

Implementation of a Modified Early Screening for Discharge Tool to Optimize Case Manager Efficiency and Impact Length of Stay

James Grafton, MSN, MHA, RN, CCM, Helene Bowen Brady, DNP, MEd, RN, NPD-BC, NEA-BC, Joanne Kelly, BSN, RN, CCM, Margaret Kelly, BSN, RN, CCM, Kathleen Lang, BSN, RN, CCM, Paula Wolski, MSN, RN-BC, Soumi Ray, PhD, Cori Loescher, MM, BSN, RN, NEA-BC, Madelyn Pearson, DNP, RN, NEA-BC, and Mallika Mendu, MD, MBA

ABSTRACT

Purpose of Study: The postacute landscape has been challenged since the onset of the COVID-19 pandemic by staffing shortages and a decline in postacute bed availability. As a result, patients in acute care hospitals are experiencing longer lengths of stay (LOS) and case managers (CMs) are managing increasingly complex discharge plans. This project involved the design and implementation of a modified Early Screen for Discharge Planning (ESDP) tool to support prioritizing patients with complex discharge needs, with the primary outcome of decreasing LOS.

Primary Practice Setting: The project took place in a community teaching hospital, part of a large academic health system in the Northeast, United States.

Methodology and Participants: The project was designed as a prospective controlled study (between September 1 and November 30, 2021) with defined intervention and control cohorts, involving a modified ESDP electronic health record–based score including self-rated walking limitation, age, prior living status, and mobility level of assist. A modified ESDP score of 10 and greater indicated that patients would benefit from ongoing CM support, whereas those with an ESDP score of less than 10 were unlikely to have discharge planning needs. Participants were adult patients on medical and surgical inpatient units.

The authors' contributions are specified as follows: James Grafton: project conceptualization/visualization; review of literature and application of evidence; project design, implementation, and evaluation: review of literature, project methodology, implementation, data collection, data validation, formal data analysis, and final evaluation outcome measures); dissemination; project oversight; and writing: original draft, review, and editing. Helene Bowen Brady: review of literature and application of evidence; project design and evaluation (project methodology, data validation, formal data analysis, and final evaluation outcome measures); dissemination; and writing: original draft, review, and editing. Joanne Kelly: project implementation (implementation, data collection, and data validation); dissemination; and writing: review and edits final draft. Margaret Kelly: project implementation (implementation, data collection, and data validation); dissemination; and writing: review and edits final draft. Kathleen Lang: project implementation (implementation, data collection, and data validation); dissemination; and writing: review and edits final draft. Paula Wolski: project design and implementation (technology); Technology support; and writing:

review and edit final draft. Soumi Ray: project evaluation (data validation and formal data analysis); and writing: original draft, final review of the results section including tables and editing. Cori Loescher: Project oversight, supervision, or administration; and writing: review and edit final draft. Madelyn Pearson: project oversight, supervision, or administration; and writing: review and edit final draft. Mallika Mendu: project conceptualization/visualization; project design, implementation, and evaluation (project methodology, implementation, data validation, formal data analysis, and final evaluation outcome measures); dissemination; project oversight, supervision, or administration; and writing: original draft, reviewing and editing.

Address correspondence to James Grafton, MSN, MHA, RN, CCM, Department of Care Continuum Management, Brigham and Women's Faulkner Hospital, 1153 Centre St, Boston, MA 02130 (jgrafton@bwh.harvard.edu).

All other authors have disclosed no conflicts of interest, approved the manuscript, and agree with its submission.

DOI: 10.1097/NCM.0000000000000658

Results: The project included 718 patients, 376 and 342 in the intervention and control cohorts, respectively. The modified ESDP performed comparably with the standard ESDP (14% discrepancy, with all patients appropriately identified for CM services). Implementation of the modified ESDP led to 53.5% of patients screening out of CM services, thereby increasing the time CMs were able to spend on complex discharge planning and was associated with a trend in LOS reduction (0.55 days).

Implications for Case Management Practice: The findings of this project demonstrate that implementation of a modified ESDP can improve CM efficiency and improve hospital throughput. Given the unprecedented capacity challenges in both the acute and postacute settings, there is a need to implement CM workflow strategies that will optimize the effectiveness of critical resources, while ensuring that patients' complex discharge needs are met.

