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I. INTRODUCTION

On any given night in Los Angeles County, there are over 51,000 persons who experience homelessness, including over 12,000 who are chronically homeless.1 Despite the numerous social and economic reasons for this high number, until very recently no efforts were made to develop and implement a coordinated, long-term plan to address homelessness in Los Angeles.2 A recent initiative of the United Way of Greater Los Angeles and L.A. Chamber of Commerce called Home for Good attempts to address the cycle of chronic homelessness. Prior to this, chronic conditions and lack of planning resulted in this large population concentrating in downtown Los Angeles. In a self reinforcing loop, services were provided in these Skid Row areas to address the needs, and controversially, resulted in numbers of newly homeless gravitating to the service providers, adding to the concentration at the locations. Neighboring municipalities and other organizations serving the homeless have often steered their clients to this location under the assumption that it is the only place where their clients can receive needed services. Hospitals have been no exception.

In 2008, prompted by news reports of several hospitals purportedly “dumping” patients in the skid row area, the Los Angeles City Attorney proposed and the city council adopted an ordinance that makes it illegal for a hospital to discharge a patient to downtown Los Angeles.3 Faced with potential criminal liability and an acute shortage of post-acute care services for homeless patients, hospitals were placed in the position of either keeping homeless patients longer than medically necessary or attempting to place them in increasingly limited alternative facilities.

Obviously homelessness doesn’t just occur in Los Angeles County. Other counties throughout California have similar concerns over how best to provide needed services to the homeless. So far only the city of Los Angeles has chosen to penalize hospitals for discharging homeless patients to a centralized location. Some argue that it is only a matter of time before other municipalities adopt similar ordinances.

Armed with experience gained from a 2007 Los Angeles recuperative care pilot program, National Health Foundation (NHF) attempted to address this problem by developing two self-sustaining Recuperative Care Centers, one in Los Angeles County and the other in Orange County. These centers provide 58 hospitals with a safe and appropriate place to discharge homeless patients needing ongoing support. In less than two years the centers have saved these hospitals over $6 million dollars.

This report has been written to assist both homeless advocates and service providers to better understand the steps necessary to develop and operate a successful recuperative care program. Through its dissemination, NHF hopes to inform those in a decision making capacity of the great need that exists for recuperative care and of the benefit of such programs for both the homeless they serve as well as the healthcare system at large.

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1 Homeless count data from the Los Angeles Homeless Services Authority, 2011 Point in Time Homeless Count
3 Los Angeles City Ordinance Number 179913, passed May 16, 2008.
This report consists of eight sections. Section I, the introduction, describes the purpose of the report. Next, section II summarizes how existing recuperative care programs actually look throughout the United States. Program capacity, staffing profiles and support services offered are described as well as funding sources and average patient lengths of stay.

In section III the need for recuperative care from both the patient and healthcare system perspective is discussed. Additionally, research documenting the benefits of recuperative care programs is reviewed.

Section IV covers the history and experience of NHF’s 2007 pilot recuperative care program. The results of the pilot are summarized in section V which details the many lessons learned from this pilot program and how they were implemented and operationalized in NHF’s two current recuperative care centers. In this section recommendations for financing, outreach and marketing, eligibility determination procedures, and data entry requirements are presented.

Section VI describes the process for opening both NHF’s Orange County and Los Angeles centers. Program results and development are discussed as well as specific program enhancements that were implemented after operations began.

Program outcomes are discussed in section VII. Data analysis includes admission and denial rates, estimated versus actual lengths of stay, discharge disposition, and cost savings.

Finally, a conclusions section discusses ideas for future program expansion and analysis. This is followed by an appendix which contains examples of forms and documents referenced throughout the report.

II. WHAT IS RECUPERATIVE CARE

According to the National Health Care for the Homeless Council, Recuperative Care (sometimes referred to as medical respite) provides medical care to homeless persons recovering from an acute illness or injury, no longer in need of acute care but unable to sustain recovery if living on the street or other unsuitable place. These programs ensure that medical care received in a hospital or clinic setting is not compromised due to unstable living situations after discharge. Combined with housing placement services and effective case management, recuperative care programs allow individuals with complex medical and psycho-social needs the opportunity to recover in a stable environment while reducing potential health complications and subsequent hospital readmission.

Medical respite programs fill a gap in the continuum of care for people who are experiencing homelessness. Often, homeless individuals are discharged from a hospital following treatment with instructions to rest, and complete a course of medication, woundcare or other treatment until they are fully recuperated. However, recuperation on the street is extremely difficult if not nearly impossible. Unsanitary conditions cause open wounds to become infected, clean bandages quickly become filthy, washing facilities are generally unavailable and medication requiring refrigeration is compromised. As a result, patients are often readmitted to hospitals for complications that would have been avoidable had the individual had a home or been discharged to a safe and clean place for recuperation.

Alternatively, recuperative care programs provide post-acute medical care for homeless persons who are

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5 Ibid.
too ill or frail to recover from a physical illness on
the streets, but for whom hospital care is no longer
medically necessary. Most recuperative care program
participants are referred by hospitals. During their
recuperative stay, homeless individuals are given the
opportunity to rest in a safe environment and to
receive medical oversight care and other supportive
services. Recuperative Care centers are operated in
a variety of settings including but not limited to
freestanding facilities, homeless shelters, nursing
homes, transitional housing facilities and most
recently, motels.

As of 2011, 57 medical respite programs were identi-

fied in the United States, operating in 29 of the 50 states
(14 additional programs are currently in development).6
Due to lack of regulation and licensing requirements,
little is known about the characteristics of these pro-
grams. However, some comparisons can be made.

Most recuperative care programs are run by
community based non-profit organizations (Table 1).7

TABLE 1:
AGENCIES OPERATING RECUPERATIVE CARE SITES

<table>
<thead>
<tr>
<th>OPERATING AGENCY</th>
<th># OF PROGRAMS (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Profits</td>
<td>31</td>
</tr>
<tr>
<td>HCH</td>
<td>12</td>
</tr>
<tr>
<td>HCH/Non Profit</td>
<td>6</td>
</tr>
<tr>
<td>HCH/Hospital</td>
<td>3</td>
</tr>
<tr>
<td>HCH/Hospital/Non Profit</td>
<td>1</td>
</tr>
<tr>
<td>Local Government</td>
<td>2</td>
</tr>
<tr>
<td>Local Government</td>
<td>1</td>
</tr>
<tr>
<td>Non Profit/Hospital</td>
<td>1</td>
</tr>
</tbody>
</table>

Thirty-seven percent of programs in the United
States have 10 or fewer beds, with only 12% having more
than 40 (Chart 1)8.

CHART 1: NUMBER OF RECUPERATIVE CARE BEDS
IN EACH FACILITY

![Chart showing the distribution of recuperative care beds.]

Source: National Health Care for the Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011

CHART 2: PATIENTS LENGTH OF STAY

![Chart showing the length of stay for patients.]

Source: National Health Care for the Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011

   Available at: http://www.nhchc.org/Respite/RespiteCostFinal.pdf
7 Ibid.
8 Ibid.
9 Ibid.
Funding sources vary widely and most programs are funded by more than one source. Sources include but are not limited to hospitals, foundations, HUD (US Government Department of Housing and Urban Development), and local government (TABLE 2).10

**TABLE 2: FUNDING SOURCES**

<table>
<thead>
<tr>
<th>FUNDING SOURCE</th>
<th># OF PROGRAMS (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>27</td>
</tr>
<tr>
<td>HRSA330(h) funds</td>
<td>17</td>
</tr>
<tr>
<td>HUD</td>
<td>13</td>
</tr>
<tr>
<td>Medicaid</td>
<td>8</td>
</tr>
<tr>
<td>Medicare</td>
<td>8</td>
</tr>
<tr>
<td>Private donations</td>
<td>22</td>
</tr>
<tr>
<td>Local Government</td>
<td>25</td>
</tr>
<tr>
<td>Religious organizations</td>
<td>14</td>
</tr>
<tr>
<td>Foundations</td>
<td>21</td>
</tr>
<tr>
<td>United Way</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: National Health Care for the Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011

Most programs have multiple funding sources. It should be noted that only 4 of the 57 programs reported their ONLY source of funding as private hospitals, with NHF’s programs representing 2 of the 4. One of the other two programs serves only one hospital and is funded solely by this hospital. The other program, although available to all local hospitals and similar in its method of funding to NHF’s programs, only provides a total of 4 respite beds.

Support services are also an essential component of medical respite programs in order to help patients maintain stability once they are discharged from the program. Supportive services are provided by all facilities, with the vast majority providing multiple services to their patients. The most common services provided include meals, transportation, case management and housing referrals. A small percentage of sites provide job training or placement to their patients as well (CHART 3).11

**TABLE 3: CLINICAL SERVICES PROVIDED**

<table>
<thead>
<tr>
<th>CLINICAL SERVICES PROVIDED (Either on site or by referral)</th>
<th># OF PROGRAMS (n=57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>35</td>
</tr>
<tr>
<td>Nurse Practitioner/Physician Assistant</td>
<td>35</td>
</tr>
<tr>
<td>Nurse</td>
<td>45</td>
</tr>
<tr>
<td>Dental</td>
<td>22</td>
</tr>
<tr>
<td>Eye Care</td>
<td>11</td>
</tr>
<tr>
<td>Medication Dispensing</td>
<td>27</td>
</tr>
<tr>
<td>Medication Storage</td>
<td>42</td>
</tr>
<tr>
<td>Substance Abuse/Mental Health</td>
<td>40</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: National Health Care for the Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011

Despite the current lack of regulations or licensing requirements, there are some consistencies in clinical staff utilized in the current programs. Table 3 below illustrates the various clinical services provided in the current recuperative care sites and the frequency of these services.12

The following section identifies why recuperative care should be considered an essential part of the continuum of care available to homeless individuals discharged from hospitals still needing medical oversight.

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10, 11, 12 National Health Care for the Homeless Council, “Medical Respite Care: Reducing Costs and Improving Care”, April 2011
11 Ibid.
12 Ibid.
III. NEED FOR RECUPERATIVE CARE

Individuals experiencing homelessness have disproportionate rates of acute and chronic illnesses, which drive high rates of hospital utilization. Lack of housing for this population complicates discharge planning and subsequent recovery, leading to high rates of hospital re-admission as well. This utilization pattern has substantial cost implications for the healthcare system, which is compounded by high numbers of un-insured among the homeless.

