

Safe Discharge Home: A Community Response to Rapid Reintegration of Observation Patients  
Caroline Ryan, AM (SW)

**Nature of the Problem:** ‘Observation care’ enables patients on Medicare to remain in the hospital for up to 48 hours and generate reimbursement pending a decision regarding whether the patient requires further inpatient treatment. Returning to the community is the only discharge option for most observation patients due to the lack of Medicare reimbursement for short-term inpatient rehabilitation. The combination of delays in service referrals from the hospital (frequently occurring after the patient has been discharged) and unpredictable response time of community-based providers can slow the start of supportive services, thereby negatively impacting the transition home for many vulnerable older adult observation patients.

**Approach:** Safe Discharge Home will target high-risk older adults age 60+ on Medicare in observation status at Adventist La Grange Memorial Hospital (ALMH) in Illinois who subsequently return home. To improve the transition process, Safe Discharge Home will establish an expedited referral system between ALMH and the local senior service agency, Aging Care Connections, for observation patients. A community-based case manager from Aging Care Connections will partner with hospital social workers on-site to assess the need for community-based services and discuss care options with observation patients and their caregivers prior to discharge. Safe Discharge Home will also create a partnership of community providers to establish an expedited web of services for observation patients that may include: prescription delivery and the opportunity to talk with pharmacists about medication management, fast-tracked home delivered meals and/or grocery delivery, daily well-being phone calls, transportation, and other community services. The goal of Safe Discharge Home is to reduce hospital readmissions and improve patient outcomes by identifying unmet needs, improving the community’s ability to fill service gaps, and creating additional supports for observation patients discharged home to the community.

**Sustainability:** Aging Care Connections has the potential to bill the State of Illinois for completed assessments which could provide partial financial support for the program after the fellowship ends. Dissemination of program results to hospital administrators will also facilitate discussions regarding subcontracting with Aging Care Connections to continue providing these services at Adventist La Grange Memorial Hospital.

Please [email Caroline](#) with any questions or comments regarding this project.