Key words: case management, discharge planning, early screening, length of stay

Since the beginning of the COVID-19 pandemic, the postacute landscape has been challenged by significant staffing shortages and facility closures (American Healthcare Association/National Center for Assisted Living [AHA/NCAL], n.d.; American Hospital Association, 2022; Schoenberg, 2020). As a result of decreased postacute capacity, patients in acute care hospitals are experiencing prolonged length of stay (LOS), and case managers (CMs) supporting discharge planning are navigating a complicated postacute environment, requiring increased outreach to facilities and engagement of multiple stakeholders (i.e., home health services, behavioral health services, state ombudspersons, etc.). CMs support the Centers for Medicare & Medicaid Services (CMS)-mandated comprehensive discharge planning to ensure a safe transition of care, but the role has evolved to include coordination of care needs (Bourque et al., 2021) to mitigate adverse consequences of inadequate planning (Holland et al., 2017).

Discharge planning directly impacts LOS, throughput, and readmission rates (Chen et al., 2021; Chovanec & Howard, 2021; Holland et al., 2017). One effective strategy used by CMs to improve discharge efficiency is the use of standardized discharge planning decision tools. These tools have been shown to improve discharge efficiency and reduce LOS by supporting a smooth transition for patients from acute care to other facilities or to home with services (Chen et al., 2021; Holland et al., 2017; Moosa & Khoja, 2022).

In an expanding community hospital with an increasing census of medical and surgical patients with complex discharge needs, the project team determined that the current discharge assessment process did not prioritize patients most in need.

The Early Screen for Discharge Planning (ESDP) is a decision support tool developed by Holland et al. (2017) that uses readily available data from the electronic health record (EHR). ESDP is used by CMs at the first critical decision point in the discharge planning process to flag patients at risk for complex discharge planning early in their hospital stay and maximize time to organize a multifaceted plan (Holland et al., 2017).

PURPOSE/OBJECTIVES

The objective of this project was to design and implement a modified version of the ESDP to prioritize patients with complex discharge needs and increase CM efficiency, with the primary outcome of decreasing LOS. The project team adapted a previously published ESDP tool to integrate with the institution's EHR to identify patients, who do not require CM support due to a low ESDP, and improve initiation of CM services from admission to initial CM assessment for high-risk patients. Analyses were performed to determine whether the modified ESDP (Brigham and Women's Faulkner Hospital [BWFH] ESDP) adequately identified patients with discharge planning needs. Finally, the BWFH ESDP was implemented with defined intervention and control cohorts to measure impact on LOS.

PROJECT DESIGN/DESCRIPTION

Setting

The setting for this project was a 171-bed Magnet-designated community teaching hospital that is a member of an integrated health care system in the Northeast United States. The case management team consists of a nurse director and seven CMs, each

One effective strategy used by CMs to improve discharge efficiency is the use of standardized discharge planning decision tools. These tools have been shown to improve discharge efficiency and reduce LOS by supporting a smooth transition for patients from acute care to other facilities or to home with services.

covering 18 patients. Two 36-bed units (each with two CMs) were selected as the intervention and the control cohorts (comprising medical and surgical patients). The project took place over a 90-day intervention period (September 1, 2021, to November 30, 2021), including patients who were admitted Monday through Friday. In calendar year 2021, the organization had 7,825 discharges of which 52%, 29%, 9%, 10% were discharged to home, home with services, skilled nursing facility, and other postacute facilities, respectively.

Ethical Considerations

The project met the health care system's institutional review board criteria as a quality improvement project and determined to be exempt from formal institutional review board review.

Project Design

The project was initiated to address concerns that increasing complexity of patients was requiring increased time to appropriately plan for safe patient discharge. CMs met with their nurse director to establish a formal project team and recognized that any potential practice changes would need to be operationalized without additional resources. The ESDP tool was identified as a strategy to prioritize the most complex patients. A member of the project team consulted with other organizations that had implemented ESDP to learn about their experiences. A proposal was developed for an ESDP pilot and presented to key stakeholders, including senior leadership.