In 2014, insurance coverage will be available for most people who have incomes up to 133% of the Federal Poverty Level (FPL) as a result of the passage of the Affordable Care Act (ACA). This critical expansion to low-income single adults could help most people experiencing homelessness to access needed health services, including prevention and disease management programs.

Being insured, however, does not necessarily reduce hospital utilization. In fact, a study from Canada, where health coverage is universal, found that people experiencing homelessness continued to experience longer inpatient stays and accrued significantly more in-hospital costs than their housed counterparts.

In research conducted by National Health Foundation in 2007 hospitals in Los Angeles County reported keeping homeless patients in their hospitals up to four additional days due to a lack of safe and appropriate discharge options. Where someone would normally be discharged to their home for rest and recuperation after hospitalization, people who are experiencing homelessness remain in the hospital longer than medically necessary due to the dearth of discharge placement options. The cost associated with these increased lengths of inpatient stays is substantial for both hospitals and the larger healthcare system.

Though obtaining insurance is an important step toward improving healthcare, innovative models of delivering care are needed to reduce costly and avoidable hospitalizations and re-admissions by people who are experiencing homelessness. Recuperative Care is one such model as it decreases unnecessary costs by not only eliminating the hospitals’ need to keep the patient longer than medically necessary, but also by providing the necessary medical oversight these patients need to reduce their likelihood of returning to the Emergency Department after discharge.

A 2006 study reviewed the effects of medical respite care for homeless patients. The study, conducted between 1998 and 2000, looked at the impact on inpatient days, emergency department visits, and outpatient clinics for patients of an urban public hospital. Patients were separated into two groups: patients referred and accepted into the medical respite program and patients referred but denied beds due to capacity issues. During the 12-months of follow up, the group that used medical respite services experienced fewer hospital days (3.4 vs. 8.1 days), a reduction in emergency department utilization and an increase in outpatient clinic visits (Chart 4).16

CHART 4: CHANGES IN HOSPITAL UTILIZATION BASED ON PARTICIPATION IN MEDICAL RESPITE

<table>
<thead>
<tr>
<th></th>
<th>Number of Inpatient Days</th>
<th>Emergency Department Visits</th>
<th>Outpatient Clinic Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients discharged to a medical respite program</td>
<td>3.4</td>
<td>1.4</td>
<td>6.7</td>
</tr>
<tr>
<td>Patients discharged to usual care</td>
<td>8.1</td>
<td>2.2</td>
<td>6</td>
</tr>
</tbody>
</table>


15 National Health Foundation, www.nhfca.org
A second study, published in 2009, examined whether post-hospital discharge to a medical respite program was associated with a reduced chance of a 90-day readmission compared to other disposition options. Conducted in Boston between 1998 and 2001, this study found that discharge to a medical respite program was associated with a 50% reduction in the odds of readmission at 90 days post-discharge compared to discharge to the streets and shelters. The evidence clearly shows that medical respite programs offer a cost efficient approach to improve medical care and reduce avoidable hospitalization for people who are experiencing homelessness. We next describe how and why a recuperative care pilot program was developed in Los Angeles.

IV. HISTORY - LOS ANGELES RECUPERATIVE CARE PILOT

In response to Los Angeles private hospital’s concern for a lack of appropriate discharge options for their homeless patients, in late 2007 the Hospital Association of Southern California (HASC) formed a “recuperative care steering committee.” As the committee was framing a response to this issue, the Los Angeles City Attorney proposed and the city council passed an ordinance in 2008 making it illegal for a hospital to discharge a patient to downtown Los Angeles. With hospitals’ need more urgent than ever, the committee commissioned NHF to conduct a needs assessment to determine the breadth and scope of the private hospitals’ need for recuperative care beds in Los Angeles. The needs assessment was completed in 2008 and clearly demonstrated that a large number of homeless patients were being discharged from private hospitals and that a recuperative care program was a more cost effective option for hospitals. (Hospitals indicated that homeless individuals stayed in the hospital an average of 4 days longer than necessary because there was no suitable alternative.) Based on these results, the committee decided to design and implement a two-year demonstration program that would double the number of recuperative care beds in Los Angeles County from 45 to 90. Efforts to find a facility to accommodate all 45 beds were unsuccessful and the committee settled on a facility in Bell, California that could provide 30 beds; 15 for the County of Los Angeles to use for its public hospitals (financed separately) and 15 to be utilized by private hospitals.

Working with the committee, NHF secured a $25,000 planning grant from Kaiser Health Plan Inc., and then $1 million in start-up funds for this recuperative care bed expansion project; $500,000 each from two foundations: LA Care and Queens Care. A medical provider was chosen to operate the facility. NHF served as the coordinating entity for the demonstration program and in that role, developed a database tracking system that produced monthly management reports and billing invoices for each hospital. The grants from LA Care and Queens Care covered all costs for the program development stage as well as the operational costs for the program’s first year. Program funding for the second and subsequent years was to come from hospitals paying for services on a per diem basis. It was anticipated that the program would be financially

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18 LA Care Health Plan is a community-accountable health plan that serves nearly 800,000 Los Angeles County residents through four free or low-cost health insurance plans. QueensCare is a 501(c)(3) public charity providing healthcare to low income and uninsured working individuals and families residing in Los Angeles County. It is unique in that it provides direct patient care, as well as charitable grants to other non-profit healthcare agencies.
self-sustaining in year two and thereafter, if at least 13 of the 15 private hospital beds were filled. When the program was launched in March 2008 due to the tremendous potential demand identified in the needs assessment, the committee did not anticipate this census requirement would be a problem. Early on, however, it became apparent that was not the case.

Despite the documented need, the program’s private hospital census never exceeded 10, and more often than not it averaged well below that number. This was unexpected, and consequently rendered the financial model ineffective. The model assumed that in addition to the $1 million startup funds provided by foundations, private hospital utilization on a fee for service basis would generate enough revenue to fund year two and each year thereafter. The original financial model guaranteed the provider a flat monthly fee irrespective of the census. With low census figures, more money was being paid to the provider than was being generated by actual census. Given this census problem, in order to assure sustainability, the committee negotiated a new payment arrangement with the provider. This agreement changed the way the provider was reimbursed. Instead of a guaranteed monthly rate, it called for reimbursement for actual census thereby ensuring that the funds paid to the provider did not exceed those received from the hospitals.

Even with this new financial model, actual occupancy did not improve, and averaged only 7 private hospital beds per day. The provider, while having extensive experience operating a recuperative care facility, lacked experience managing fee for service programs. Staff was unable to adapt to this new business model, and census continued to flounder. Although money being paid to the provider did not exceed funds received from hospitals, the provider’s costs required a minimum census of 13 and they therefore were not able to sustain the program. After almost two years, the pilot ended in March 2010.

Several operational issues and lessons learned from this pilot program were identified by the committee. These lessons were applied to a new recuperative care site launched on January 1st, 2010 in Orange County. A year of successfully operating the Orange County recuperative care program resulted in the identification of additional operational practices which improved utilization and care. These new operational practices, coupled with the lessons learned from the previous Los Angeles pilot program, were later used to open a second site in Los Angeles. Opening in October 2010, this site has been in operation for over 18 months. The lessons learned and the adaptation of new practices resulting from both the LA pilot program and the Orange County recuperative care program’s first year of operations are described in the next section.

V. LESSONS LEARNED

One of the coalition’s most important decisions during the planning process for the pilot program was identifying a service provider. The organization selected had a 30 year history of serving the homeless in Los Angeles, and was the only organization with an existing recuperative care program. Although this organization’s existing recuperative care program was funded primarily by Los Angeles County funds and operated within county-defined guidelines, the provider was confident that the service delivery and management structure in place for their existing program could simultaneously accommodate the needs of private hospitals (which would be operated on a fee for service basis). Several unanticipated problems emerged when trying to serve the private sector...
hospitals’ client base with a system designed for a public/government program.

Upon the pilot program’s closure in March 2010, private hospital discharge planners, social workers and various management personnel shared with NHF their experiences utilizing the program and described in detail the ways the pilot failed to meet their hospitals’ needs. Careful analysis of these experiences have resulted in a series of lessons learned that are currently being utilized at both of NHF’s current recuperative care sites. Each lesson learned is described below followed by an explanation of the resulting new practice.

**LESSON 1: CLASH OF BUSINESS MODELS:**

Throughout the provider’s years of service delivery it has been largely a publicly funded organization; government grants have been its primary source of funding with a much smaller percentage of private grants. Although public funding sources often require very specific program deliverables and measurable quality expectations, once funding is granted, it is awarded immediately or according to a specific, regular funding schedule not dependant on daily census numbers. As long as program and quality expectations continue to be met and reports are submitted on time, funding continues as scheduled. This allows the provider the ability to maintain staffing patterns regardless of census, as funding levels are consistent and guaranteed. Accordingly, publicly funded operations (including the provider of the pilot program) typically foster a culture that is internally focused on meeting predetermined program goals reflected in reports required by government funders, and not tied to customer service and/or satisfaction. The government program is the client. In the pilot, however, the private hospitals had a different focus.

For the hospitals participating in the pilot, patient census drives the funding and there is a great emphasis placed on providing quality services to both the client as well as the referring hospital. By ensuring that the hospitals’ needs are met and giving the highest level of service possible, a provider can expect to continue to receive the referrals necessary to maintain census at the optimum level.

Both administrative and line staff employed by the pilot program’s provider were unable to make the operating adjustments necessary to shift from their government funded business model. Therefore, management of the census never became a priority for staff and subsequently never reached the levels needed for program sustainability.

“**It has taken our staff no less than 5 days of much work and communication with the program to effect a referral. We sent them 46 pages of the patient’s record and they still haven’t given us an answer. Wouldn’t you think 46 pages of the person’s history would have given (them) enough of an explanation? This is making us crazy.”**

-LA Hospital Social Worker

**RECOMMENDATION #1**

**CREATE A "CUSTOMER FIRST" CULTURE**

After the pilot’s experience, NHF sought a new program provider with the operational culture in place to run a fee for service program. Together with NHF, a “customer first” philosophy has been established with the staff at both centers. This has enabled the programs to maintain high satisfaction rates amongst the hospitals in both counties while also ensuring that program guidelines are enforced and the financing is in balance.

