DEMystifying patient throughput to optimize revenue & patient satisfaction

It’s not about increasing bed capacity, it’s about optimal patient placement.

By: Patricia Kloehn, Executive Vice President, West Coast Region
Executive Summary
In the 1990’s, conventional wisdom indicated that widespread HMO coverage would diminish future utilization in the nation’s hospitals. Hospitals responded by consolidating services, reclassifying beds and closing hospitals. However, this prognostication has proven untrue as the American public “voted out” HMOs in favor of PPOs. Since PPOs are a less stringent gatekeeper, utilization of services has risen steadily and the industry is in the midst of a capacity and patient throughput crisis. Problems with patient throughput have resulted in lost revenue, ineffective policies and procedures, and dissatisfied patients.

In response to the increased patient demand for services, many hospitals are redesigning patient flow and facing a wide array of unsolved issues. These issues include overcapacity, diversions to competitor facilities, excessive wait times, poor bed placement control and a poor discharge process.

Overcapacity. A facility that is consistently over 85% occupied is likely to experience throughput issues as well as ED related delays.

Diversions. Many hospitals divert patients to competitor facilities, when in fact they have beds available.

Excessive Wait Times. Inpatient and outpatient procedures as well as ED visits may experience unnecessary delays and excessive wait times for treatment and/or placement.

Poor Bed Placement Control. There may be a huge disconnect between departmental and hospital information systems.

Poor Discharge Process. The workflow for patients leaving the facility is disjointed. Stratification must be in place to properly process patients at discharge.

A “whole system solution” is required for all areas of patient throughput, not just the emergency department. Process enhancement is the key to solving many of the problems created by increased demand for your healthcare services. Bedside registration, interdepartmental process redesign, new policies and procedures, revamped technology, a new discharge lounge workflow and management of people are key action items required to improve patient throughput. It is important to redesign throughput as a whole continuum of patient care. Benchmarking to industry key performance indicators is key to getting the results you desire.

In order to address throughput issues, you must have support within all areas representing the continuum of patient care. Throughput task forces or groups can be effective if properly supported. The hospital must also have a “champion” to lead the process. This champion could be a clinical director, ED director or nursing management.

There is a financial benefit as well. Industry research shows that a hospital can obtain a 15 to 20% increase in bed and service capacity via throughput redesign. This can add millions of dollars to the bottom line of many hospitals.
Hospitals across the nation are experiencing a capacity crisis. After a 10-year process during which many hospitals experienced consolidations, bed reclassification and closures, bed capacity is now at a premium. Population growth and ageing of the baby boomers has put additional strain on hospitals whereby older patients who experience a longer length of stay due to healing requirements are now taking up beds. Additionally, we are seeing a rise in emergency room visits and admissions. According to the American Hospital Association’s annual survey, admissions for last year rose 2% to 34.1 million, while the total aggregate of inpatient days grew 2%. Emergency room visits increased 4% to 110 million with the average length of stay at five days.

Many would argue that the nation’s emergency departments have not been able to adequately absorb the increase in patient volumes. According to a recent report by Modern Healthcare, crisis in Los Angeles is having a serious ripple effect on patient care. Next month, a study to be published in the Annals of Emergency Medicine will cite how delays are forcing dozens of ambulances to sit idle outside hospitals while paramedics wait to transfer patients to an increasingly scarce supply of beds. A 12-month study revealed that, in Los Angeles, 21,240 ambulances--one in every eight transports--waited to transfer patients requiring hospitalization. This critical issue causes the entire system to back up and reduces the quality of patient care.

More and more facilities are experiencing similar dilemmas. Patient throughput is going through a period of dramatic change, resulting in the manifestation of multiple problems throughout the entire healthcare system, which is why a “whole system solution” is crucial to addressing throughput breakdowns rather than emergency department re-design or expansion.