Intervention Design

The project was designed as a prospective controlled study. The ESDP score is based on four criteria: self-rated walking limitation, age, prior living status, and the Rankin Disability Scale (Holland et al., 2017). A high ESDP score (≥ 10) indicates patients who would benefit from early discharge planning, whereas those with a low ESDP score (< 10) are unlikely to have discharge planning needs. The admission nursing assessment included the first three components of the ESDP but not the Rankin Scale. A decision was

made to substitute the Modified Rankin Disability Scale with the BWFH Mobility Level of Assist (MLA) scale present within the institution's version of Epic (see Figure 1), as the nursing informatics team identified that the MLA captured variables comparable with the Rankin Scale. The BWFH Modified ESDP decision support tool was integrated into the organization's electronic patient assessment flow sheet (see Figure 2).

Implementation Into CM Practice

CMs assigned to the intervention cohort started their day by reviewing the ESDP score for new admissions. Patients with an ESDP score of 10 and greater were prioritized to receive the usual CM evaluation. For patients with an ESDP score of less than 10, validated by chart review, the CM documented this assessment in the EHR. An ESDP charting shortcut (smart phrase) was developed by CMs to document that a chart review was conducted, and that the patient's clinical course would be followed during daily interdisciplinary rounds. This documentation indicated that the patient did not meet criteria for further CM support at that time, but that CM would be available as indicated.

For patients with an ESDP score of less than 10 who had identified discharge planning needs, either through chart review or from interdisciplinary rounds, the CMs completed a full assessment, and the usual admission CM note was documented. The CMs participated in daily interdisciplinary rounds to ensure that patients with unanticipated discharge planning needs are captured.

Auditing

To determine the ability of the ESDP tool to correctly identify patients' discharge planning needs, independent audits were conducted by two CMs, who were members of the project team but not involved in the implementation. The auditors conducted an independent chart review to determine a standard ESDP score (inclusive of the original Rankin Scale) for each patient, which was compared with the BWFH ESDP score (inclusive of the MLA). Discrepancies were identified and auditors wrote a detailed comment for each discrepancy.

Statistical Analyses

Demographic and descriptive analyses are presented as counts and percentages. LOS analyses were conducted utilizing internal databases categorizing patients by service and unit. R (version 4.1.2) software was used to conduct statistical analysis, including χ^2 test for categorical variables

The project was initiated to address concerns that increasing complexity of patients was requiring increased time to appropriately plan for safe patient discharge.

Modified Rankin Disability Scale

Score Description

- 0 No symptoms at all
- 1 No significant disability despite symptoms; able to carry out all usual duties and activities
- 2 Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
- 3 Moderate disability; requiring some help, but able to walk without assistance
- 4 Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
- 5 Severe disability; bedridden, incontinent and requiring constant nursing care and attention
- 6 Dead

TOTAL (0–6): _____

BWFH Mobility Level of Assist (MLA) scale

BWFH Mobility Level of Assist Scale	
Score Description	
0	Independent
1	Modified Independent
2	Set-up Supervisor
3	Minimal Assist
4	Moderate Assist
5	Total Assistance

Note: Tool is owned by BWFH and used with permission.

Tool will not be included in the publisher's ownership and overall copyright of the article.

FIGURE 1

Modified Rankin Disability Scale and the BWFH Mobility Level of Assist Scale. BWFH = Brigham and Women's Faulkner Hospital. From "Cerebral Vascular Accidents in Patients Over the Age of 60. II. Prognosis," by J. Rankin, 1957, *Scottish Medical Journal*, 2(5), pp. 200–215. <https://doi.org/10.1177/003693305700200504>

(demographic variables) and *t* test for continuous variables (LOS).

RESULTS

The project included a total patient population of 718: 376 in the intervention and 342 in the control cohorts. There were no significant demographic differences between the two cohorts for age, gender, ethnicity, race, or primary language spoken (see Table 1).

