Father Joe's Villages
Recuperative Care Program

Father Joe's Villages Recuperative Care Program:

Referral & Transition of Care Process

Thank you for your interest in referring to Father Joe's Villages' Recuperative Care Program (RCP)! General information on the program can be viewed on our website, including the program brochure and electronic referral submission link. Please direct program-related correspondence to Recuperative.Care@neighbor.org and one of our team members will be in touch with you shortly.

Referral Process

1. Please review our program's eligibility criteria before submitting a referral (at https://my.neighbor.org/RecuperativeCare/ you can find eligibility criteria and a link to the electronic referral form).
    a. If you are uncertain about any of these requirements you may contact us through Recuperative.Care@neighbor.org to discuss specifics.
2. Upon identification of an appropriate program participant, please do the following:
    a. Health Plans with contracts with our program: complete the electronic referral form (link on https://my.neighbor.org/RecuperativeCare/).
    b. Hospitals or other healthcare facilities: contact the patient's Health Plan to ensure they agree with entry into the RCP. Note that the Health Plan must be contracted with our program. If the Health Plan agrees with the RCP referral, complete the electronic referral form (link on https://my.neighbor.org/RecuperativeCare/).
3. Shortly after completion/submission of the electronic referral, a Registered Nurse (RN) will begin review. This team member will reach out to you to inquire about additional documentation that may be needed to determine if an applicant is a match for our program.
    a. You are welcome to email us at Recuperative.Care@neighbor.org to inform us of your electronic submission though this is not necessary.
    b. You might consider sending over key contact information and availability information for yourself, an assigned Social Worker and/or Case Manager, or others who will participate in the referral process should you believe this will be useful to facilitate a timely referral process.
    c. You are welcome to send additional referral documentation, as well, via encrypted email. Consider sending an H&P, most recent progress note (if still in hospital), psychiatry consult notes (if present), discharge summary (if recently discharged), medication list, and most recent PT/OT notes. Sending these notes would be covered as "care coordination" under HIPAA, though ensure you follow your organization's privacy policies.
4. Once a completed packet of referral materials has been received (including all material needed to decide about appropriateness for program participation), the RN will confer with the Residential Director. In most circumstances, the process ends here, and a determination is made about program acceptance.
    a. If additional questions arise or more care documentation is required, you will be made aware.

   b. At times, we will request to facilitate a phone call or Zoom meeting with the potential program participant to discuss program requirements (e.g. ADL requirements, rules related to smoking or active substance use, etc.)
5. A final determination will be provided to you through your preferred contact method.

Next Steps after Program Acceptance

Intake Scheduling

One of our RCP team members will work with you to coordinate a seamless transition of care. A "Welcome!" document (available in English & Spanish) will be provided to assist you and the incoming RCP resident in this process. This document includes information on the program location, what to do when they arrive, etc. The team will collect additional information from you about the program participant (preferred pronouns, immediate needs upon program entry, etc.).

Our RCP team welcomes new residents through an integrated intake process – this includes participation by both residential and health center team members. Transition of care processes must be scheduled in advance; intakes between 10-11am are preferred. The referring party is asked to coordinate transportation to the RCP.

We will do our best to support the referring party's discharge plan; however, we cannot assure that RCP intake is feasible within your preferred timeline. Please expect the referral and transition of care process to take 72 hours or longer.

Continuation of Needed Services

Scheduling of in-home services, ordering of DME, and provision of critical medications should be considered in advance of transition of care by the referring provider. If assistance is needed, please make our team aware in advance.