Many hospitals are operating at sub-optimal patient placement levels, as evidenced by increased capacity and operating costs. A common planning error of the 1990’s was a result of the widespread faulty assumption that aggressive HMOs would discourage patients from using hospital emergency departments and that hospitals’ urgent care centers would further reduce demand. Instead, managed care is in retreat and the number of uninsured Americans is climbing, pushing patient volumes beyond the limits of many emergency departments. Furthermore, squeezed operating margins have closed 64 facilities across the nation, prompting patients to patronize surrounding facilities and push capacity beyond growth projections. According to Hospital Statistics 2004, the aggregate hospital profit
margin was 4.3% in 2002, compared with 4.1% in the previous year, which indicates that profit margins are stagnant or dropping. Additionally, hospitals are experiencing great difficulty in employing and retaining qualified medical personnel to operate at full capacity. Such nationwide clinical shortages have an adverse effect on patient throughput.

To meet increased patient demands, many hospitals are in the process of, or planning to redesign their emergency departments within the next 10 years. Redesign projects costing $10 million to $20 million aren’t unusual and allow hospitals to double or triple their current square footage. While this may be necessary from a clinical standpoint, merely redesigning the emergency department will not solve throughput issues. The interdepartmental nature of the patient flow continuum can cause delays and backlogs throughout the hospital, including the emergency department, post-anesthesia care and medical surgical units, admitting lobby, and, ultimately, back-up on floors. Backlogs can lead to unacceptably long wait times in the emergency department, diversions to competitors’ hospitals, surgical delays and overtime of high-cost surgical staffing.

The problem is becoming such an issue that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has proposed a new Emergency Department Overcrowding Standard, Rationale and Elements of Performance. The proposal cites “increased scarcity of available inpatient and long-term care beds and alternate care settings” as a cause that leads to overcrowding in the emergency department. Government targets suggest that less than 1 percent of ED patients should wait more than four hours, once the decision to admit has been made. Ultimately, backlogs and delays lead to patient dissatisfaction, physician and staff frustration, and missed revenue.

Revenue losses can be a result of delays in Medical/Surgical discharges which back-up transfers from high-cost ICUs and CCUs, which require 1:1 staffing. Higher costs are not needed when patients become non-critical. Given the high fixed operating costs hospitals face, an unfilled bed equals a significant revenue loss. Dirty beds can place a hospital in financial hardship, without most even recognizing the dilemma. Additionally, diverting patients to other hospitals is a huge revenue loss.

Expanding capacity by adding beds can be a costly way to address throughput issues. In fact, in some markets, the estimated cost of adding physical capacity can exceed $1 million per bed, without taking into account the cost of acquiring the capital. In a hospital with a five-day average length of stay, each bed “buys” about 70 admissions annually, making physical expansion an expensive investment. Add to this the time-intensive licensure and approval process required to expand facilities, and some hospitals are finding that physically increasing capacity is either too expensive or too slow to meet current needs. (Tapping into hidden hospital bed capacity. Kirby & Kjesbo, Healthcare Financial Management, November 2003).
Common Symptoms and Signs: When do you know you are in trouble?

These key indicators, if out of balance, may point to patient throughput issues:

**Over capacity** - A key operating capacity level is 85% occupancy throughout the day. Once your facility begins to nudge above this on a consistent basis, you are likely experiencing throughput issues throughout the house. ED lengths of stay appear to increase extensively when hospital occupancy levels exceed a threshold of 90%. (The effect of hospital occupancy on emergency department length of stay and patient disposition. Forster, A.J., Stiell, I., Wells, G., Lee, A.J., and van Walraven C., Acad Emerg Med. 2003 Feb;10(2):127-33).

**Diversions** - Regularly diverting to competitors’ facilities can cause patient and physician dissatisfaction, as well as loss of potential revenue. Diversions must be broken down by time of day and diagnosis. Additionally, it should be noted how many beds are held in reserve by clinical staff each day which contribute to diversions. It is not uncommon for a hospital experiencing 80% occupancy to show ghost numbers of 120% occupancy. There is a similar ghost bed saving process with outpatient procedures, whereby physicians hold open the option of admitting a patient to the hospital, just in case there are complications or unforeseen outcomes. These “just in case” ghost beds peak in the middle of the day, causing hospitals to divert when in actuality beds are available for patients.