**Thank you, thank you, thank you! The referral process is exactly as you said. We know what to expect and that makes our jobs so much easier.**

– LA County Private Hospital • March, 2012
LESSON 2: QUICK AND CLEAR ELIGIBILITY DETERMINATION IS MANDATORY:

The pilot program provider had a long history of solely serving county clients in its existing recuperative care program, and had as part of its own intake procedures to screen potential clients for admission. Specifically, a physician on-site at the largest county hospital who was well versed with the provider’s admission requirements could examine each patient and make a determination of eligibility on the spot. The provider proposed to have a traveling nurse perform this function for private hospitals, but attempts to do so proved impossible due to the large geographic area covered by the project. In an attempt to address this issue, the provider developed a process whereby private hospitals’ intake paperwork was faxed to and reviewed by the provider’s physician. However, this too became difficult because of the time necessary to transfer the paperwork, the provider physician’s other job commitments, and the lack of an in-person assessment (which the provider’s medical director felt strongly was the only means to assess patient eligibility for the program). In response, the medical director often required additional paperwork be completed by the private hospital (this “additional paperwork” was in addition to the 12 page intake form). This process could take as long as 12 days to complete and often was inconsistent in terms of reasons for denial. Both discharge planners and patients at the private hospitals quickly became overwhelmed with this lengthy “back and forth” process and excessive paperwork and often opted for alternative discharge arrangements (or patients simply walked out of the hospital Against Medical Advice). This extensive, inconsistent process contributed to an acceptance rate of under 45%. With research indicating hospitals kept homeless patients an additional four days due to lack of appropriate discharge options, the protracted process defeated the program’s purpose.

LESSON 3: ONGOING OUTREACH PROGRAM IS REQUIRED:

Despite initial efforts, there was an underestimation of the need to have an aggressive and ongoing outreach and marketing program to private hospitals. Even though an announcement of the demonstration program was sent to each participating hospital and an in-depth training session was offered to all hospital discharge personnel, no systematic or ongoing follow-up was conducted. Therefore, as hospital staff turnover occurred, knowledge of the program diminished resulting in many hospitals being unaware of their participation in the program.

RECOMMENDATION #2
GIVE HOSPITALS ADMISSION DECISION WITHIN 4 BUSINESS HOURS

Hospitals submitting a referral to the program now experience a much improved process. First, the 12 page intake paperwork has been reduced to a 1 page form (appendix 1). This form provides NHF and the medical provider with the information necessary to make an acceptance decision for the referred patient. If more information is needed, often a phone call or email can capture what is necessary. Further, this form is available online and can be submitted by fax or electronically. Second, hospitals are given a decision of acceptance or denial within four business hours of the referral. This quick turn-around has resulted in a large percentage of patients actually being admitted on the same day of referral.

“The Center takes patients that we have no other place to discharge and does this often the same day!! The program is a real life saver!”
– LA County Private Hospital · March, 2012
LESSON 4: SERVICE LEVELS FOR MEDICAL OVERSIGHT MUST BE DETERMINED AT INTAKE:

At the onset of the pilot project, patients’ average length of stay was projected to be 10 to 15 days. This average length of stay was decided by the coalition during the project planning stage and represents an assumption of the time persons in the program would need medical oversight. After this short stay, the person should then be ready for discharge to an alternative housing or shelter situation. The provider accepted this length of stay as an accurate estimate of the average time needed for medical oversight.

This decision was extremely important for the project because in order for the hospitals to agree to pay for the recuperative care services, they needed to be assured that they were paying for the period of necessary medical oversight only and not for additional time needed for case management, social and/or housing services. Hospitals agreed that these services should be offered in conjunction with the medical oversight in hopes of locating a housing option for the patient during that time frame, but once the medical need had been resolved, the patient should no longer be the financial responsibility of the hospital. This approach was quite different than the one the provider was used to providing the county as part of their existing recuperative care program, where the expected length of stay was a minimum of 30 days and included keeping the patient as long as necessary to locate housing— even if the medical condition for which they were referred was long resolved.

Consequently, staff at the demonstration site had a difficult time understanding why so much importance was being placed on getting private sector patients out of recuperative beds in the 10 to 15 day time period since this same requirement did not exist for their main book of business, the county patients. Staff did not share the “sense of urgency” necessary to locate housing options in the 10-15 day window set by the pilot contract and subsequently kept private patients well beyond the 10-15 days the hospitals were originally promised. When hospitals received the invoices for these extended lengths of stay, they expressed great concern over seemingly excessive lengths of stay.

“(We) are becoming very discouraged working through the referrals to this program. As much as we want to support the recuperative care program and provide the best care for our homeless patients, the process is a nightmare!!”

-LA Hospital Social Worker, 2008
and whether the long stay was primarily for the purposes of seeking housing and not medical oversight.

The provider was not able to rectify this problem and therefore many private hospitals discontinued use of the program.

LESSON 5: REGULAR FEEDBACK TO HOSPITALS IS ESSENTIAL:

After a few months of operating the pilot program, several hospitals expressed concerns not only about timely admissions and patient lengths of stay far beyond that which was promised, but also about the inability to obtain information on their patient’s final discharge destination after leaving the recuperative care site. Due to the sensitivity of the “dumping” allegations, many hospitals felt it necessary to document the patient’s final discharge destination into their patient medical record. The provider did not have any mechanism in place to report this information back to the hospital.

LESSON 6: DATA NEEDS TO BE ON A “REAL TIME” BASIS:

A requirement of the demonstration project was that the provider input client information into the database daily. The provider’s staff did not have this daily requirement before the demonstration project.

RECOMMENDATION #4

ESTABLISH THE SERVICE LEVELS AT INTAKE

In order for hospitals to feel comfortable that the length of stay determined for their patient is representative only of time necessary to provide the needed medical oversight, a completely new intake process is now in place. This new system removes the entire patient management process from the provider and introduces a third party (NHF) which serves as the manager for the patient as he/she moves through the system. The process drives off a one page form faxed or emailed to NHF documenting the patient’s need for medical oversight for a specified number of days. NHF commits to a response within 4 business hours. This gives the hospital control of the length of stay and enhances the hospital’s confidence in the process.

RECOMMENDATION #5

REPORT PATIENT OUTCOMES TO HOSPITAL

Recommendation #4 outlined the new intake process and how it provides hospitals with a determination of their patient’s acceptance into the program within 4 business hours; provides a length of stay which the hospital has agreed upon, and an ability to admit their patients into the recuperative care program much faster than in the pilot program. However, one of the best features of this new intake process is the fact that by taking the provider out of the process all together, hospitals now have ONE point of contact for all communication before, during and after the patients discharge from the hospital.

Creating a clear path of communication allows hospitals the opportunity to stay up to date on the patient’s progress during their time at the recuperative care site. Hospitals receive “check in” phone calls from NHF during their patients stay. If an extended length of stay is needed, NHF provides hospitals with progress notes from the medical staff at the recuperative care site explaining the need for the extended LOS request, thus giving the hospital the ability to determine if they agree with the extended LOS request. Upon the patient’s discharge from the site, NHF provides hospitals with a patient outcome summary, outlining the patient’s discharge plan and the details of the patient’s final discharge destination (appendix 3).

This ongoing communication has provided hospitals with the written discharge documentation they required, but equally as important, it has helped build much needed rapport and trust between the program and the hospitals.

“We love the reports! They help us to both understand what happened to our patients but also justify the extension requests when they are requested.”

– Social Worker, LA Hospital, March, 2012
and consequently had difficulty complying. This data was critical in determining patient demographics, program outcomes (LOS, admittance percentages, time to intake), but it also served as the billing mechanism for the program. This problem was never resolved and data collected for the period of the demonstration project was incomplete at best.

**RECOMMENDATION #6**

**ASSURE ACCURATE DATA**

With the implementation of the new intake process, NHF has assumed all responsibility for the data collection and analysis. Currently, NHF collects data on the patient’s demographics, length of stay, admitting diagnosis, and discharge destination. In addition, NHF’s database also generates the monthly invoices for each hospital.

**LESSON 7: HOSPITALS NEED TO DETERMINE LENGTH OF STAY:**

For the pilot, the initial assumption was that average length of stay for recuperative care patients would be 10 to 15 days. During the planning process for the pilot program, the committee designed a medical review committee which was to review each discharged patient’s case to determine if the length of stay was appropriate for their medical condition. The committee was to be made up of medical personnel from participating hospitals as well as the provider. Since this was a demonstration program, the committee felt that such a function would assist in understanding the appropriate treatment and associated length of stay for each patient. Further, the review committee would ensure that these decisions were made jointly between participating hospitals and the provider in an attempt to further clarify the purpose of the program. Despite numerous efforts by both NHF and the planning committee as a whole, the provider never implemented the medical review committee. The provider believed the effort was too time consuming and unnecessary. Consequently, when hospitals began to encounter issues with patient’s extended lengths of stay; there was no system in place to explain to them how the extended stay was justified. This caused hospitals to distrust the program, resulting in many hospitals refusing to pay for services rendered and ultimately discontinuing utilization of the program.

**RECOMMENDATION #7**

**HAVE A PROCESS IN PLACE TO ADJUST THE EXPECTED LENGTH OF STAY**

The one page intake form now includes a place for hospitals to complete their “Estimated LOS”. This is reviewed by the provider at the time of intake. The provider either agrees with the hospital’s estimate and the patient is admitted with that LOS as the medical oversight goal, or the provider communicates to NHF the medical reasons they feel a longer LOS is necessary. NHF serves as the intermediary between the two until a LOS is agreed upon by both parties BEFORE the patient is admitted into the recuperative care site. Should the need for additional days be required after admission, the hospital is provided with progress notes and an extended LOS request. If necessary, the negotiation procedure outlined above is repeated. This “all inclusive” process has negated the need for a medical oversight committee as the LOS is set upfront. Hospitals feel that they are able to determine the amount of medical oversight required for each of their patients and subsequently do not feel that the patients are staying longer than medically necessary.

It should be noted since the implementation of this new system, hospital invoice collections have been at 100%, and not one hospital has disputed any patient LOS with which they were billed.

“We really do want to collaborate, but after all this, the workers feel jerked around and not so inclined to refer to recuperative care again. Isn’t there someone we can talk to about this?

-Social Service Director, LA Hospital, 2008

“It (Recuperative Care) is worth every penny! It’s perfect! I would not change a thing!”

