When the VCL and the Office of Mental Health Operations (OMHO) became aware of the issue in 2014, when a back-up center placed VCL calls on hold, VCL and OMHO met with the contractor to immediately address the issue, and as a result of this incident, VA included additional specific contract language addressing system checks following IT upgrades to prevent future occurrences. Please know that VA's practice has always been, and remains such, to never place callers on hold at the VCL.

This was an isolated event at one contracted back-up center that was discovered in 2014. Voicemail was inadvertently initiated due to an IT system upgrade error, and the situation was addressed immediately. As such, the contractor deactivated the voicemail, and VCL staff provided outreach to ensure the safety of the callers who left twenty total voicemail messages. Within the first day, the VCL verified that nine callers had been in touch with VCL within the past two months and no concerns were noted in their medical records; therefore, no further outreach was warranted. The VCL also reached an additional six callers and verified their safety. Five of the remaining twenty messages lacked sufficient information for VCL to take follow-up action. We regret that we were not able to contact the callers who left those five voicemails as we had no contact information.

As a result of this issue, VA took immediate action to prevent this type of lapse from ever occurring again. For example, in addition to modifying the back-up center contract to explicitly prohibit the use of voicemail, OMHO determined through over 200 test calls made since this 2014 incident, voicemail has not been used at either the VCL or any of the back-up centers. Furthermore, the contracted back-up center involved in this incident no longer provides back-up center services.

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VA made changes in early 2015 to provide the needed support to VCL. OMHO launched an aggressive, comprehensive organizational transformation initiative that encompasses changes across four main areas: people, policy and process, technology, and space. This initiative will be further supported by the recent transition of VCL management to our Member Services (call center) division. These changes are aimed at ensuring that the VCL is a world-class crisis call center for Veterans, staffed by well-trained call responders who are supported in their resilience, situated on a state of the art information telecommunications platform, and supported and managed through standardized call-center policies and processes. This transformation initiative was already in place to address the recommendations in the recent OIG report long before the report was published. In addition, in December 2015, OMHO hired a new VCL Director, an experienced clinician administrator, and recently selected a Deputy Director with call-center business operations expertise. Additional hiring of supervisory, front-line, operations, training, and quality management staff is nearly complete, and these critical hires will further support our key operational improvements. Multiple complex project plans also accompany this effort, and all are on track for their targeted completion dates—many of which are scheduled for completion in summer 2016.

We acknowledge that the VCL is not perfect and improvements are needed. In Fall 2014, VCL Senior Leaders worked with VA's MyVA to examine the current VCL processes, determine if and where process failures existed, and systematically improve any failures addressed. VCL worked with members, including Lean Six Sigma Black Belt experts from the Veterans Engineering Resource Center (VERC) and VA Center for Applied Systems Engineering (CASE) lead process improvement reviews. VERC is a multidisciplinary program collaborating with academics, researchers, clinicians, and operations staff to improve the way work is done on local, regional, and national levels. VERC's goal is to apply engineering and improvement methods to important health care problems so VA can efficiently, effectively, and reliably provide exceptional care to Veterans. More information about VERC is available at the following website: <http://www.newengland.va.gov/verc/#sthash.zDvXqnKV.dpuf>. Similarly, VA CASE, an interdisciplinary VERC, works with Healthcare Systems Engineering faculty, Veterans Health Administration (VHA) medical center staff, and affiliated academic partners to improve operational and technical systems engineering and informatics, as well as transformation VHA's health care delivery systems.

During the third week of January 2015, VERC and VA CASE facilitators led a process improvement team consisting of VCL leaders and staff members and VA subject matter experts to identify problems and develop solutions. During this 3-day event, our team completed a report and developed a plan to hold 6 Rapid Process Improvement Events (RPIEs) throughout 2015 to discuss the following topics: standard work, comprehensive employee wellness, staff optimization/workforce management, comprehensive training programs, comprehensive quality management programs, and knowledge management. As of March 2016, VCL has implemented almost all of the actions items that came from these RPIEs, and VCL will continue working to finish implementing the remaining action items.

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Additionally, VCL has had leadership changes, including a new VCL Director, an experienced clinician administrator who was hired in December 2015, and a Deputy Director with clinical and call-center business operations expertise was recently selected. VCL hiring of additional supervisory, front-line, operations, training, and quality management staff is nearly complete, and these critical hires will further support our key operational improvements. Multiple complex project plans also accompany this effort, and all are on track for their targeted completion dates—many of which are scheduled for completion in summer 2016. A few key efforts in VCL performance improvement are outlined below:

Training: Improvements to the VCL's comprehensive training program for both Health Science Specialists (HSS Responders) and Social Service Assistants (SSAs) is currently underway. Specialized training for new HSS and SSA employees, lasting approximately 6-7 weeks, includes five phases including administrative call center training, VCL basic training, VCL operations training, VCL job skills-based training, and transition to independent work training. All components of training are led by VCL trainers and experienced HSS & SSA employees who direct front line experience. Once on the floor, staff will work directly with their peers as part of the VCL's preceptor program and cleared for independent work by a supervisor.

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

VA is committed to providing our Veterans with the care and services they have earned and deserve, and we hope this information is helpful to you in better understanding the complex and dynamic nature of the VCL's work. We acknowledge the VCL is not perfect and improvements are needed; however, we know that callers who receive VCL services are overwhelmingly satisfied with the services they receive. Recent satisfaction data showed that 97.1 percent of Veterans would call the VCL again if they were in crisis. Further, VCL continues to make a powerful impact on Veterans lives every day, and this is evidenced by the many positive postings on the "Power of One" website available at: <https://www.veteranscrisisline.net/ThePowerof1.aspx>. We assure you that these improvements are in process, and we have full confidence that the new VCL leadership and organizational plan will support the VCL's continuing success in serving Veterans in crisis.