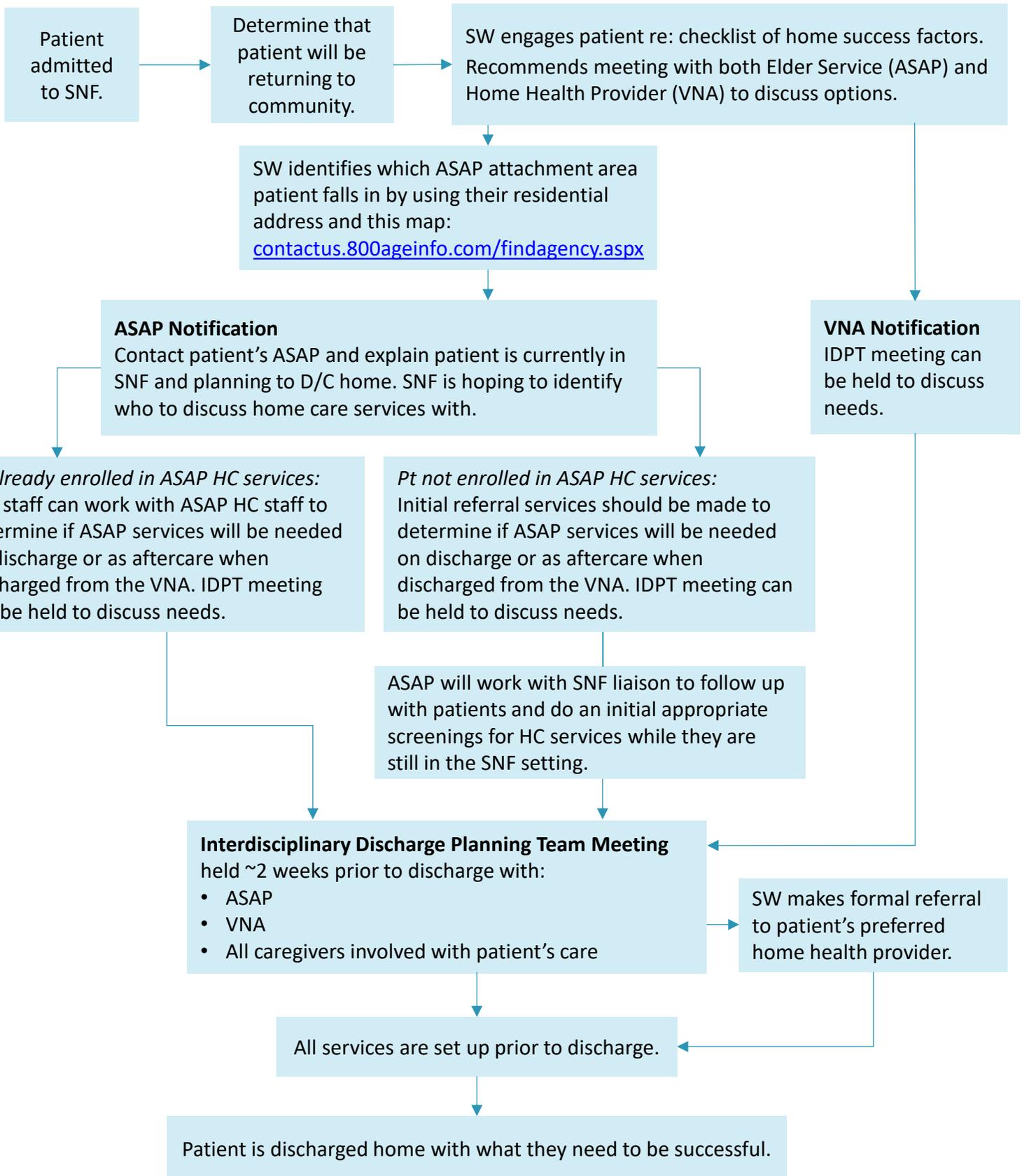


ASAP and VNA Referral Workflow



Supporting the transition home through strategic, patient-centered engagement with Community Providers and Programs

For many patients, their time in the facility has been an opportunity to heal, to improve, and to begin to gain physical independence, but that is not always enough.

Many patients have continuing rehab and recovery needs (i.e. physical therapy, wound care, teaching about how to manage their illness at home). This can be complicated, especially with nutritional, transportation, and activities of daily living challenges. Connection with Elder Services (Aging Services Access Point - ASAP) and Home Health (Visiting Nurse Association - VNA) helps patients/families identify areas to address that could help make recovery, independence, and long term success much more likely.

If you have a patient who may benefit from some sort of Elder/ASAP services, it is important to call the patient's local ASAP for next steps and to not make the determination of their eligibility on your own. Identify which ASAP catchment area patient falls in (their local ASAP) by using their residential address and referring to this map: <https://contactus.800ageinfo.com/findagency.aspx>

Elder Services and Home Health have decades of experience in helping patients to get needed home health care to recover to their maximum level of independence and to access the community resources, such as Meals on Wheels, transportation, etc. that can make life so much easier for little to no cost.

Meeting with the on-site care transition specialists/liaisons from ASAP and VNA will help the patient and care teams construct an individualized plan to connect with needs and be prepared for success in the transition home.

**Created by Bristol Elder Services, the Brockton Visiting Nurse Association,
Coastline Elderly Services, Old Colony Elder Services, and Healthcentric Advisors**