ASAP and VNA Referral Workflow

Patient admitted to SNF.

Determine that patient will be returning to community.

SW engages patient re: checklist of home success factors. Recommends meeting with both Elder Service (ASAP) and Home Health Provider (VNA) to discuss options.

SW identifies which ASAP attachment area patient falls in by using their residential address and this map: contactus.800ageinfo.com/findagency.aspx

ASAP Notification
Contact patient's ASAP and explain patient is currently in SNF and planning to D/C home. SNF is hoping to identify who to discuss home care services with.

VNA Notification
IDPT meeting can be held to discuss needs.

Pt already enrolled in ASAP HC services:
SNF staff can work with ASAP HC staff to determine if ASAP services will be needed on discharge or as aftercare when discharged from the VNA. IDPT meeting can be held to discuss needs.

Pt not enrolled in ASAP HC services:
Initial referral services should be made to determine if ASAP services will be needed on discharge or as aftercare when discharged from the VNA. IDPT meeting can be held to discuss needs.

ASAP will work with SNF liaison to follow up with patients and do an initial appropriate screenings for HC services while they are still in the SNF setting.

Interdisciplinary Discharge Planning Team Meeting
held ~2 weeks prior to discharge with:

- ASAP
- VNA
- All caregivers involved with patient's care

SW makes formal referral to patient's preferred home health provider.

All services are set up prior to discharge.

Patient is discharged home with what they need to be successful.

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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

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