– Social Worker, LA Hospital, March, 2012
LESSON 8: LOCATION IS KEY:

After many NIMBY (Not In My Back Yard) issues, political roadblocks, and almost a year lost, the committee was able to find a location for the pilot recuperative care site: The Bell Shelter. Although the site was thought to be ideal due to its close proximity to the Salvation Army Homeless Shelter, it quickly became a problem. The center was located in an industrial area in Bell, California, and therefore was isolated from greater Los Angeles and difficult to find. Hospitals repeatedly reported difficulty convincing their patients to be discharged to the site due to its location. And, the farther the referring hospital was from Bell, the greater this obstacle became to the hospital’s participation.

Although the pilot project closed, the lessons learned were essential to the development of a new program that is very successfully meeting the needs of private hospitals in both Los Angeles and Orange Counties. Feedback continues to be overwhelmingly positive from both counties. Despite these programs’ similarities, however, each has components that are unique and reflective of the respective county. The following section will describe these features in detail.

“We at (our) Hospital have used the Recuperative Care Program with great success, and great outcomes for our patients. Thank you very much. Both the Mission and Laguna Beach Campus’s appreciate your hard work and efforts!”

-Orange County Hospital Social Worker, 2010

“We love this program! It has been such a positive and good outcome for our patients. We just can’t thank you enough for making it possible.”

-Orange County Management Supervisor, 2010

VI. OPEN FOR BUSINESS

In partnership with HASC and the Illumination Foundation (IF), an Orange County non-profit social service agency serving the homeless, NHF opened the Recuperative Care Center of Orange County in January 2010 building on the lessons identified from the pilot. After much success in Orange County, NHF decided to bring the program back into Los Angeles County. Details of each site’s development, launch, location and hospital participation are outlined below. In addition, information regarding site-specific details is also reviewed.

RECUPERATIVE CARE CENTER OF ORANGE COUNTY

Results Summary: During its first 25 months of operations, the Recuperative Care Center of Orange County achieved the following results:
670 total referrals made by hospitals
- 504 of these were eligible referrals (166 referrals were withdrawn by the hospital prior to patient discharge)
- 91% of eligible referrals were accepted and admitted into the program
- 55% patients were discharged to transitional or permanent housing
- Only 9% of patients were readmitted to hospitals during their stay in recuperative care
- Patient average length of stay is 13.5 days
- Estimated cost savings to Orange County hospitals are $3,180,000

**Program Development:** In April of 2009, HASC approached NHF with a request to participate in the planning of a Recuperative Care Center in Orange County. A HASC-facilitated committee comprised of both hospital representatives and homeless providers had already formed and was at the beginning stages of exploring the potential for a program. NHF immediately became actively involved and shared with the committee the lessons learned and recommendations developed from the pilot. NHF prepared a business and management plan for the Orange County Recuperative Care site, which the committee approved. NHF would serve as the management agent for the program. The committee distributed an RFP to local homeless service organizations to identify the best service provider for the program. Two agencies were vetted through this process, and the committee selected Illumination Foundation (IF).

NHF, IF and HASC worked together over the next several months to develop program policies, procedures and protocols. The program was heavily marketed to all Orange County hospitals. Those that chose to participate were asked to sign a Letter of Agreement (LOA, appendix 6). This letter outlined the terms of program utilization and the daily rate for the program; $200.00 per day. The most important part of the LOA, however, was the fact that the program would operate on a Fee for Service basis, meaning that hospitals would only be charged for services provided and if they did not use the program, would never be required to pay any fee.

**Site Information:** The program was to be housed at the Costa Mesa Motor Inn in Costa Mesa, California. This was the current location for many of IF’s programs and it was the ideal site for the recuperative care program. The motel management was amenable to the additional clients and staff above those already in place for IF’s other programs. The motel operates over 100 rooms, a block of which are utilized by IF’s programs. The motel was easily accessible and located within walking distance to local transportation.

**The Launch:**
The recuperative care program launch and ribbon-cutting ceremony was held at the Costa Mesa Motor Inn on Friday, January 8th, 2010. The ribbon cutting was attended by over 85 hospitals, community, and Orange County representatives. County Supervisor John Moorlach and Costa Mesa Mayor Allan Mansoor were in attendance. Joining these representatives of Orange County to commemorate the occasion was Chairman of the Board Janet Nguyen as well as several state legislators. NHF President and CEO, J. Eugene Grigsby III, spoke at the event as did Paul Leon, President and CEO of Illumination Foundation, and Julie Puentes, Orange County Regional Vice President from Hospital Association of Southern California. A press release was distributed regarding the program as

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19 The Illumination Foundation (IF) is a non-profit 501 (c) (3), non-denominational, grassroots organization that addresses the crisis of homelessness in Orange County through integrated services that provide appropriate solutions.
During the recuperative care center’s first week of operations, six homeless patients were admitted to the program.

**Participating Hospitals:** At the time of its launch, eighteen hospitals signed LOA’s in order to participate in the program. Today, there are twenty-two hospitals actively utilizing the recuperative care program in Orange County. A list of these hospitals can be found in **TABLE 4**.

**TABLE 4:**
**ORANGE COUNTY HOSPITALS UTILIZING RECUPERATIVE CARE**

- Anaheim Regional Medical Center
- Chapman Medical Center
- Fountain Valley Regional Hospital
- Garden Grove Hospital and Medical Center
- Hoag Memorial Hospital Presbyterian
- Huntington Beach Hospital
- Kaiser Permanente/Anaheim
- Kaiser Permanente/Irvine
- La Palma Intercommunity Hospital
- Los Alamitos Medical Center
- Mission Hospital Regional Medical Center
- Mission Hospital Laguna Beach
- Orange Coast Memorial Medical Center
- Placentia Linda Hospital
- Saddleback Memorial Medical Center
- San Clemente Campus of SMMC
- St. Joseph Hospital
- St. Jude Medical Center
- UCI Medical Center
- West Anaheim Medical Center
- Western Medical Center/Anaheim
- Western Medical Center/Santa Ana

**Program Specifics:** The Orange County Recuperative Care Program was designed using the pilot program lessons and recommendations as the core of its policies and procedures. Although serving as a solid starting point, various operational issues arose as the program continued that required further development of the program’s policies and procedures, such as:

- **Medical Services Initiative:** Medical Services Initiative (MSI) is a Federal, State and County funded healthcare program that provides a full range of medical care for Orange County’s low-income citizens 21 through 64 years of age. The MSI program contracts with all of the County’s key clinics and hospitals. Due to HASC advocacy efforts, effective July 1st, 2011, recuperative care services were included in the scope of benefits for MSI patients who are homeless. Hospitals are now able to bill for recuperative care services for the eligible patients they discharge and to receive partial reimbursement. The inclusion of recuperative care services in the MSI program represents an important acknowledgement that recuperative care is an essential part of the continuum of care for homeless patients in Orange County. Education and outreach efforts were implemented immediately by both HASC and NHF to educate the hospital community of this MSI benefit change and the approval process that was required.

  It was anticipated that this newly added benefit would increase the number of patient referrals hospitals made to the recuperative care program since the costs were partially paid by MSI. The concern arose, however, that despite the extensive educational efforts made by NHF and HASC that the addition of this MSI benefit would somehow imply that only MSI patients should be referred to recuperative care, consequently discouraging hospitals from referring those homeless patients to the program who were not MSI eligible. Early indicators suggest that referrals to the program have not increased in the 8 months since Recuperative Care was added as a benefit to MSI. NHF plans to collect additional data in the coming months to better address this concern and identify any trends associated with this benefit change.

- **Monthly team meetings:** In an effort to address new program and operational issues that occur as the program continues to function, NHF instituted Monthly Team Meetings. Conducted at the

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Recuperative Care site, staff from both NHF and Illumination Foundation attend these meetings and discuss any pertinent issues that arose in the previous month. Policies and procedures are reviewed and updated, and new policies are developed as deemed necessary. This monthly meeting provides an open forum for staff of both organizations to work together to continue developing the operational aspects of the program. Seen as an important addition to the program, these meetings are now also conducted at the Los Angeles site.

- **Hospital Program Review calls:** On an annual basis, NHF and HASC conduct Hospital Program Review conference calls for all participating hospitals. These calls serve as a way for NHF to review the program with hospitals to determine any problems or concerns they may have regarding the program. This process also allows hospitals the opportunity to talk to one another about the program and offer suggestions or recommendations to each other about how they manage the recuperative care program within the constraints of their hospitals protocols. Participation on the call is voluntary; however, over 70% participation has been secured on all calls conducted to date. Issues discussed include MSI, admission criteria, placement disposition, and ideas for improving the program. Due to its success, this process also takes place at the Los Angeles site.

**Program Development:** NHF, in collaboration with HASC successfully developed and launched the Orange County Recuperative Care Program on January 8th, 2010 by incorporating the lessons learned from the pilot project in Los Angeles and by evolving from successfully operating the Orange County program. NHF was eager to “re-open” its program in Los Angeles as well, but was unsure if a provider could be found that would be able to implement this program design. As the success of the Orange County program continued, Illumination Foundation approached NHF requesting that they be considered as the medical provider for the future Los Angeles site. Although Illumination Foundation had no service provision experience in Los Angeles, NHF felt that the successful partnership between NHF and IF to date would serve as the foundation necessary to launch a successful recuperative care program in Los Angeles.

The new LA program was designed to programmatically mirror the program in Orange County. However, despite the documented programmatic success in Orange County and the plan to implement these changes in Los Angeles, many hospitals voiced their hesitancy to try the program again, fearing they would experience the same results as with the pilot. To address their reluctance, NHF aggressively marketed to hospitals, and provided on-site training regarding the

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**“The feedback from my staff has been overwhelmingly positive- they say how well run and effective the new incarnation of the recuperative program is.”**

—Los Angeles ACM Manager, Medical Social Worker, May, 2011

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**RECUPERATIVE CARE CENTER OF LOS ANGELES**

**Results Summary:** During its first 17 months of operations, the Recuperative Care Center of Los Angeles achieved the following results:

- 599 total referrals made by hospitals
- 401 of these were eligible referrals (198 withdrawn by the hospital prior to patient discharge)
- 95% of eligible referrals were accepted and admitted into the program
- 34% patients were discharged to transitional or permanent housing
- Only 12% of patients were readmitted to hospitals during their stay in recuperative care
- Patient average length of stay is 11.5 days
- Estimated cost savings to Los Angeles County hospitals is $2,684,000

**Estimated cost savings to Los Angeles County hospitals is $2,684,000**
programmatic improvements featured in the new program. In addition, funding was secured from West Coast University to give the first 20 hospitals that utilized the new program a $2,000 credit towards their bill to encourage them to try the new program.