**Excessive wait times** - Wait times for patients seen and treated in the emergency department, patients waiting to be admitted to a bed from the emergency department or as a direct admit, and patients moving from Medical/Surgical or PACU to a bed may all contribute to excessive wait times and unnecessary delays in care for treatment. Studies indicate that reducing the number of admitted patients waiting in the ED for inpatient beds is associated with a decrease in the interval that treat-and-release patients spend in the ED. (Do admitted patients held in the emergency department impact the throughput of treat-and-release patients? Bazarian, J. J., Schneider, S. M., Newman, V. J., and Chodosh, J., Acad Emerg Med. 1996, Dec; 3 (12):113-8).

**Left Without Being Seen (LWBS)** - If your facility experiences a high volume of patients who leave without being seen, throughput is most likely an issue you face. Beyond moving emergency department patients through the system faster, studies suggest that communicating estimated waiting time and the availability of immediate treatments for minor injuries or symptoms might increase the time patients are willing to wait, and decrease an emergency department’s LWBS rate. (The Left-Without-Being-Seen Patients: What Would Keep Them From Leaving? Katherine W. Arendt, MD, Annie T. Sadosty, MD, Amy L. Weaver, MS, Christopher R. Brent, MHA, and Eric T. Boie, MD. Ann Emerg Med. 2003;42:317-323).

**Discharge policy non-existent or ignored** - Many facilities have a discharge policy of 11 a.m., yet physicians do not release patients until they make their rounds in the afternoon. Another problem occurs when patients have been discharged but are occupying a bed waiting for someone to pick them up. Additionally, patients may have been discharged out of their room, but nursing or unit clerks do not enter the discharge into the ADT system until a shift change has occurred so new patients cannot be received. Discharge times must be tracked, and adherence to a policy must be monitored. Physicians must be educated on how many patients they discharge after discharge hours in conjunction with house saturation levels. If a patient has been discharged late due to physician or transportation circumstances and the hospital is in diversion, education must take place.
**Patient dissatisfaction** - Although many factors drive patient satisfaction, length of stay in the emergency department and perceptions of staff treatment impact it most. (Ed Free-Flow, Deborah Prodoehl, *Nursing Management*, September 2002). Often, patient dissatisfaction is more likely to increase when there is an increase in wait times and lack of communication regarding wait expectations. Additionally, studies suggest that there is an emotional toll on patients detained in the ED and PACU because patients and families have no access to each other as they would have in private rooms. Holding beds are less conducive to privacy, decreasing patient satisfaction. Patient satisfaction should be tracked and monitored in conjunction with house saturation levels.

**Why does this happen?**
In order to effectively move patients through the system, it is important to look at the systemic cause of the backlogs and inefficiencies. The first step to address throughput issues is to develop an understanding of the areas that affect patient flow and capacity. Drivers of capacity constraints and key opportunities for performance improvements must be measured. This can be achieved by:

- Monitoring diversions;
- Understanding how systems and tools interface for patient admission, discharge and transfer (ADT); and
- Determining the efficiency of activities such as bed tracking and control, patient transportation, housekeeping and care delivery.

The key indicators below should be tracked and monitored for throughput efficiency.

<table>
<thead>
<tr>
<th>1. Enhanced Revenue</th>
<th>1. Revenue to increase by contract rates/DRGs multiplied by increased patient capacity. Proper patient placement by level of acuity will lead to increased revenue.</th>
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</thead>
<tbody>
<tr>
<td>2. Reduced Diversions</td>
<td>2. Reducing High Cost/High Acuity Diversions to be given priority. Diversions to be tracked and benchmarked from previous year. Roll-out plan devoted to High Cost/High Acuity areas.</td>
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<tr>
<td>3. Increased Capacity</td>
<td>3. Increased Occupancy: Two areas to be monitored: Increased capacity in ED as a result of patient placement; Increased capacity in house.</td>
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<tr>
<td>4. Decreased Wait Times</td>
<td>4. Decreased Wait Times: Decreased wait times to lead to increased patient satisfaction. Track wait times/bed placement from ED and wait times/bed placement on direct admits</td>
</tr>
<tr>
<td>5. Timely Discharges</td>
<td>5. Timely Discharges: Enforce discharge policy, which would dictate 11 a.m. discharge. Enforce Nurses entering discharges into ADT system.</td>
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<tr>
<td>7. Decreased Bad Debt</td>
<td>7. Decreased Bad Debt: Bad debt quantifiably decreased as patients are financially secured in discharge lounge.</td>
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Throughout our consulting history, we have found the following to add exponentially to throughput delays:

