The Day Everything Changed

BY SHELLEY O'BRIEN, MSW, LICSW, CCM

This article summarizes the project selected to receive the 2022 CMSA Foundation Process Improvement Award.

March 11, 2020, was a historic day. It was the day everything changed. On March 11, 2020, the World Health Organization declared SARSr-CoV-2 a global pandemic. Living and working in Washington state offered a slightly different perspective on the now-identified pandemic. Locally, there had been growing concern much earlier, with the first confirmed case of what became known as COVID-19 being identified on January 20, just north of Seattle. What was becoming increasingly more evident was that what was unfolding was like nothing we had ever experienced before. What transpired in the months to follow brought a host of new personal as well as professional challenges that could never have been foreseen.

Kaiser Permanente of Washington (KPWA) serves more than 500,000 members in the state. In our network of services are nine partner hospital sites that are staffed by KPWA employees who provide comprehensive case management services. Inpatient case managers perform initial assessment, ongoing case management activity and discharge planning for members in these partner facilities. Pre-pandemic, staffing was built on a traditional model of hiring staff for specific locations where those services were delivered face to face. As was the case across the country, Washington and in particular the more densely populated areas of Puget Sound had difficulty in successfully recruiting qualified candidates for vacancies. What added to the challenge is that KPWA provides a wide variety of case management services across the organization and frequently found that we were competing with ourselves for the few qualified candidates that we were getting. In addition to these challenges, current staff were grappling with their own fears of infection as well as the changing environment in their own home of having their children taking part in remote learning as well as the possibility of other family members also working from home.

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At the height of the pandemic, we found ourselves with a vacancy rate of 40% with limited success in recruiting and, for that matter, retention. We had to temporarily suspend services at one site, asking the hospital to assume full case management responsibility due to our inability to staff the site adequately. Because of the growing vacant positions and increasing census numbers in the hospitals, caseloads became difficult to manage and the ability to backfill open shifts became almost

impossible. The coverage for call outs that we secured per site was insufficient and resulted in disjointed service to our members. As a result of the heavy caseloads and the stress associated with daily staffing, several more employees expressed an interest in finding other employment. Most current employees and candidates stated that they desired the flexibility of working remotely. As Socrates said, necessity is the mother of invention. Indeed, we were about to embark on our own journey of discovery.

To stabilize the workforce and improve patient outcomes, a concept was developed. The decision was made to move all hospital case management staff to a voluntary, remote status. Case management staff were presented with a model of care plan that talked about the creation of a virtual inpatient (VIP) team where staff would be pooled to distribute caseloads evenly across all partner hospitals. Remote work was voluntary, and staffing was balanced on a daily basis. By using this model, we were able to provide more equity to our staff and ultimately better services to our KPWA members. This resulted in more timely engagement and action in the care of our members and, ultimately, better outcomes. Clinical case management (CM) staff were trained in all hospital EMRs, which allowed for effective cross-coverage and clinical documentation. A virtual preceptor and training program was developed, and communication channels were established through Microsoft Teams chat groups. This helped streamline the work necessary to progress patients to the most appropriate level of care at each location.

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Arriving at this decision was not easy or taken lightly, but it proved to pave the way for the successful and immediate stabilization of our staff. Additionally, there was a marked increase in qualified candidates applying for posted positions once we allowed for the voluntary remote work. In just under three weeks' time, a total of 15 new staff had been interviewed and hired for our new VIP team. Since its inception, staffing levels have remained stable for the VIP team at KPWA. What followed was a series of check and adjust check-ins that allowed us to further refine the program as well as bolster the resources available to the staff.

This initiative was driven primarily by the senior director of case management/network hospital operations and the director of case management/network hospital operations. In addition, there were managers of case management, a senior IT consultant and project management. Despite being outside their regular scope of work, this initiative was conducted internationally, and as such incurred no additional costs for the organization. To accomplish this initiative, we partnered with each hospital leadership group when face-to-face observation or assessment was required from onsite case management, nursing or physicians. Through offering the ability to work remotely, the team was motivated to make this change in the delivery of services. All staff were equipped with the necessary IT equipment and applications to facilitate the removal of cases from the case management system. Town hall-style meetings were held with all impacted staff to present the plan and timeline for implementation and to address questions and concerns that were raised during the process. Through this engagement style with front-line staff, a smooth transition was achieved, as well as the subsequent process of checking and adjusting.