Site information: Due to the Orange County success of the “Motel Model”, both partners quickly agreed that this model would also be utilized in Los Angeles. Illumination Foundation researched several potential motel sites for the new Los Angeles Program and after several site visits selected the Reno Motel. Unlike the motel utilized for the Orange County program, the Reno Motel was very small (20 beds), and the Recuperative Care program would utilize the entire facility. The motel was in the mid-city area, very easily accessible and located within walking distance to local transportation.

Arrangements were made with the motel manager and minimal site improvements were made including new twin beds in each room (making all rooms double occupancy), and the modification of one room into office space for Illumination Staff. All of these changes were complete within 60 days of securing the site.

The Launch: The Los Angeles Recuperative Care program officially opened on October 1st, 2010. An open house was held at the Reno Motel on Wednesday, October 6th, 2010. Several hospitals attended the open house including Providence Holy Cross Medical Center, Olympia Medical Center, and St. Francis Medical Center. Although utilization was slow in the beginning, the grant from West Coast University allowed NHF to convince many hospitals to give the new program a try. Once hospitals experienced the programmatic changes, utilization began to build quickly.

Utilizing Hospitals: At the time of the launch, only five hospitals signed LOA’s in order to participate in the newly designed Los Angeles Recuperative Care program. Today, there are thirty-six hospitals with signed letters of agreement. A list of these hospitals can be found in TABLE 5.

Program Specifics: Similar to Orange County’s program, the Los Angeles Recuperative Care program was designed using the previously-identified lessons as well as some new procedures developed and implemented in Orange County (check in calls and monthly meetings). As operations continued, additional operational issues arose that required further definition of the program’s policies and procedures, such as:

<table>
<thead>
<tr>
<th>TABLE 5: LOS ANGELES HOSPITALS UTILIZING RECUERATIVE CARE</th>
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<tbody>
<tr>
<td>• Alhambra Hospital</td>
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<tr>
<td>• Beverly Hospital</td>
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<tr>
<td>• California Hospital Medical Center</td>
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<tr>
<td>• Cedars-Sinai Medical Center</td>
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<tr>
<td>• Citrus Valley Medical Center – Queen of the Valley Campus</td>
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<tr>
<td>• Citrus Valley Medical Center-Inter Community Campus</td>
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<tr>
<td>• Downey Regional Medical Center</td>
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<tr>
<td>• East L. A. Doctor’s Hospital</td>
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<tr>
<td>• Foothill Presbyterian Hospital</td>
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<tr>
<td>• Garfield Medical Center</td>
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<tr>
<td>• Glendale Presbyterian Hospital</td>
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<tr>
<td>• Greater El Monte Hospital</td>
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<tr>
<td>• Henry Mayo Newhall Memorial Hospital</td>
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<tr>
<td>• Hollywood Presbyterian Medical Center</td>
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<tr>
<td>• Huntington Memorial Hospital</td>
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<tr>
<td>• Kaiser Permanente – Baldwin Park</td>
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<tr>
<td>• Long Beach Memorial Medical Center</td>
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<tr>
<td>• Memorial Hospital of Gardena</td>
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<tr>
<td>• Monterey Park Hospital</td>
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<tr>
<td>• Olympia Medical Center</td>
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<tr>
<td>• Pacific Hospital of Long Beach</td>
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<tr>
<td>• Pomona Valley Hospital Medical Center</td>
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<tr>
<td>• Presbyterian Intercommunity Hospital</td>
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<tr>
<td>• Providence Holy Cross Medical Center</td>
</tr>
<tr>
<td>• Providence Little Company of Mary – Torrance</td>
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<tr>
<td>• Providence Little Company of Mary-San Pedro</td>
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<tr>
<td>• Providence Saint Joseph Medical Center</td>
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<tr>
<td>• Providence Tarzana Medical Center</td>
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<tr>
<td>• Rancho Los Amigos Rehabilitation Center</td>
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<tr>
<td>• St. Francis Medical Center</td>
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<tr>
<td>• St. John’s Health Center</td>
</tr>
<tr>
<td>• UCLA Hospital Systems – Ronald Reagan</td>
</tr>
<tr>
<td>• UCLA Hospital Systems – Santa Monica</td>
</tr>
<tr>
<td>• Valley Presbyterian Hospital</td>
</tr>
<tr>
<td>• West Hills Hospital – Grossman Center</td>
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<tr>
<td>• Whittier Hospital Medical Center</td>
</tr>
</tbody>
</table>
• **911/ Non 911 Forms:** Despite efforts to the contrary, sometimes it is necessary for a patient to return to the hospital. When this occurs, whether by paramedic or recuperative transportation, the patient arrives at the hospital through its emergency department. Despite NHF’s constant communication with discharge personnel both before and during a patient’s admission, patient information does not necessarily make it to the ED staff. Therefore when the patient arrives from recuperative care to the ED, staff are not aware of the patient’s medical history or the fact that they are participating in recuperative care. A new process was put in place to ensure that not only ED staff were aware that the patient came from recuperative care, but also that they can return. Contact information for recuperative care is on the form to help ED staff with the patient’s discharge back to the program. A copy of both forms can be found in appendices 8 and 9.

• **Checklist:** Hospitals embraced the one page form and found it very clear and easy to use. However, once a patient was accepted, there are certain things each discharge planner has to complete in order to effect an admission into the recuperative care center. For example, transportation arrangements must be made and medication must be prepared. In an effort to help discharge planners complete these steps, NHF designed a checklist which contains all of the steps each hospital must complete and also contains information about the center (i.e. address). This process was also adopted in the Orange County Recuperative Care Center. These checklists can be found in appendices 10 and 11.

• **Paperless referral process:** In order to reduce the amount of paper consumed by the program and to implement a paperless management system, the provider, Illumination Foundation, and NHF utilize E-Fax. Substantial research was conducted to identify an E-Fax company that was compliant with all HIPAA (Health Insurance Portability and Accountability Act) regulations. This new system not only provides a more efficient method for managing patient files, it also allows NHF recuperative care staff to be more responsive when working from different sites. Patient referrals forms can be received via a lap top or smart phone (encrypted), reviewed on the spot and transferred immediately to the provider for approval. This seamless process enables NHF staff to operationalize its outreach and marketing strategy while also managing incoming referrals. It also allows the two partners to transfer and share patient information in a productive and efficient manner.

In the next section outcomes of patients participating in the two recuperative care programs are presented.

**VII. OUTCOMES**

In order to measure the programmatic and patient outcomes for both the Los Angeles and Orange County recuperative care programs, NHF tracks relevant program and patient data. These data enable NHF to better monitor the results of the program and identify trends and areas for further improvement.

The Recuperative Care Center of Orange County received 670 referrals to the program from January 2010 to February 2012. Of these, 166 were withdrawn by the hospital before discharge could take place (reasons for withdrawal include patient leaving hospital against medical advice (AMA), refusing to go to Recuperative Care Center, or finding other discharge options) leaving 504 eligible referrals. Four hundred sixty-one, or 91% of the eligible referrals were admitted to the program. For the Los Angeles program there were 599 referrals between October 2010 and February 2012. One hundred ninety-eight of these were withdrawn leaving 401 eligible referrals. Four hundred sixty-one, or 91% of the eligible referrals were admitted to the program. For the Los Angeles program there were 599 referrals between October 2010 and February 2012. One hundred ninety-eight of these were withdrawn leaving 401 eligible referrals. Of these, 382 or 95% were admitted to the program. Tables 6 and 7 show the referral admittance percentage for both the Orange County and Los Angeles County programs.
The Recuperative Care Center of Los Angeles admitted 382 patients from October 2010 to February 2012. The average number of patients admitted each month was 21.5. Table 8 compares these actual admissions each month to the program average admission rate of the program.

The Recuperative Care Center of Orange County admitted 461 patients through February 2012. The average number of patients admitted each month was 18. Table 9 below compares actual admissions each month to the program average admission rate. Despite the fact that almost two years of data is available to review, no real trends are notable regarding the number of admits in any given month.

The Recuperative Care Center of Los Angeles admitted 382 patients from October 2010 to February 2012. The average number of patients admitted each month was 21.5. Table 8 compares these actual admissions each month to the program average admission rate of the program.
Table 10 below compares the Recuperative Care Center of Los Angeles patient estimated length of stay to the actual length of stay. The average Estimated LOS is 11.22 days and the average Actual Los is 10.48, and this difference is statistically significant at the 1% level. The largest percentage differential is noted in the “less than five day” category; where only 2% of patients were estimated to need a LOS of less than 5 days, yet 17% actually stayed less than 5 days. A large contributor to this may be the number of patients who walk out of the program within a few days of admission, despite the fact that they are still in need of services.

Table 11 below compares the Recuperative Care Center of Orange County patient Estimated LOS to the Actual LOS. Although similar but not at a statistically significant level, like the Los Angeles Center numbers there is also a noted difference in the number of patients with an estimated LOS of less than 5 days (1% estimated versus 9% actual). However, Orange County shows a difference in those patients estimated to stay more than 15 days; 6% were estimated to need a length of stay longer than 14 days and 14% actually stayed that long. Several factors may have impacted this difference including the newly approved MSI reimbursement or the steady increase of the provider making length of stay extension requests.

Discharge planning starts at the moment the patient enters the recuperative care center. Each of the two centers is staffed with a full time social worker whose job, among other things, is to locate and secure a discharge placement for each of the patients admitted. Every effort is made to place each patient into a transitional or permanent housing program. However barriers, such as short lengths of stay, dearth of available services and patient ambivalence play a role in the percentages that are actually placed into one of these ideal alternatives.
Table 12 below illustrates the discharge disposition for the Orange County Recuperative Care Center. This table shows that once patients receive the medical oversight needed to complete their recuperation, 55% are discharged to either permanent or transitional housing programs. Twenty-one percent are discharged to a shelter while only a small percentage (9%) are readmitted to the hospital.

**Table 12:**
**DISCHARGE DISPOSITION FOR ORANGE COUNTY RECUPERATIVE CARE CENTER**
**JANUARY 2010 - FEBRUARY 2012**

<table>
<thead>
<tr>
<th>Discharge Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Housing</td>
<td>36%</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>19%</td>
</tr>
<tr>
<td>Shelter</td>
<td>21%</td>
</tr>
<tr>
<td>*Other</td>
<td>9%</td>
</tr>
<tr>
<td>Readmit to Hospital</td>
<td>55%</td>
</tr>
</tbody>
</table>

*Patient walked out of program or declined housing option  n=459
Source: NHF Recuperative Care data base

Table 13 illustrates the discharge disposition for the Los Angeles County Recuperative Care Center. This table shows that at the point of discharge, 36% of patients are discharged to either permanent or transitional housing programs. An additional 30% are discharged to a shelter and 12% return to the hospital.