**Clinical reluctance to take new patients** - Often, nurses do not want a new patient for various reasons: 1. Taking a new patient involves a higher workload due to the addition of patient work-up, versus monitoring an existing patient; 2. Nurses may become attached to their patients and do not want to discharge patients to a discharge lounge or waiting area after clinical discharge has occurred; 3. Convenience around work shifts can take precedence over patient admit times. Studies reveal that often when nurses are responsible for entering discharges, a significant amount of discharges occur right before a shift change, thereby giving the oncoming staff the new admits. While this may make sense from a duty shift standpoint, throughput havoc occurs.

**Ineffective discharge and intake** - Discharge and intake are not well-defined, audited processes, but are guided by physicians’ schedules. Studies reveal that when nurses take more control over discharge times and discharge expectations are communicated to patients, patients are more likely to experience a shorter or standard length of stay. When nurses acknowledge the average length of stay based on diagnosis and communicate the information to patients, adherence is more likely. This article revealed that a surprising amount of nurses did not know the average length of stay based on the common diagnosis of their floors and relied on physician orders and interpretation. This may be an interesting study for your nurses to undergo. What is the average length of stay based on the most common diagnosis treated at your facility?

**Discharges triggered by schedule changes and not entered into ADT** - Although discharges may be taking place regularly throughout the morning, they may be stacking up at a unit clerk or nurses station waiting for input into the ADT system, which often triggers bed assignment. It is imperative to have several checks and balances in place to monitor discharge inputs. See below for examples.

**Beds are dirty, environmental services not notified systematically** - Surprisingly, many hospitals administer archaic measures when monitoring available and dirty beds. Oftentimes, environmental services are pulled (literally) to the next bed for cleaning. Stat cleans are the mantra for each bed needed and prioritization is confusing at best. Many facilities that are on diversion actually have dirty beds in-house, but cannot deploy the necessary staff to systematically notify environmental services which beds must be cleaned. A system must be automated in order to optimize efficiency and prioritize bed needs. Manual bed boards do not work within the dynamic interplay between department and patient needs and are a waste haven for inefficiencies and loss of revenue.

**Bed control** - Where bed control resides influences successful patient throughput. If admitting representatives are responsible for patient placement, nurses can easily decline patient acceptance with minimal repercussions. Bed control is most functional under the authority of nursing when coupled with an aggressive clinical figure that puts patient placement at the forefront. Additionally, when nursing oversees bed control, they also possess the nursing staffing schedule and have real time access to nursing-to-patient ratios. This is often a blind spot for admitting representatives.

**Solutions**

Hospitals are combating throughput issues with varying solutions, all aimed at minimizing key pressure points throughout the patient flow cycle. A multi-disciplinary approach must be taken in order to realize throughput efficiencies. Success revolves around enhancing or altering broken processes. Enabling people to be more accountable in the patient flow continuum and using key technology enablers...
(foundational support for implementing accurate policies and procedures) are key in reaching desired results.

**Process Enhancement**

**Bedside registration** - Expanding the number of registration personnel and maintaining dedicated ambulance, fast track and walk-in registrars reduces wait time and minimizes patient flow inefficiencies. Processes and protocols to be implemented upon patient admission or triage, including bedside registration, enhance patient flow and satisfaction – especially at times of high census and high acuity.

**Interdepartmental processes** - The following departments can make or break effective patient flow single-handedly. Processes that outline the handoff between departments are critical to overall success. The following areas must have sound processes in order to interact efficiently. Most often, these include:

- **Admitting** - Coordination with Admitting is essential for proper patient placement of those with pre-admit status and direct admits.