Objective 1: Determine Ability of the Modified ESDP to Correctly Identify Patients With Discharge Planning Needs

CMs wanted to ensure that the revised process was reliable and that patients were appropriately categorized (needing ongoing CM support or not). Two designated CMs, who did not work on the intervention unit, completed 370 chart audits comparing the standard ESDP score with the modified ESDP to determine the percentage of discrepancy

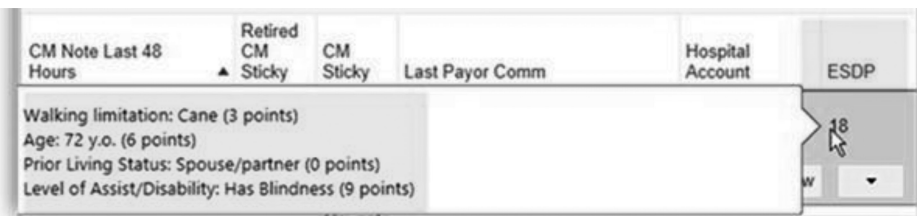


FIGURE 2

BWFH Modified ESDP scoring example. CM = case manager; ESDP = Early Screen for Discharge Planning. Used with permission from Brigham and Women's Faulkner Hospital.

TABLE 1
Demographic Characteristics of Control and Intervention Cohorts

Characteristic	Control Cohort (N = 342)	Intervention Cohort (N = 376)	p
Age, mean (SD)	64.7 (19.0)	65.7 (18.2)	.298
Gender (%)			
Female	389 (53.9)	527 (55.5)	.533
Male	333 (46.1)	422 (44.5)	
Ethnicity (%)			
Hispanic	97 (13.4)	126 (13.3)	.831
Non-Hispanic	610 (84.5)	799 (84.2)	
Unknown	15 (2.1)	24 (2.5)	
Race (%)			
Asian	11 (1.5)	5 (0.5)	.321
Black	137 (19.0)	176 (18.5)	
Other	98 (13.6)	123 (13.0)	
Unknown	14 (1.9)	18 (1.9)	
White	462 (64.0)	627 (66.1)	
Language (%)			
English	647 (89.6)	842 (88.7)	.82
Non-English	74 (10.2)	106 (11.2)	
Unknown	1 (0.1)	1 (0.1)	

between the scores. Of the 370 chart audits completed, 14% ($n = 50$) revealed a discrepancy (see Table 2). Of the 50 audited charts with a discrepancy, 10% ($n = 35$) of the patients had a modified ESDP score of 10 and greater (vs. standard ESDP score of <10) and were automatically assessed by CM. Only 4% ($n = 15$) of patients with a modified ESDP score of less than 10 (standard ESDP score of ≥ 10) did not receive a CM assessment on admission. CMs completed an assessment for 10 of these patients after admission, following discussions at daily interdisciplinary rounds and/or after the CM completed a chart review. In all cases, the patients had unique situations that warranted additional support (e.g., travel outside the United States). For the remaining five patients, an additional chart review was conducted, which revealed that the modified ESDP score was appropriate on admission. Three patients had a change in condition during hospitalization, identified during

interdisciplinary rounds. One patient was waiting for psychiatric placement and did not require postdischarge services. One patient received CM services as part of a surgical recovery pathway.

Objective 2: Improve Resource Efficiency of Case Management Services

The second objective was to determine whether implementation of the modified ESDP improved efficiency of CM services. CMs identified the percentage of patients who screened out for services within 24 hr of admission using the ESDP. On the intervention unit, 53.5% ($n = 201$) of patients had an ESDP score of less than 10 and were screened out of requiring a full CM discharge planning needs assessment (see Table 3). CMs reported that they were able to allocate the extra time (53.5% workload change) in their schedule to the patients with complex discharge planning needs.

Objective 3: Decrease LOS

The third objective was to determine whether the implementation of ESDP was associated with a decreased LOS. The team observed a decreased LOS on the intervention unit, unadjusted and adjusted for case mix index (CMI). CMS (n.d.) uses a hospital's CMI to determine reimbursement rates for Medicare and Medicaid beneficiaries. CMI "reflects the diversity, complexity, and severity of patient illnesses treated" (Definitive Healthcare, 2023, para 1) with a higher CMI indicating that the organization treats a greater number of "complex, resource-intensive patients" (Definitive Healthcare, 2023, para 2). Over the project period, the average LOS on the intervention unit was 5.43 compared with 5.96 on the control unit. For the same time period, the CMI-adjusted LOS was lower on the intervention unit (3.91) than on the control unit (4.46), with a trend toward statistical significance ($p = .083$; see Figure 3). We postulate that although the patients on the intervention unit had a slightly higher CMI, indicating that they may have been more medically complex than patients on the control unit, their discharge process was more efficient, leading to a trend toward decreased LOS.