There are several factors that could have played a role in the fact that the Los Angeles program did not have as high of a percentage of housing placements as the Orange County program. One reason may be the fact that the homeless population in Los Angeles is much larger making greater demand on existing housing programs. A second reason may be that the provider, IF, having a long history of service provision in Orange County is very knowledgeable of and greatly networked with programs in the Orange County area, but being new to the Los Angeles was not equally knowledgeable of housing services in Los Angeles County. As the program continues to operate this second factor should become less of an issue. A third factor could also be that due to its history of homeless service provision in Orange County, IF has other programs that directly provide assistance with temporary housing and is therefore able to directly refer individuals that are discharged from recuperative care into their other programs.

Providing appropriate care at the appropriate level is not only a medical benefit to the patient, it is cost effective as well. As stated previously, research conducted by NHF showed that homeless patients in Los Angeles stayed in hospitals 4 days longer than medically necessary due to a lack of appropriate discharge locations. These additional inpatient days not only cost the hospital a significant amount of money, they are ultimately costly to the healthcare system as a whole.

**Table 13:**
**DISCHARGE DISPOSITION FOR LOS ANGELES RECUPERATIVE CARE CENTER**
**JANUARY 2010 - FEBRUARY 2012**

<table>
<thead>
<tr>
<th>Discharge Location</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Permanent Housing</td>
<td>36%</td>
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<tr>
<td>Transitional Housing</td>
<td>22%</td>
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<tr>
<td>Shelter</td>
<td>30%</td>
</tr>
<tr>
<td>*Other</td>
<td>12%</td>
</tr>
<tr>
<td>Readmit to Hospital</td>
<td>14%</td>
</tr>
</tbody>
</table>

*Patient walked out of program or declined housing option  n=459
Source: NHF Recuperative Care data base

Table 14 illustrates the estimated cost savings hospitals in Los Angeles and Orange County have received by utilizing the recuperative care programs. Although virtually impossible to calculate an exact amount of cost savings, a formula was used to calculate the savings for each county using the average hospital adjusted expense for California of $2,279 per patient.
day\textsuperscript{21}, NHF’s research findings, and an estimated average recuperative care LOS of 10 days. Even using this very conservative formula, hospitals in Orange County and Los Angeles County have collectively saved almost $6 million dollars in the short time the two sites have been open.

**TABLE 14: ESTIMATED HOSPITAL COST SAVINGS**

<table>
<thead>
<tr>
<th></th>
<th>*Potential Costs</th>
<th>**Actual Costs</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>$3,482,312</td>
<td>$797,600</td>
<td>$2,684,712</td>
</tr>
<tr>
<td>Orange County</td>
<td>$4,202,476</td>
<td>$1,022,200</td>
<td>$3,180,276</td>
</tr>
<tr>
<td>Combined</td>
<td>$7,684,788</td>
<td>$1,819,800</td>
<td>$5,864,988</td>
</tr>
</tbody>
</table>

*Potential cost is based on patients staying an average 3-4 days longer than necessary in hospital.

**Average hospital adjusted expenses per inpatient stay is $2,279 (California State Level).

Source: Kaiser Foundation State Health Facts, 2008

VIII: CONCLUSIONS & THOUGHTS FOR THE FUTURE

Recuperative Care programs play an increasingly important role in the healthcare continuum. By providing medical support to the homeless, these programs improve the quality of care for homeless individuals who might otherwise have no other options but to attempt to manage their health on the streets. The program provides hospitals with a safe and appropriate discharge option for their homeless patients, avoiding the need to keep them in the hospital longer than necessary or risk penalties for discharge to skid row. And finally, they reduce the costs of care for this population as homeless patients receiving post-acute medical oversight and social services during their stay in recuperative care programs are less likely to return to the hospital.

NHF has developed two of the 57 recuperative care centers currently operating in the United States. Lessons learned from a pilot project in 2007, coupled with ongoing improvements, have shaped the policies and procedures used today. Hospitals in both Los Angeles and Orange Counties report high satisfaction with the program and with the outcomes for both their patients and their hospital. Even with the success as discussed in this report, there are several recommendations explored below that could possibly enhance the programs and make them even more successful in the future.

Include Home Health: Many hospitals in both counties have expressed difficulty securing a home health agency willing to follow their patients to the recuperative care site. Similarly, the provider, Illumination Foundation, has reported that often employees from these home health agencies, despite agreeing at the time of patient discharge to follow the patient, often fail to report to the site for service provision. Despite attempts to forge relationships with these agencies, efforts have not been very effective since multiple home health agencies are used by the participating hospitals. When needed home health services are not received, medical progress for these patients is delayed,

\textsuperscript{21}Kaiser Family Foundation State Health Facts, 2008
sometimes resulting in re-hospitalization.

In an effort to address this issue, NHF is exploring the possibility of contracting with one home health agency to provide services to all patients in both recuperative care sites. Hospitals would no longer need to arrange these services on an individual basis, eliminating the problem of locating a service willing to follow their patients. The provider could count on home health employees arriving consistently at the center as it would be a contracted service. Hospitals have expressed interest in this added benefit to the recuperative care program, and NHF has started negotiations with a local Home Health agency to provide the service.

**Determine average LOS for the 5 most referred diagnoses:** NHF has analyzed recuperative care data and identified the top five most referred diagnoses of the patients admitted into both recuperative care centers. Unfortunately since the program is still young, there is not enough data per diagnosis category to determine if there is a length of stay most commonly associated with each of these diagnoses. However, once enough data becomes available this analysis would allow NHF to better understand how long a patient with one of these diagnoses needs to be in recuperative care. Armed with this information, NHF can then better communicate to hospitals this information so that the length of stay for these patients matches this average, avoiding unnecessary program extension requests. This information could then be shared with other recuperative care centers nationally and potentially be helpful in developing program standards and best practices.

**Emergency Departments and Skilled Nursing Facilities:** Currently, all patient admissions to both recuperative care centers come directly from a hospital’s acute care beds. These patients have been admitted to the hospital for at least 24 hours and are discharged directly to recuperative care. However, hospitals have expressed an interest in exploring the possibility of recuperative care accepting admissions from the Emergency Departments as well. Should the program add this component, hospitals could avoid admitting patients into acute care unnecessarily, avoiding the costs associated with these admissions. In order to accomplish this, the intake process would need to be streamlined even further to accomplish a discharge from the ED to recuperative care in a matter of a few hours. NHF would like to explore this program expansion with one of its highest hospital utilizers and possibly design a pilot.

Additionally, one hospital has expressed an interest in NHF accepting patients directly from a Skilled Nursing Facility (SNF) with which it contracts. Currently, the hospital transfers patients from their hospital that no longer required acute care to this SNF so care can be continued at the appropriate lower level. This hospital approached NHF to explore adding recuperative care to this already existing continuum of care. Specifically, after the patient no longer needs skilled care, they could then be discharged from the SNF directly to recuperative care. This would allow the patient to receive the appropriate care at the appropriate level, potentially avoiding additional unnecessary costs. NHF is currently piloting this concept and has accepted two patients so far directly from the hospital contracted SNF. If proven successful, NHF will explore other similar arrangements.

**Managing Site Operations:** The success of any project or program is predicated on the success of the partnerships involved. NHF’s recuperative care programs are no exception. After the pilot project, NHF has found the partnership with Illumination Foundation to be very productive and beneficial. Even
with all of its success, areas remain that could be improved. Despite a deep understanding of the issues surrounding the need for recuperative care (concerns for patient dumping) by the administration, the provider’s staff sometimes question hospitals’ intentions when discharging patients to recuperative care. This may be due to the fact that Illumination Foundation staff work directly with only the homeless patients and not with the hospitals. Or it may be a result of staff turnover and an incomplete orientation of new staff. Regardless, these negative assumptions of hospitals’ intentions lead to minor programmatic issues including extension requests, patient re-admittance to hospitals, and potentially inappropriate denials.

In order to assure the continued success of the programs, NHF may need to develop contingency plans for greater involvement in operations in order to address these issues.

**Patient Follow-up:** As mentioned previously, NHF is interested in providing further follow up of patients after they are discharged from the recuperative care programs. Specifically, NHF would like to explore what happens to patients that leave the recuperative care programs and directly enter either a temporary or permanent living program. How long do they stay? Are they less likely to utilize emergency rooms? Do they become connected to a medical home? These and other questions could be answered if NHF were able to conduct this post discharge patient follow-up.

**National and Local Networking:** As NHF continues to develop its expertise and data with its recuperative care programs, it becomes important to share these within the national and local homeless provider community. Additionally, by becoming more involved in the various networks and coalitions, NHF can further educate homeless healthcare advocates about recuperative care, the outcomes of which can be better health, housing and services for the clients. As data in Section II indicate, recuperative care/medical respite programs are still few in number and developing along a variety of models. With greater exchange, all programs can access improvements and alternatives, and together strengthen the role of this key component of caring, efficient, cost effective healthcare.
Recuperative Care Center Preliminary Referral Form

To refer a patient from your hospital, please complete entire form and fax to 877-551-5580
Call National Health Foundation at 714-703-1875 or 213-538-0769 with referral questions.

<table>
<thead>
<tr>
<th>Referring Hospital:</th>
<th>Attending Physician:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Planner:</td>
<td>Phone #: Pgr:</td>
</tr>
<tr>
<td>Case Manager:</td>
<td>Phone #: Pgr:</td>
</tr>
<tr>
<td>Authorized by: (For internal Hospital Use)</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>Name:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: <em><strong>/</strong></em>/______</td>
<td></td>
</tr>
<tr>
<td>Date Admitted to Hospital: <em><strong>/</strong></em>/______ Anticipated discharge date: <em><strong>/</strong></em>/______</td>
<td></td>
</tr>
<tr>
<td>Please explain the medical reason for hospital admission:</td>
<td></td>
</tr>
</tbody>
</table>

Please explain any surgical procedures and/or patient limitations:

Is wound care required? □ Yes □ No If Yes: Size ___ cm by ___ cm Depth ___ cm Stage ___

Is Home Health needed? □ Yes □ No If Yes, please explain:

Does the patient have any mental or substance abuse issues?