- **Intake Unit** - Intake Unit must respond to ED needs to prep patients for floor placement or act as holding area for ED patients waiting for a bed. Intake Unit may also be used for direct admits needing prepping.

- **Nursing** - Nursing must enter all discharges in a timely manner for processes to work at optimal levels. Nursing must adhere to policies and accept patient placement from bed control. Nursing huddles will take place twice daily to determine patient placement and candidates for discharge lounge.

- **Bed Control** - Bed Control will be responsible for patient placement throughout the entire hospital. Bed Control will have authority to place patients and, with support from Nursing, will divert and prioritize patients when saturated.

**Housekeeping** - Housekeeping must respond to all clean requests within required time frames. Staffing must be kept at appropriate levels in order to clean all rooms in a timely, efficient manner.

**Discharge Lounge** - Discharge Lounge will be clinically secured area for low-end care patients. Lounge Coordinator must proactively seek patients for discharge lounge at multiple points throughout the day. Discharge Lounge may also be area for financial discussions with patients.

Key policies and procedures that must be taken into consideration include the following:

- **Direct Admission Policy** (to include acceptable circumstances for direct admission, criteria in diverting a direct admit when more acute patient is incoming, registration and discharge process).

- **Admission from Emergency Department** (to include acuity levels and minimum/maximum minutes for room assignment and patient placement. Policy should outline the importance of direct contact between triage and charge nurses, who in turn, keeps track of patients awaiting treatment and prioritize. Policy should also address ED patients waiting to go to ICU, CCU or telemetry, ED patients waiting to be admitted or observed, and patients stacked in PACU, ED or hallways).

- **Hospital Diversion Policy** (to include full plan followed by EMTs and hospital staff, this should liken a disaster plan and not be tolerated as an everyday occurrence).

- **Discharge Policy** (to include discharge time and process to follow, policy must include protocol on entering discharges into ADT system in order to notify housekeeping of a dirty beds. Following guiding principle should be discussed; discharge on the low care end and admit on the high care end. Consequences and accountability to discharge policy must be established).
Discharge Lounge (to include criteria for admission into the discharge lounge, staffing ratios and proactive protocol on finding patients who may meet lounge criteria).

Rapid Intake Unit (to include criteria for admission to intake unit; definitions describing prepping patients for placement on floors. For example, nurses can begin routine checks of vitals, IVs and administer fluids. Floors are more likely to accept a patient who has been prepped and entered into the system, thereby increasing patient placement and acceptance.)

People Enhancement
To effectively tackle throughput issues, it is imperative to have the cooperation of key supporting members representing the continuum of patient care. Many facilities form patient throughput task forces or groups that are responsible for keeping patient throughput at the forefront and monitoring bottleneck issues. It is also key to have someone to champion successful implementation of these throughput efforts. Likely candidates include: Clinical Director for Medical/Surgical; ED Director; Director of Nursing; or another authority figure.

Key members of such a task force may include the following:

- Admitting staff;
- Medical/Surgical staff;
- Emergency Department staff;
- Critical Care staff;
- Nursing staff;
- Dietary staff;
- Pharmacy staff;
- Bed Control staff;
- Physicians; and
- Environmental Services.

The team is generally responsible for establishing a baseline 60 days prior to throughput change implementation. They also track length of time patients wait in the PACU, ED, ICU, and lobby for admission or transfer, always identifying the reason for any backlog or delay. The team also monitors the length of time discharge orders are signed versus the time the patient is discharged from system. Diversions to other facilities are tracked as well as dirty beds held overnight, stat cleans and the time it takes to clean each room.

It is important to note that the team may encounter some obstacles along the way. Obstructive groups adverse to implementing throughput changes often include nursing staff due to the perception that their caseload will increase and/or they feel empathy toward their patients and are reluctant to send them to a clinically staffed discharge lounge.

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EXAMPLE:

Admission Criteria for the Discharge Lounge

Patients eligible for admission to the discharge lounge:

- Ambulatory patients capable of waiting in a recliner for 2-3 hours.

