Cardiology Unit Performance Analysis

Report for the Hospital Management Team

Executive Summary

- The **high recurrence of readmissions (20.57%)** indicates an urgent need for immediate action to prevent avoidable rehospitalizations.
- 4.04% of discharges result in a **readmission within 30 days**.
- **Prolonged hospital stays** among readmitted patients significantly increase operational costs.
- In 2023, readmissions accounted for 22,651 hospitalization days, representing an **estimated total cost of €15.86 million**.
- **Older patients** (average age: 64.94 years) represent a **high-risk group** requiring targeted strategies.

A **six-point strategic action plan** is proposed to address these challenges:

1) Strengthen **post-discharge follow-up**.
2) Optimize protocols for **geriatric patients.**
3) Reduce hospital **length of stay**.
4) **Minimize readmissions** within 30 days.
5) Improve **hospital resource management**.
6) **Educate patients** and caregivers.

To enable the implementation of these measures, we recommend developing a **Risk Score Card** that provides visibility into **each patient's readmission ris**k, both for medical staff and hospital management

Conclusions and Key Findings

Main Evidence:

- Significant recurrence of readmissions among **chronic patients** (20.57%).
- Longer hospital stays for **readmitted patients** (7.03 days vs. 6.04 days), increasing bed occupancy and operational costs, though this indicator remains close to the national average ([1]).
- Average age of deceased patients: 64.94 years, confirming their **vulnerability and the need for targeted care programs.**
- 4.04% of discharges result in readmissions within 30 days, impacting perceived quality and system efficiency.
- In 2023, readmissions represented 22,651 hospital days, with an **estimated total cost of €15.86 million** ([2]).

Strategic Recommendations:

1) **Strengthen Post-Discharge Follow-Up**
- Establish **multidisciplinary teams** to provide comprehensive support to high-risk patients.
- Implement **telemedicine technology for remote monitoring** and improved continuity of care.

2) **Optimize Protocols for Geriatric Patients**
- Develop **strategies for elderly care management**, including targeted rehabilitation and nutritional support programs.
- Create **specialized geriatric care units** within the hospital.

3) **Reduce Length of Hospital Stay**
- **Review internal processes** to identify bottlenecks that prolong hospitalization.
- **Introduce accelerated discharge protocols** for low-risk patients.

4) **Minimize 30-Day Readmissions**

- Conduct **audits of readmission cases** to detect recurring patterns and improvement areas
- Ensure that **discharge instructions** are clear and that patients receive appropriate follow-up care.

5) **Improve Hospital Resource Management**

- Continuously **monitor bed occupancy** to dynamically allocate resources.
- Develop **contingency plans to avoid saturation** during peak demand periods.
- Strengthen **collaboration with primary care**, creating communication channels with clinics and general practitioners.

6) **Educate Patients and Caregivers**

- Organize **training workshops and distribute educational materials** to empower patients in managing their conditions.
- **Focus these programs on chronic diseases** such as heart failure and diabetes.

Implement a Risk Score Card

➔ **Use historical data** to identify patients at higher risk of readmission and support proactive interventions.

➔ **Train medical staff** to use these tools for data-driven decision-making in patient management.

External sources

(1) https://www.sanidad.gob.es/estadEstudios/sanidadDatos/tablas/tabla24.htm

(2) https://www.elespanol.com/invertia/observatorios/sanidad/20201208/dia-ingreso-hospital-cuesta-sanidad-publica-euros/541696545_0.html