Mental Health: □ Bipolar □ Depression □ Schizophrenia □ Other:

Substance Abuse: □ Alcohol □ Cocaine □ Heroin □ Methamphetamine □ Other:

Any other medical or behavioral problems?

ReQUIRES Oxygen? □ Y □ N Self-administer medicine? □ Y □ N If No: □ Needs reminders □ Needs assistance

Continent of Bowel & Bladder? □ Y □ N Requires IV Antibiotic? □ Y □ N Communicable disease? □ Y □ N

Ambulatory? □ Y □ N Assistive device? □ Y □ N If Yes: □ Walker □ Cane □ Wheelchair □ Crutches □ Other:

Blood work (Coumadin)? □ Y □ N Diabetic? □ Y □ N If Yes: □ Requires Insulin? □ Y □ N

Estimated length of stay in recuperative care center: _____ days ______ Medications List (please fax)

FOR RECUP STAFF USE ONLY

Approved? □ Y □ N If denied, reason: ____________________________ Referal ID: □ LA □ OCC

Reviewed by: ____________________________ Date: ___________ Time: ____________________________

Admission Date: ___________ Time: ___________ Hospital Update: □ Y □ N □ 1st F □ 2nd F

Discharge Date: ___________ Time: ___________ Patient Summary: □ Y □ N □ Medical □ OTHER: ___________

NOTES: 2011 National Health Foundation RCC
APPENDIX 2

Recuperative Care Center of Orange County

12 Beds Available
Quick Links
Submit Referral Online click here.
Program Criteria click here.

Week of March 12, 2012
Hospital Reminders
- Check that you have the current referral form. Visit: www.nhfc.org/recup.
- Check that patients have all medications according to discharge instructions prior to leaving your facility.
- Contact National Health Foundation with any changes or delays in the discharge time for patients approved for recuperative care.

Thank you for your support and utilization of recuperative care!

Contact Information
Elizabeth Yang, Director T: 714-703-1875
Jeannine Pugliese, Coordinator T: 213-538-0762

Recuperative Care Center of Los Angeles

8 Beds Available
Quick Links
Submit Referral Online click here.
Program Criteria click here.

Week of March 19, 2012
Did You Know?
- Saturday admissions may be considered on a case by case basis.
- Recuperative care patients share a double occupancy room.
- Detailed voice messages can be left after 5:00pm at 213-538-0760.

Contact Information
Submit patient referrals: Monday - Friday 8:00am-5:00pm.
Please include the patient’s medication list. Fax #877-551-5580

Elizabeth Yang, Director
T: 213-538-0769 eyang@nhfca.org

Jeannine Pugliese, Coordinator
T: 213-538-0782 jpu@nhfca.org
**APPENDIX 3**

**Sample Patient Outcome Summary**

<table>
<thead>
<tr>
<th></th>
<th>Jane Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of Stay</td>
<td>14 days</td>
</tr>
<tr>
<td>Admitted:</td>
<td>11/8/11</td>
</tr>
<tr>
<td>Exit</td>
<td>11/22/11</td>
</tr>
<tr>
<td>Reason for Leaving</td>
<td>Patient completed Program</td>
</tr>
<tr>
<td>Discharge Destination</td>
<td>Permanent Housing: Client was accepted and transported to Sunrise Convalescent in Pasadena for long-term placement.</td>
</tr>
<tr>
<td>CM</td>
<td>CM has met with client to explore housing options. Client has no monthly income. Client does not have CA identification. Recup took Client to Norwalk and paid for birth certificate. 11/21, CM took Client to DMV and paid for CA ID. CM attended SS disability with interview with Client and assisted in application for disability. CM arranged for Client to be accepted to Sunrise Convalescent in Pasadena pending Medi-Cal approval. 11/22/11, client’s Medi-Cal was approved. Client was exited from Recup and CM transported to convalescent facility in Pasadena</td>
</tr>
<tr>
<td>Medical</td>
<td>Client has been feeling “alright” with no c/o pain. Client has been taking medications as prescribed and right leg swelling has decreased. Right leg still has peeling mid-shin, however, and continues to have redness. Left leg has less swelling than right leg and less peeling on bottom of leg. Client had follow-up appointment at Venice Family Clinic on 11/17/11, where client was prescribed with PO diuretic and antibiotic pills. At clinic, client reported that legs look “okay” but “right leg is warmer than left leg.” Client could not recall any other information that was said at clinic. Client has been taking newly prescribed medications as recommended by clinic.</td>
</tr>
<tr>
<td>Client</td>
<td>Client is following rules but at times loses her patience and become very angry. Client was uncooperative and foul-mouthed at medical clinic and was almost not seen because of her attitude. Recup staff was required to sit with her while waiting for appointment in light of her attitude. Client became cooperative with CM as resources were obtained and she recognized and internalized the caring attitude assistance of Recup staff. Client exited thankful and excited to be off the streets after 15 years of homelessness.</td>
</tr>
</tbody>
</table>
Recuperative Care Center of Orange County

Patient Information Form

Why am I going to the Recuperative Care Center? So that you can get:

- A safe and clean place to rest, three meals, and continue to recover

How long will I be there? Where do I go afterwards?

- Your length of stay will be determined in advance by the hospital
- The hospital is paying for your stay to allow you to rest and get connected to services within the community

What can I expect?

- A caring and supportive environment
- A nurse to help you follow your doctor’s orders
- Support to attend your follow-up medical appointment(s)
- A case manager to help connect you with services
- Counseling sessions
- A “harm-free” environment that abides by the motel rules
- Daily “wellness checks” to ensure your safety
- Support to help you transition back into the community
- Flexibility to leave site by using an off-site pass

A joint effort of National Health Foundation and Illumination Foundation
APPENDIX 5

PATIENT INFORMATION FORM

Recuperative Care Center
of Los Angeles

Why am I going to the Recuperative Care Center? So that you can get:
- A safe, clean place to rest and continue to recover
- A nurse to help you follow your doctor’s orders
- A case manager to connect you with services and counseling
- Support to help you transition back into the community

What can I expect?
- Transportation to the center
- Friendly professional staff to help meet your needs
- A clean bed
- Three healthy meals a day
- Your prescribed medications
- Hygiene supplies
- A “harm-free” environment that abides by the motel rules
- Daily “wellness checks” to ensure your safety

How long will I be there?
Where do I go afterwards?
- Your doctor will decide in advance how long you need to stay at the Center
- The hospital is paying for your stay to allow you to rest.
- The case manager will help you connect to services within the community and explore housing options

A joint effort of National Health Foundation and Illumination Foundation
Date

Name
Hosp
Addr
City, State, Zip

Re: Letter of Agreement: Orange County Recuperative Care Program

Dear [Name]:

Earlier this year you signed a Commitment Letter to participate in the Orange County Recuperative Care Demonstration Program (template enclosed for your convenience). We are happy to announce that the program is scheduled to launch [date]. This document serves as the Letter of Agreement between your Hospital and the Program Administrator, the National Health Foundation (NHF). It confirms the services to be provided to your hospital on an as-needed basis and outlines the terms of service. Please return an executed copy of this Letter of Agreement in the enclosed envelope before the close of business on [date].

By way of review, your commitment to participate in this program means you understand that:

1. Billing for your hospital is calculated on a fee-for-service basis and based upon ACTUAL program utilization at a per diem rate of $200/day and assumes a 10 day average length of stay.
2. Lengths of stay longer than that agreed upon at time of discharge will require hospital approval.
3. Upon discharge from the hospital, supply of necessary medications congruent with the patient's agreed-upon length of stay in the recuperative program will be provided to the patient.
4. You may use the program as often or little as you need. However, referral of your homeless patients is on an exclusive basis into this program when the patients meet program criteria.

Please see the attachment to this letter for additional facts about this program.

You may opt out of the program at any time with written notice to NHF. However, we have every confidence this program will save your hospital significant dollars in avoided hospital days, that it will minimize the likelihood of return visits to your emergency room, and that it will improve health outcomes for your patients who could otherwise be discharged to environments less appropriate to their optimal recovery. We look forward to serving you.

Sincerely,

[Signature]

J. Eugene Grigsby, III
President & CEO
National Health Foundation

Agreed by Hospital:

____________________________
Name of Hospital

____________________________
CEO

____________________________
Date
APPENDIX 7

Contact: Jennifer Bayer  
(213) 538-0730  

For Immediate Release:  
January 6, 2010

PRESS EVENT

Date: Friday, January 8, 2010  
Time: 10:30 a.m.

Location: Illumination Foundation  
Costa Mesa Motor Inn  
2277 Harbor Blvd., Costa Mesa, CA 92626

RECUPERATIVE CARE BED PROGRAM OPENS TO PROVIDE CARE FOR  
THE HOMELESS AFTER HOSPITAL DISCHARGE

Costa Mesa - Press conference and ribbon cutting ceremony Friday, January 8 - 10:30a.m. announcing the launch and grand opening of the Orange County Recuperative Care Program.

Launched by the Hospital Association of Southern California, National Health Foundation and Illumination Foundation, the project provides homeless individuals needing further recovery from illness or injury after hospitalizations a clean, safe place to recuperate with medical oversight.

Despite a homeless population estimated at nearly 21,500, Orange County had no recuperative care beds available to provide this type of post-hospital care until the launch of this program. The new program will augment services to the homeless provided at the Costa Mesa Motor Inn operated by Illumination Foundation, a non-profit organization that addresses the crisis of homelessness in Orange County through integrated services that provide appropriate solutions.

In addition to providing a safe and clean environment for clients to recover, clients will be connected to follow-up social services, including temporary / permanent housing, when they leave recuperative care. The project offers a proactive holistic solution for individuals who no longer need to be in an acute hospital environment.

About the Hospital Association of Southern California

The Hospital Association of Southern California (HASC) is a not-for-profit 501(c)(6) regional trade association comprised of hospitals and health systems, related professional associations and
associate members with a common interest in improving the operating environment for hospitals and improving the health status of the communities they serve. HASC represents 160 hospitals which operate a total of 41,000 beds in Los Angeles, Orange, Riverside, San Bernardino, Santa Barbara and Ventura counties. Our mission is to serve the political, economic, informational and educational needs of hospitals in our regions, and improve the quality and accessibility of health care services and thereby improving the health status of communities.

For more information about the Hospital Association of Southern California, please visit www.hasc.org.