The team observed a decreased LOS on the intervention unit, unadjusted and adjusted for case mix index (CMI). CMS uses a hospital's CMI to determine reimbursement rates for Medicare and Medicaid beneficiaries. CMI reflects the diversity, complexity, and severity of patient illnesses treated with a higher CMI indicating that the organization treats a greater number of complex, resource-intensive patients.

TABLE 2**Modified ESDP Percentage Discrepancy With Standard ESDP Among Intervention Cohort****Total Charts Audited (N = 370)**

Discrepancies, N (%)

50 (14%)

ESDP score of ≥ 10 :

Automatic trigger for CM assessment, N (%)

35 (10%)

ESDP score of < 10 :

CM assessment not conducted on admission, N (%)

15 (4%)

Patients with ESDP score of < 10 and rationale for subsequent CM assessment

Changes in patient condition during hospitalization (3)

MA Section 12/Psychiatric Placement (1)

Surgical Pathway (1)

Note. CM = case manager; ESDP = Early Screen for Discharge Planning.**Limitations**

The primary limitations of this project include the small sample size and single community-hospital setting, limiting generalizability to other settings. Applicability to a large, tertiary care hospital with greater breadth of clinical conditions is unclear. Another limitation was that the creation of the modified ESDP was necessary due to lack of availability of the Rankin Scale within our institution's version of the EHR. However, the modified score performed similarly to the standard score, with a 14% rate of discrepancy; only 4% had a modified score of less than 10 compared with standard ESDP score of 10 and greater and ultimately received CM support due to identification during daily rounds. In addition, it was not possible to randomize the intervention, so there may be unidentified confounders, though both cohorts were relatively balanced. Finally, the intervention was implemented during a time of postacute staffing shortages, leading to CM time constraints; it is possible that the efficiency and LOS impacts could be attenuated by improved postacute capacity.

DISCUSSION

In this project, the team implemented a modified ESDP score that substituted the Rankin disability scale with an MLA assessment and found that it

performed comparably with the standard ESDP in identifying low-risk patients, not requiring CM services. Implementation of the modified ESDP led to 53.5% of patients screening out of CM services and increased time spent on complex patients, associated with a 0.55-day LOS reduction approaching statistical significance. This project was novel as it involved implementation of a screening tool during a period of postacute capacity challenges, providing an opportunity to maximize the efficiency of CMs, and examines its impact on a meaningful outcome, LOS.

Although there is limited research to date, other researchers have demonstrated that early screening discharge tools can improve clinical outcomes. Chen et al. (2021) found that screening patients with community-acquired pneumonia for complex medical conditions, utilization, family structure, activities of daily living, home supports, and socioeconomic factors to initiate discharge planning led to 7-day statistically significant reduction in LOS. Moosa and Khoja (2022) implemented an early multidisciplinary round discharge planning checklist, which resulted in a 1.4-day LOS reduction. These studies support the use of early screening tools to support discharge, but further evolution is needed to ensure incorporation into inpatient CM workflows.

CMs are expected to be knowledgeable about all aspects of care coordination, including complex rules and regulations (such as the CMS Conditions of Participation), actively engaging patients in the process, while being fiscally responsible with limited resources (McLaughlin Davis & Morley, 2022). Notably, as the population ages and develops more complex medical, socioeconomic conditions, the workload of CMs will continue to increase, and, therefore, more sophisticated tools are needed to augment the abilities of this critical workforce.