Patients who may not be eligible depending on their ability to wait for short periods of time:

1. Special assistance for ambulation is required (post-op total knee and total hip patients)
2. Extremely weak patients
3. Patients requiring oxygen and have a limited portable oxygen supply

Patients ineligible for the discharge lounge:

1. Require ambulance for transportation
2. Acutely ill; awaiting transfer to another facility
3. Confused patients without supervision
4. Incontinent patients
5. Mothers and newborns
6. Non-ambulatory patients
Technology Enhancement

Most leading facilities have a clinically driven bed control process whereby Bed Control acts as the central patient placement hub and is responsible for coordinating patient placement of all direct admits, ED admits, discharges and transfers, and initiating housekeeping staff to clean beds. In addition, Bed Control should also be responsible for or have access to nursing staffing ratios on each floor and staffed by clinically experienced personnel.

Bed Tracking (electronic housekeeping system) - An electronic housekeeping system can provide an excellent communication foundation between Bed Control, Housekeeping, Admitting and each floor. Prioritization of cleaning beds can be communicated in real-time format to housekeeping staff by alphanumeric pagers. Bed Control can ascertain status of bed cleaning on electronic bed board, thereby educating holding areas on time to place patients. Priorities can be altered according to patient needs and bed availability, thereby increasing revenue-based optimal patient placement. Full tracking and monitoring capabilities are part of the deliverables.

Electronic Bed Board - An electronic bed board can link Bed Control, Housekeeping, Admitting, and each floor to the hospital’s available space. Each floor and the emergency department are able to request beds and transfer patients from their own computers. If desired, each floor can see a mini-version of the bed board and/or their own patients. Communication is done in real-time format and future or pending patients can be given rooms as well. This system minimizes patient wait times, focuses all parties on a consistent goal and can reduce unnecessary costs such as sending meals to discharged patients and excessive delays in cleaning dirty beds. Full tracking and monitoring capabilities are part of the deliverables.

ClearProfit Scorecardz™ - Zimmerman has developed a proprietary monitoring system, which tracks Key Performance Indicators on a daily basis, to guide patient throughput success. Goals and variances are viewed on a weekly basis. Such information includes: percent diverted; average cost of diversion; percent of patients waiting over two hours; percent occupancy; percent dirty beds overnight; number of clean beds; number of dirty beds; average time to clean beds; and the number of stat cleans.
In-Depth Review: How to Set Up a Discharge Lounge

A discharge lounge is simply an area where patients can wait for prescriptions, follow-up instructions, transportation home, and financial clearance. It is an area clinically monitored where patients can rest comfortably and be served a hot meal. Discharge lounges can often satisfy two primary purposes: 1.) Low-end care patients already discharged and waiting for transport can have an effective, clinically monitored holding place, thereby freeing up beds for acute care and new patients. 2.) Discharge lounges can be used for financial counseling functions and become an integral part of the discharge process for all patients requiring further financial discussions.

When setting up a discharge lounge, it is important to consider location for the lounge. Find an area that maintains the patient’s dignity, comfort and safety until final discharge. Additionally, more successful lounges have been placed close to admission or the emergency department. Hiding the lounge in an unpopular area will increase reluctance to use the lounge by clinical staff.

When introducing the discharge lounge to the staff it is important to outline benefits:

1. Discharges to the lounge should occur primarily on the day shift when both nursing and ancillary staffing levels are the highest;
2. Greater efficiency, including fewer telephone inquiries about room readiness;
3. Increased patient satisfaction;
4. Placement based on acuity, which improves patient care; and
5. The lounge can be staffed during saturation and does not necessarily have to be operational 100% of the time.

Greater chances of success can occur when patients are introduced to the discharge lounge upon admission or during a pre-admission interview or tour. Often, patients adhere to the discharge policy (11 a.m. exit deadline) when it is communicated to them early on in their care process because they can arrange transportation ahead of time, thus avoiding dispatch to the lounge.