About the Illumination Foundation

The Illumination Foundation (IF) is a non-profit 501 (c) (3), non-denominational, grassroots organization that addresses the crisis of homelessness in Orange County through integrated services that provide appropriate solutions. Illumination Foundation was founded in 2007 to bridge the gaps in existing services for homeless families and individuals. Illumination Foundation’s Outreach Program, the Mobile Multi-Service Center, connects homeless or at-risk families and individuals with medical, dental, vision, employment and housing services on-site at locations throughout Orange County. Illumination Foundation’s Interim Housing and Wrap-Around Program provides housing and comprehensive services to underserved families with children. This program provides the only safety net for an extremely vulnerable population that has nowhere else to go and would otherwise end up on our streets. Since the program’s inception, Illumination Foundation has taken 114 families (consisting of 238 children and 172 adults) off the streets into a safer, more stable environment. Using Homeless Prevention and Rapid Re-housing (HPRP) funds, Illumination Foundation’s Permanent Housing Program assists those who are homeless or at-risk of homelessness by transitioning them into affordable permanent housing to facilitate long-term stability.

For more information about the Illumination Foundation, please visit www.ifhomeless.org.

About the National Health Foundation

The National Health Foundation (NHF) is an independent, tax exempt 501 (c)(3) public charity dedicated to improving and enhancing the healthcare of the underserved by developing and supporting innovative programs that 1) can become independently viable, provide systematic solutions to gaps in healthcare access and delivery, and 3) have the potential to be replicated nationally.

For more information about the National Health Foundation, please visit www.nhfca.org.

###
Recuperative Care Client – 911

CLIENT NAME: ____________________________________________________________

MEDICAL REASON: _______________________________________________________

911 CALL BY: ___ IF Medical Specialist ___ Recup Patient ___ Other

ALERT CALL TO HOSPITAL ED: ___ Yes ___ No ___ Other

NAME OF ED CONTACT: ___________________________________________________

Instructions: Please contact the Recuperative Care Program for additional patient information and progress in the program. Please leave a detailed message, name and contact number.

Director, National Health Foundation: Elizabeth at evanq@nhfca.org or 213.538.0769 Hours: 8:00am-5:00pm (Weekdays)
*Response will be provided within 4 business hours

IF Recuperative Care Program Site: Lindie at 415.847.7639
Weekdays (After 5:00pm) and Weekends/Holidays

Note: The recuperative care client cannot return to the program without prior communication and advanced coordination with the Recuperative Care Program. Thank you.

LARCP 911 Form_May2011
Recuperative Care Client (Non-911)

CLIENT NAME: ____________________________________________________________

MEDICAL REASON: ________________________________________________________

________________________________________________________________________

CALL BY: ___ IF Medical Specialist ___Recup Patient ___Other

ALERT CALL TO HOSPITAL ED: ___ Yes ___No ___Other

NAME OF HOSPITAL ED CONTACTED: ________________________________

Hospital Instructions:
Please contact the Recuperative Care Program for additional patient information and progress in the program. Please leave a detailed message and contact number.

IF Recuperative Care Program Site: Lindie at 415.847.7639
Weekdays (After 5:00pm) and Weekends/Holidays

Director, National Health Foundation – Elizabeth Yang
eyang@nhfca.org or 213.538.0769 Hours: 8:00am-5:00pm (Weekdays)
*Response will be provided within 4 business hours

Note: The recuperative care client cannot return to the program without prior communication and advanced coordination with the Recuperative Care Program. Thank you.

LARCP Non-911 Form 2011
Los Angeles Recuperative Care Center: Hospital Checklist

HOSPITAL: ___________________________  CM: ___________________________

PATIENT NAME: ___________________________  Discharge Date: _____________

☐ Referral Status Approved

Instructions: Thank you for your efforts for a successful patient admission to the recuperative care center. Please complete hospital checklist and when completed fax to 877-551-5580 prior to patient’s discharge for recuperative care site. Should there be any delays or changes with discharge date or time, please call 213-538-0769 (leave a detailed voice message).

☐ COORDINATE TRANSPORTATION  DISCHARGE TIME: _____________

Patient Admission Hours: Mon-Fri, 9:00am-6:00pm  
(Note: We are unable to accept patient admissions after 7:00pm)

Address: Reno Motel/Illumination Foundation  
5136 W. Washington Blvd.  
Los Angeles, CA 90016

Call Elizabeth or Jeannine at 213-538-0769 with delays/changes  
(Please leave a detailed voice messages)

☐ FAX DISCHARGE INSTRUCTIONS  FAX# (877)551-5580
Use completed checklist as fax coversheet and fax along with discharge instructions prior to patient leaving hospital.

☐ MEDICATIONS & SUPPLIES  PATIENT’S LOS: ___________ days
Fill patient’s medications according to discharge instructions and provide supplies.

*Patient is diabetic and insulin-dependent (required):  Glucometer  Test Strips

*DME: Walker  I FWW  Crutches  Wheelchair  Other: ___________

☐ HOSPITAL CONTACT (After 5:00pm)
Staff Name & Phone: ___________________________

☐ HOME HEALTH SERVICES  □ YES  □ Not Applicable
If Yes, for what service: □ Wound Care  □ IV Therapy  Other: ___________

Agency: ___________________________  Contact: ___________________________  Phone: ___________________________
# Orange County Recuperative Care Center: Hospital Checklist

**HOSPITAL:**

**CM:**

**PATIENT NAME:**

**Discharge Date:**

**Referral Status Approved**

**Instructions:** Thank you for your efforts for a successful patient admission to the recuperative care center. Please complete hospital checklist and when completed fax to 877-551-5580 prior to patient's discharge for recuperative care site. Should there be any delays or changes with discharge date or time, please call 714-703-1875 (leave a detailed message).

### COORDINATE TRANSPORTATION

**Address:**

Costa Mesa Motor Inn/Illumination Foundation

2277 Harbor Blvd.

Costa Mesa, CA 92626

**Patient Admission Hours:** Mon-Fri. 9:00am-5:00pm

*Instruct patient to check in at front lobby.

**FAX DISCHARGE INSTRUCTIONS**

**FAX# (877)551-5580**

Use completed checklist as coversheet and fax to (877)551-5580 along with discharge instructions prior to patient leaving hospital.

**MEDICATIONS & SUPPLIES**

**LOS:**

---

*If Diabetic and insulin-dependent: Glucometer Test Strips

*DME: Walker FWW Crutches Wheelchair Other: _________

**HOSPITAL CONTACT (After 5:00pm)**

**Staff Name & Phone:**

---

**HOME HEALTH SERVICES**

**YES No Not Applicable**

If Yes, for what service:

- Wound Care
- IV Therapy

**Other:**

**Agency:**

---

**Contact:**

---

**Phone:**

---

**RCC Checklist 2012**
Recuperative Care Center
YTD Summary

Los Angeles: October 1, 2010 – February 29, 2012
Orange County: January 1, 2010 – February 29, 2012

<table>
<thead>
<tr>
<th>DISPOSITION</th>
<th>LA YTD</th>
<th>YTD %</th>
<th>OC YTD</th>
<th>YTD %</th>
<th>Combined YTD</th>
<th>Combined YTD %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total # Referrals</td>
<td>599</td>
<td>--</td>
<td>670</td>
<td>--</td>
<td>1269</td>
<td>28.8%</td>
</tr>
<tr>
<td>Total # Withdrawn</td>
<td>199</td>
<td>33.2%</td>
<td>166</td>
<td>24.8%</td>
<td>365</td>
<td>28.8%</td>
</tr>
<tr>
<td>Total # Eligible Referrals</td>
<td>401</td>
<td>--</td>
<td>504</td>
<td>--</td>
<td>905</td>
<td>--</td>
</tr>
<tr>
<td>Total # Admitted</td>
<td>382</td>
<td>95.2%</td>
<td>461</td>
<td>91.5%</td>
<td>843</td>
<td>93.1%</td>
</tr>
<tr>
<td>Total # Denied</td>
<td>19</td>
<td>4.7%</td>
<td>43</td>
<td>8.5%</td>
<td>62</td>
<td>7.3%</td>
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<tr>
<td>Total # Discharged</td>
<td>374</td>
<td>--</td>
<td>459</td>
<td>--</td>
<td>833</td>
<td>--</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>84</td>
<td>22.5%</td>
<td>85</td>
<td>18.5%</td>
<td>169</td>
<td>20.3%</td>
</tr>
<tr>
<td>Permanent Housing</td>
<td>54</td>
<td>14.4%</td>
<td>164</td>
<td>35.7%</td>
<td>218</td>
<td>26.2%</td>
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<tr>
<td>Shelter</td>
<td>113</td>
<td>30.2%</td>
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<td>21.0%</td>
<td>209</td>
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<tr>
<td>Re-admitted to Hospital</td>
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<td>43</td>
<td>9.3%</td>
<td>86</td>
<td>10.3%</td>
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<tr>
<td>Other**</td>
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<td>21.4%</td>
<td>71</td>
<td>15.5%</td>
<td>151</td>
<td>18.1%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>11.5</td>
<td>--</td>
<td>13.5</td>
<td>--</td>
<td>12.5</td>
<td>--</td>
</tr>
<tr>
<td>Total# Days</td>
<td>3988</td>
<td>--</td>
<td>5111</td>
<td>--</td>
<td>9099</td>
<td>--</td>
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</table>

<table>
<thead>
<tr>
<th>Hospital Costs</th>
<th>Year To Date</th>
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<tbody>
<tr>
<td></td>
<td>Potential</td>
</tr>
<tr>
<td>Combined</td>
<td>$7,684,788</td>
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<tr>
<td>Los Angeles</td>
<td>$3,482,312</td>
</tr>
<tr>
<td>Orange County</td>
<td>$4,202,476</td>
</tr>
</tbody>
</table>

**Potential cost is based on patients staying an average 3-4 days longer than necessary in hospital. Average hospital adjusted expenses per inpatient stay $2278 (adult level). Source: Kaiser Family Foundation State Health Facts (figures reflect 2008 data, the most recent data available as of March 2011)

RCC Combined YTD - As of February 29, 2012
NHF RECUPERATIVE CARE STAFF

Elizabeth Yang, Director, Recuperative Care
Jeannine Pugliese, Recuperative Care Coordinator

NHF would like to acknowledge our recuperative care partner, the Illumination Foundation. The Illumination Foundation (IF) is a non-profit 501(c)(3), non-denominational, grassroots organization that addresses the crisis of homelessness in Orange County through integrated services that provide appropriate solutions.