Nationally, we are facing an unprecedented capacity crisis, due to a myriad of factors—deferred

TABLE 3**Percentage of Patients With an Early Screen for Discharge Planning Score of Less Than 10 Screened Out for Case Manager Services**

	Control N (%)	Intervention N (%)
Total number of patients	342	376
Percentage of patients screened out	0 (0%)	205 (53.5%)

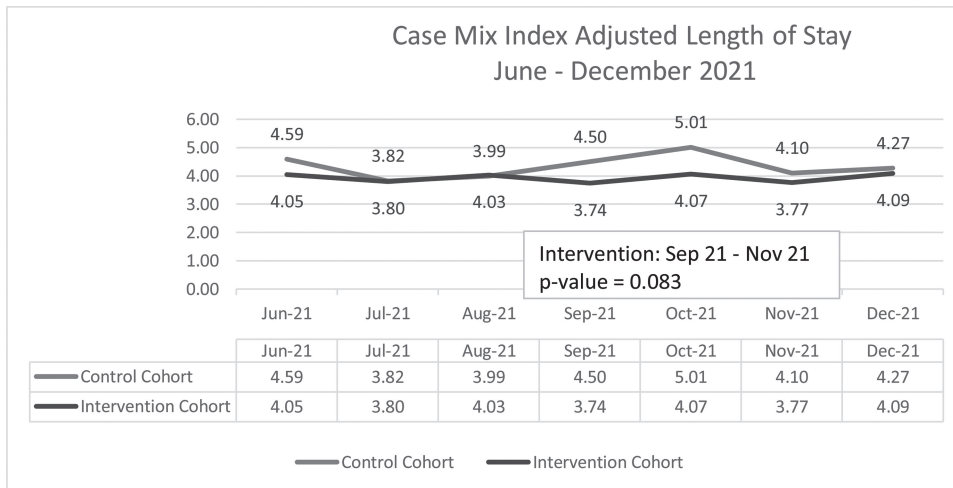


FIGURE 3

Trend toward decreased case mix index-adjusted length of stay: control versus intervention units.

CMs are expected to be knowledgeable about all aspects of care coordination, including complex rules and regulations (such as the CMS Conditions of Participation), actively engaging patients in the process, while being fiscally responsible with limited resources.

care due to COVID-19, increased demand for medical and surgical care, and a “great resignation” of health care staffing across all role types (Schoenberg, 2022). Postacute facilities have been among the hardest hit, leading to months long delays for some patients to be discharged (AHA/NCAL, 2022). The implications of the acute hospital and postacute capacity crises are multifold and additive, ultimately resulting in patients’ progression of care being delayed potentially leading to worse clinical outcomes. As such, innovative strategies are needed to improve the delivery of CM services provided and ensure that adequate attention is given to those with the most complex of discharge plans. Use of early discharge planning that leverages screening tools can ensure timely, appropriate transition from the hospital to the postacute care setting, while maintaining patient’s goals of care and treatment preferences (CMS, 2019).

Implications for Case Management Practice

The findings from this project have direct implications for CM practice. CMs were able to adapt their workflow to review the ESDP scores to prioritize patients for assessment. Concerns about patients being “missed” were addressed through the audit process with validation that daily interdisciplinary rounds were successful in ensuring that patients with evolving conditions were consistently identified in follow-up. Organizations considering implementation of a modified ESDP should identify specific patients who may benefit from CM assessment regardless of a low ESDP score, due to standardized care pathways. The implementation of a modified ESDP is a successful, valid, and cost-effective strategy that can identify patients with complex discharge planning needs early in the hospitalization.

Nationally, we are facing an unprecedented capacity crisis, due to a myriad of factors—deferred care due to COVID-19, increased demand for medical and surgical care, and a “great resignation” of health care staffing across all role types (Schoenberg, 2022). Postacute facilities have been among the hardest hit, leading to months long delays for some patients to be discharged.

CONCLUSION

The modified ESDP tool represents an evolution of an early screening tool and workflow adaptation that offers the opportunity to improve CM efficiency and LOS. Further study is needed to understand its generalizability across diverse settings, but it is practical and feasible to implement across a broad population. Given the current acute and postacute capacity challenges and the complexities of managing discharge planning with often limited staffing, we advocate for further innovative approaches to optimize case management care delivery.

