Project Minerva: High-Risk Patient Strategy

Executive Summary

Analysis confirms that **patients over the age of 65** impose a disproportionate burden on hospital resources due to a readmission rate of **57.14%**. This high rate is concentrated heavily in the **North and East regions**, indicating a failure in post-discharge care, environmental factors, and potentially inadequate resource allocation in these areas.

Immediate intervention is required to transition from reactive care (treating pain) to a holistic, patient-centered, and proactive follow-up model.

Key Findings & Metrics

Metric	Result	Insight
Elderly Population (Age > 65) Readmission Rate	**57.14%** (4 readmissions / 7 visits)	This is the primary systemic risk factor identified.
Regional Concentration (Visits)	North: 4 visits, East: 4 visits	These two regions account for 66% of total elderly patient volume.
North & East Combined Readmission Rate	**50.00%** (3 readmissions / 6 elderly patients)	The most urgent operational failure point is localized in the North and East. For every 4 elderly patients discharged in these regions, 2 are readmitted.

Root Cause Analysis

The data suggests readmissions are driven by factors outside the immediate hospital stay, leading to rapid deterioration post-discharge:

1. **Environmental and Social Determinants:** As highlighted, weakened immune systems combined with poor home environments significantly increase the likelihood of return visits.
2. **Insufficient Discharge & Monitoring:** Rapid patient discharge, lack of monitoring, and insufficient pain relief suggest a system focused on throughput rather than sustained patient stability.
3. **Absence of Follow-up Care:** The lack of a structured program to check medication adherence and overall condition creates a void that frequently results in an expensive

readmission.

Strategic Recommendations

Based on the evidence of high, concentrated risk, the following steps are required for a sustainable reduction in readmission rates:

1. **Dedicated Nurse Follow-up Team:** Establish a specialized, designated team of nurses whose **sole role** is proactive, regular check-ins with aged patients post-discharge. This team will monitor medication adherence, address symptoms, and perform remote wellness checks.
2. **Mandatory Extended Monitoring Stay:** Implement a policy to allow aged patients to remain in the hospital for a minimum of **3 days before discharge**. This period should be dedicated to condition stabilization, comprehensive monitoring, and thorough discharge planning.
3. **Holistic Patient-Centered Care Model:** Adopt a philosophy that allows patients to fully articulate all issues before action is taken. This moves beyond treating a symptom to understanding the **entire condition** and ensuring patient needs are fully addressed.
4. **Community & Relative Education:** Develop and distribute educational materials (e.g., mosquito nets, balanced diet pamphlets) to patients and their relatives, focusing on creating a clean, safe post-hospital environment to prevent recurrence.