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The project included developing a system for balancing staffing based on real-time census numbers for all nine locations, which was initially managed by the department's leadership. With tools and processes developed for their use, this work was eventually trained and transferred to the administrative support staff. The balancing of staffing based on the changing census at each location resulted in immediate improvement in ratios and a reduction in turnover. Algorithms and decision tools were required to assist those employees in making decisions regarding staffing allocations daily. In the beginning, access was a significant concern since obtaining EMR access for all staff was a lengthy process. A check and balance system was implemented with one team assigning staff, followed by another direct hospital site administrative staff who validated the census to staffing allocation and performed direct assignments to ensure standard expectations were met. Staffing allocation was driven by 1) balancing staff to patient ratios, 2) ensuring access and capability at each location, 3) creating continuity for members and 4) pairing the attending physician and case manager.

Each day, 300 or more KPWA members require inpatient hospital case management services. Prior to the VIP model implementation, there were sites with caseload ratios exceeding 25:1 daily, when ideal staffing levels should be 15:1 or less. KPWA employs an all-inclusive model in which the case manager assists with discharge planning, comprehensive case

management and utilization review, so the ratio spikes had a significant impact on every aspect of the program. On March 15, 2022, leadership announced plans to move to a voluntary virtual inpatient case management model. It should be noted that there was only one additional staff turnover occurring prior to the launch on May 1, 2022. During the six months following launch, no other turnover occurred. There was a significant reduction in the staff-to-patient ratio as soon as the system was launched, and the ratio has consistently been less than 15:1 without an increase in staff. Once the remaining staff members were hired, the ratios reached the desired 12:1 with full staffing.

Over the course of the first year of the program, several additional virtual supports have been added. In order to provide more complex psycho-social support, the department has layered in a social worker at the MSW level as a resource staff member for all sites. There was also the development of Teams channels where employees could post questions to department leaders in real time for the purpose of real-time escalation, resulting in faster response and resolution. The CM managers were having difficulty being present in the team chat rooms of each site, and since it would not be a reasonable expectation for the CM manager to monitor all conversations in person, a leader line was established for the escalation of manager-specific questions. Although none of the hospital leaders desired to move to a virtual model, some loved it, and none were opposed to the move since they also had significant staffing constraints and were unable to perform any additional duties to compensate for our staff shortages.

A virtual online resource repository was established for staff as well as a leader and support chat to assist current and new employees for consultative purposes. In consultation with our support services, access to electronic medical records, training and resources were discussed. In addition, we had partnerships with all hospitals to support potential in-person needs. Because our work had a direct impact on the hospitals, these agreements needed to be sustainable, although they were at times challenging to negotiate. It was also necessary to develop new ways of performing the work and maintaining the healthcare standards at these hospitals and healthcare systems who were experiencing staffing crises as well.

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As a result of our change to a virtual inpatient model of care, the staff turnover rate decreased from 30% at the end of 2021 to 15.1% at the end of 2022. Without any other adjustments, the length of stay for these locations decreased from 5.32 to 5.13, saving nearly two-tenths of a day. Year over year, readmissions observed to expected remained flat. Despite a slight improvement in the specific category of satisfaction with discharge information, overall satisfaction at the various hospitals remained flat.

With the transition to the VIP case management model, KPWA was able to continue to provide inpatient case management teams with staff who were familiar with our systems and services and could conduct the patient's care efficiently throughout the continuum. During a time when many hospitals and healthcare organizations were hiring or seeking temporary staff, we were able to stabilize and backfill vacant positions, enabling us to provide services more efficiently. As a result of our efforts, we were able to demonstrate to executive leadership a positive impact on readmission rates as well as length of stay, which in turn provided the ability to progress patients in a timelier manner to our partner hospitals during a time when hospital resources were extremely limited. As we transition into an endemic phase of operations, we will embark on a new phase of check and adjust in our healthcare delivery system, always keeping the patient at the center of our focus and serving as our true north.

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