REFERENCES

- American Healthcare Association/National Center for Assisted Living. (n.d.). *Nursing home closures by the numbers*. <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/SNF-Closures-Report.pdf>
- American Healthcare Association/National Center for Assisted Living. (2022). *In case you missed it: Nursing home staffing shortages causing hospital backlogs*. <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/In-Case-You-Missed-It-Nursing-Home-Staffing-Shortages-Causing-Hospital-Backlogs.aspx>
- American Hospital Association. (2022). *Fact sheet: Workforce shortages delay patient discharges and exacerbate provider's severe financial challenges*. <https://www.aha.org/fact-sheets/2022-12-05-workforce-shortages-delay-patient-discharges-and-exacerbate-providers-severe-financial-challenges>
- Bourque, M., DeFilippis, D., & Adkins, L. (2021). Creating a new model of care by integrating case management nurses in a children's hospital. *Professional Case Management*, 26(5), 242–249. <https://doi.org/10.1097/NCM.0000000000000494>
- Centers for Medicare & Medicaid Services. (n.d.). *Case mix index*. CMS.gov. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Acute-Inpatient-Files-for-Download-Items/CMS022630>
- Centers for Medicare & Medicaid Services. (2019, September 30). *42 CFR 482.43 CMS regulation § 482.43: Condition of participation: Discharge planning*. https://www.govregs.com/regulations/title42_chapterIV-i3_part482_subpartC_section482.43
- Chen, H., Hara, Y., Horita, N., Saigusa, Y., & Kaneko, T. (2021). An early screening tool for discharge planning shortened length of hospital stay for elderly patients with community-acquired pneumonia. *Clinical Interventions in Aging*, 16, 443–450. <https://doi.org/10.2147/CIA.S296390>
- Chovanec, K., & Howard, N. R. (2021). Acute care management during a pandemic. *Professional Case Management*, 26(1), 11–18. <https://doi.org/10.1097/NCM.0000000000000467>
- Definitive Healthcare. (2023). *Case mix index (CMI)*. <https://www.definitivehc.com/resources/glossary/case-mix-index>
- Holland, D. E., Brandt, C., Targonski, P. V., & Bowles, K. H. (2017). Validating performance of a hospital discharge planning decision tool in community hospitals. *Professional Case Management*, 22(5), E1–E2. <https://doi.org/10.1097/NCM.0000000000000246>
- McLaughlin Davis, M., & Morley C. (2022). Hospital case management: A review: 2019–2022. *Professional Case Management*, 27(5), 223–228. <https://doi.org/10.1097/NCM.0000000000000565>
- Moosa, L., & Khoja, A. (2022). Impact of a standardized discharge planning process on patients' length of stay. *MEDSURG Nursing*, 31(5), 301–302, 322. <https://www.thefreelibrary.com/Impact+of+a+Standardized+Discharge+Planning+Process+on+Patients%27...-a0725083464>
- Rankin, J. (1957). Cerebral vascular accidents in patients over the age of 60. II. Prognosis. *Scottish Medical Journal*, 2(5), 200–215. <https://doi.org/10.1177/003693305700200504>
- Schoenberg, S. (2020). *Sudders warns of future nursing home closures*. Commonwealth. <https://commonwealthmagazine.org/health-care/sudders-warns-of-future-nursing-home-closures/>
- Schoenberg, S. (2022). *Hospitals report over 1,000 patients awaiting discharges with nowhere to go*. Commonwealth. <https://commonwealthmagazine.org/health-care/hospitals-report-over-1000-patients-awaiting-discharges-with-nowhere-to-go/>
- James Grafton, MSN, MHA, RN, CCM**, is director of care continuum management at Brigham and Women's Faulkner Hospital in Boston, MA. He is currently pursuing his doctorate in nursing at the MGH Institute of Health Professions in Boston, MA.
- Helene Bowen Brady, DNP, MEd, RN, NP-D, NEA-BC**, is a nurse scientist at Brigham and Women's Faulkner Hospital in Boston, MA, and adjunct faculty, Young School of Nursing, Regis College, Weston, MA. Her research interests include nursing peer review, evidence-based practice, shared governance, and nurse residency programs.
- Joanne Kelly, BSN, RN, CCM**, is a certified case manager at Brigham and Women's Faulkner Hospital in Boston, MA. Her focus is on assessment of patients and transitioning from the hospital to the appropriate level of care safely.
- Margaret Kelly, BSN, RN, CCM**, is a certified case manager at Brigham and Women's Faulkner Hospital in Boston, MA. Kelly's focus is adult inpatient case management in the hospital setting with an interest in optimizing use of systems to improve the patient transition process and maximize case management efficiency.
- Kathleen Lang, BSN, RN, CCM**, is a certified case manager at Brigham and Women's Faulkner Hospital in Boston, MA. Lang is an experienced addiction recovery nurse who transitioned to case management in 2016 working with patients undergoing surgical procedures, focusing on supporting optimal recovery for this patient population.
- Paula Wolski, MSN, RN-BC**, is the program director, Informatics, Nursing and Patient Care Services at Brigham and Women's Faulkner Hospital, Boston, MA. Wolski holds ANCC certification in informatics. She is a member of numerous regional and national informatics committees.

