**PURPOSE**

To outline the process for collaboration between a Residential Care Facility/Assisted Living Facility (RCF/ALF) and Ohio Living Home Health and Hospice to determine if the needs of the Hospice or Home Health patient can be safely met at the RCF/ALF after the patient’s 120 skilled days within a 12-month period, have been exhausted.

A skilled day for this purpose is defined as nursing care being provided such as medication administration, supervision of therapeutic diets or application of dressings, if the residential care facility does not provide these services. Skilled care provided in an RCF/ALF is intermittent, less than 8 hours per day or less than 40 hours per week.

**POLICY**

Ohio Living Home Health and Hospice will collaborate with the RCF/ALF to determine if the needs of the Hospice or Home Health patient can be safely met at the facility after the patient’s skilled days have been exhausted.

**PROCEDURE**

1. At the time of referral, the team member should inquire of the referral source if the resident has used any skilled days in the past 12 months. This should be documented on the QRF or in the patient’s chart.
2. If the number of skilled days is not obtained prior to admission, the Admitting Nurse should obtain this information and document the information in the patient’s chart. If unable to obtain this information, the patient’s care team should follow up with facility staff.
3. Collaboration on the number of skilled days should be done prior to recertification for both Home Health and Hospice. This information should be documented in the patient’s chart if obtained. If during the course of care, Ohio Living is unable to obtain the number of skilled days from the facility, this should be documented in the patient’s chart.
4. Ohio Living Home Health and Hospice will make every effort to attend the Plan of Care meeting scheduled by the facility in person. The meeting may be attended by a social worker, spiritual counselor, nurse or designee.
5. It is determined that the patient’s care needs can be safely met, a letter of agreement would be completed and signed by all parties.
6. The Letter of Agreement will be filed in the patient’s chart.
7. If the patient is on hospice, the hospice team will be updated at IDG and patient’s attending will also be updated, if any.
8. Future plan of care meetings to discuss patient’s safety and care needs would be attended to ensure the patient can continue to have their needs met safely at the facility.
9. If determination is made that the resident’s needs can no longer be safely provided for at the RCF/ALF, Ohio Living would collaborate with the facility for alternate options for care. This should be documented in the patient’s chart.