Discharge lounge coordinators and managers can make or break the activity of the lounge. Increased active participation in assisting with discharge activities on medical and surgical units leads to increased discharge lounge compliance. Patients are more readily transferred from units where managers actively support the concept. Additionally, when a discharge lounge nurse makes rounds to help facilitate discharges, calls about prospective discharges, and participates in teaching and discharge processes, the use of a lounge often doubles. Providing a beeper for the lounge nurse to be summoned during rounds often enhances communication.

Elements of a discharge lounge often include the following:

- Recliner, personal belonging cart
- Oral medication access (PYXIS)
- General/emergency medical equipment
- Refrigerator with snacks
- Bathroom
- Entertainment (TV, phones, Internet access, magazines, patient/medical information)
- Workstations
- Space for discharge lounge – low visibility; limited access to admission/discharge/ED.

First steps in setting up a lounge include the following:

- Produce a clear operational policy
- Disseminate information as widely as possible
- Produce a patient informational leaflet
- Choose area with easy access
- Ensure that the lounge becomes an integral part of discharge procedure for all appropriate patients.
An example of the copy used in discharge lounge brochure follows:

In this leaflet, you will find information that will answer some of your questions and introduce you to the discharge lounge routine.

Opening times are:
Monday - Thursday: 9 a.m. – 7 p.m.
Friday: 9 a.m. – 5 p.m.

The lounge is situated on level B of the Day Hospital
The direct number to dial is 0-1-(935) 384-4444.

If your transportation is unable to collect you before 11 a.m., you may be transferred to the discharge lounge until it arrives. This helps the hospital provide beds for patients waiting to be admitted. The lounge is equipped with comfortable chairs, a television area and telephone. Daily papers and magazines are also available.

Hot meals or sandwiches and hot and cold beverages are available. A packed lunch/ or supper can be provided if your journey home coincides with a mealtime. The patio area of the garden can be used when weather permits.

Access for relatives, hospital or other transport is gained via the entrance to the Day Hospital.

The discharge lounge coordinator will look after your needs while you wait in the lounge. S/he will liaise with the appropriate ward, pharmacy, and hospital transport and porter services to ensure your smooth discharge home.

S/he will complete any remaining aspects of your discharge and will ensure your needs are catered to while you wait comfortably in the lounge.

We wish you a safe journey home.

**Conclusion**

Patient throughput is a dynamic process that is undergoing dramatic change. It is important to study throughput as a whole, along the continuum of patient care, and monitor success and failure through a set of key performance indicators. When monitored effectively, throughput can be optimized, creating increased revenue and patient satisfaction.
Through targeted reengineering and data-rich publications, Zimmerman helps healthcare providers improve their margin so they can fulfill their mission.

Your Margin. Our Mission™: Our engagements have laser like focus and discipline on creating the most economic and strategic value possible. This is achieved by applying a value-based framework and methodology called Revenue Cycle Architecture™ in order to create real and lasting income statement and balance sheet improvement through revenue cycle performance improvement. Most organizations have an opportunity to improve their bottom line by an additional 3-6% of net revenue.

The Zimmerman team of turnaround champions and consulting pros— including former hospital CEOs, CFOs and revenue cycle VPs— has a proven track record. Our clients range from large, complex health systems to small rural hospitals. We focus on revenue enhancement as opposed to expense reduction, and we design most solutions to be self-funded. Our goal is to build an infrastructure so external resources can be kept at a minimum.

We focus on results. Since the firm’s inception, we have realized billions of dollars in cash flow improvement. In fact, our last three major engagements resulted in more than $100 million in balance sheet and income statement gains. Through our many delivery mechanisms, Zimmerman has provided revenue cycle solutions to more than 75% of the nation’s hospitals.

Zimmerman is the premier provider of benchmarking information for the healthcare revenue cycle, with a suite of Best Practice Reports that provide timely intelligence on best-in-breed performers. Our Revenue Cycle Management, Collecting in Healthcare and Patient Access Monthly newsletters supply practical, real-world information to revenue cycle CFOs and managers. We also offer staff training, teleconferences, books, audio programs, special reports and seminars.