She is currently the at-large member of the Alliance for Nursing Informatics Governing Directors Steering Committee.

Soumi Ray, PhD, is a senior analyst for care continuum management at Brigham and Women's Hospital (BWH), Boston, MA. She is heavily involved in operational research aimed at optimizing patient throughput.

Cori Loescher, MM, BSN, RN, NEA-BC, is chief nursing officer and vice president for patient care services at Brigham and Women's Faulkner Hospital, Boston, MA. She has led hospital-wide and system-wide efforts to improve patient care across the Mass General Brigham health care system.

Madelyn Pearson, DNP, RN, NEA-BC, is senior vice president of Patient Care Services and chief nursing officer at Brigham and Women's Hospital, Boston, MA. Under her leadership, the hospital has received numerous honors and accolades. Pearson influences nursing practice and leadership regionally and nationally in her roles outside of the Brigham.

Mallika Mendu, MD, MBA, is associate chief medical officer and vice president of medical affairs at Brigham and Women's Hospital, Boston, MA. In her role, she leads inpatient operations, care continuum management, and value-based care teams. Mendu has published extensively related to care delivery innovation, quality, and population health.

For more than 58 additional continuing education articles related to case management topics, go to [NursingCenter.com/CE](https://www.nursingcenter.com/CE).

Lippincott
NursingCenter®

CCM
PACE
The National
Continuing Education

CE

NCPD

Nursing Continuing
Professional Development

INSTRUCTIONS

Implementation of a Modified Early Screening for Discharge Tool to Optimize Case Manager Efficiency and Impact Length of Stay

Instructions:

- Read the article. The test for this CE activity can only be taken online at www.nursingcenter.com/ce/PCM.
- You will need to create (its free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Professional Development online CE activities for you.
- There is only one correct answer for each question. A passing score for this test is 7 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Professional Development: 1-800-787-8985.

Continuing Education Information for Certified Case Managers:

This Continuing Education (CE) program is provided by Lippincott Professional Development and has been preapproved by the Commission for Case Manager Certification (CCMC) to provide CE credit to Certified Case Managers (CCMs) for 1.0 contact hours. This CE program is approved for meeting the requirements for certification renewal.

Registration Deadline: November 1, 2024

Continuing Education Information for Certified Professionals in Healthcare Quality (CPHQ):

This continuing education (CE) activity is provided by Lippincott Professional Development and has been approved by the National Association for Healthcare Quality (NAHQ) for 2.0 CE Hours. CPHQ

CE Hours are based on a 60-minute hour. This CE is approved for meeting requirements for certification renewal.

This CPHQ CE activity expires on November 1, 2024.

Continuing Education Information for Nurses:

Lippincott Professional Development will award 2.0 contact hours for this continuing nursing education activity.

LPD is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749. LPD is also an approved provider by the District of Columbia, Georgia, West Virginia, New Mexico, South Carolina, and Florida CE Broker #50-1223.

Registration Deadline for Nurses: November 1, 2024

Disclosure Statement:

The author and planners have disclosed no potential relevant financial relationships or otherwise.

Payment and Discounts:

- The registration fee for this test is \$21.95
- CMSA members can save 25% on all CE activities from *Professional Case Management*! Contact your CMSA representative to obtain the discount code to use when payment for the CE is requested.

DOI: 10.1097/NCM.0000000000000689