The “Care Assessment Needs” (CAN) score is a tool developed by the Department of Veterans Affairs to predict the risk of readmissions or deaths over 120 different variables. It has been shown to be highly effective in predicting patient outcomes. The CAN score is calculated based on factors such as age, comorbidities, and hospital length of stay, and has been shown to be a strong predictor of 30-day readmissions.

The Post-Acute Home Care Initiative started on 1/1/20 and is ongoing. The intervention was designed to provide early intervention for patients with the highest hospital utilization as a result of the program. It was also identified that this program was highly successful at transitioning patients to home care and reducing hospital readmissions.

Next Steps

The SAVAHCS program used a data-driven approach to identify patients at high-risk for hospital readmission and then employed a multidisciplinary home care team, with team visits driven by post-discharge intensive care and patients at risk of hospitalization. The team includes home care nurses, social workers, dieticians, and occupational therapists. The team visits the patient in the hospital to offer the program (96% acceptance rate) and then visits the patient in the home to prevent ED visits/hospitalizations.

The success of the program is measured by the number of patients who are discharged from the hospital and the number of readmissions within 30 days. The program’s goal is to reduce hospital readmissions by 20%, which is a significant improvement. The program’s implementation and outcomes are monitored regularly to ensure that the program continues to be effective and to identify areas for improvement.

Sources


