

## THE OFFICE

## Watch Out for Embezzlers

**F**raud and economic crime are on the rise, according to many law enforcement officials around the country. The Denver District Attorney, for example, reported that theft and embezzlement complaints increased by 30% in his jurisdiction in 2008.

A lot of embezzlement goes undetected in medical offices. People who investigate embezzlement crimes for a living say that most cases are uncovered by accident. Finding it is usually relatively easy, because most embezzlers are not particularly skillful nor very good at covering their tracks, but many cases go undetected because no one is looking.

The experience of a friend of mine was all too typical: His bookkeeper wrote sizable checks to herself, entering them in the ledger as payments to vendors commonly used by his practice. Since she also balanced the checkbook, she got away with it for many months.

"It wasn't at all clever," he said, "and I'm somewhat chagrined to admit that it happened to me." Is it happening to you, too? You won't know unless you look.

Detecting fraud is an inexact science. There is no textbook approach that one can follow, but a few simple measures will uncover or prevent a large percentage of dishonest behavior:

► **Hire honest employees.** This may seem obvious, but it is amazing how few doctors check applicants' references. Call them and find out if the applicants are really as good as they look on paper. For a few dollars, you can screen prospective employees on public information Web sites such as [www.KnowX.com](http://www.KnowX.com) to see if they have criminal records or if they have been sued or are suing others.

► **Minimize opportunities for dishonesty.** Theft and embezzlement are the products of motivation and opportunity. It is hard to control motivation, other than paying a fair, competitive wage and doing what you can to maximize job satisfaction, but there are lots of things you can do to minimize opportunities for dishonesty. No one person should be in charge of the entire bookkeeping process. The person who enters charges should be different from the one who enters payments. The em-

ployee who writes the checks should not balance the checkbook, and so on. Internal audits should be done on a regular basis, and all employees should know that. Be on the lookout for holes in your accounting system that provide opportunity for theft, and if you find one, close it. Your accountant can help with this.

► **Reconcile receipts and cash daily.** The most common form of embezzlement is simply taking cash out of the till. In a typical scenario, a patient pays a \$15 copay in cash but the receptionist records the payment as \$5 and pockets the rest. Make sure a receipt is generated for every cash transaction, and that someone other than the person accepting cash reconciles the receipts and the cash daily.

► **Insist on separate accounting duties.** Another common scam is false invoices: You think you are paying for supplies and services, but the money is going to an employee. Once again, separation of duties is the key to prevention. One employee should enter invoices into the data system, another should issue the check, and a third should match invoices to goods and services received.

► **Verify expense reports.** False expense reports are another common form of fraud. When an employee asks for re-

imbursement of expenses, make sure they are real.

► **Safeguard your computer.** You would think that computers would have helped to alleviate embezzlement, but they have made it easier and more tempting. Data are usually concentrated in one place, accounts can be accessed from remote workstations or off-premises servers, and a paper trail is often eliminated. Your computer vendor should be aware of this, and should have safeguards built into your system. Ask about them.

► **Look for red flags.** Do you have an employee who refuses to take vacations, because someone else will have to look at the books? Does someone insist on approving or entering expenses that are another employee's responsibility? Is an employee suddenly living beyond his or her means?

► **Consider bonding your employees.** The mere knowledge that your staff is bonded will scare away most applicants with a history of dishonesty, and you will be assured of some measure of recovery should the above safeguards fail. ■

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BY JOSEPH S. EASTERN, M.D.

## Family-Centered Rounding Helps Bridge Transition Home

BY JOYCE FRIEDEN

**T**he idea of "family-centered rounding" may sound like a daunting task: coordinating a dozen schedules and cramming 12 or more people into a small hospital room to meet with patients and their family members.

But those who have tried it say it's worth it, because it improves communication among physicians, nurses, and other patient caregivers, and it makes the patient's family members feel more like a part of the team.

"The big advantage of family-centered rounding is family engagement and getting the family involved in the process," said Dr. Glen Tamura, medical director of the inpatient unit at Seattle Children's Hospital, which has been using family-centered rounding (FCR) for about 5 years. "We are really trying to engage families and get their feedback on the plan, as well as make sure they understand how we think their child is doing."

Dr. Nanci Rascoff, a third-year resident who has participated in FCR at Seattle Children's, agreed. "I like that we give them this role and responsibility to become really involved in their child's care," she said. "It's easy to give them the 'worried parent' role, but by including them in the rounding process, they are empowered to become part of their child's care plan."

Dr. Rascoff said she sees a change occur in the parents, even if their child is only in the hospital for a few days. "On the first day, they are like a deer in the headlights, overwhelmed and thinking, 'There are 12 people in the circle and they're in white coats and they're talking about my child.' But then a transition happens, and they join us the next day with a notebook in hand filled with questions. It gives them an additional focus and outlet for their concerns."

Another benefit to having the whole care team and the family there is that the afternoon "rework" that hap-

pens with some cases can often be avoided, said Dr. Tamura, who was one of several speakers on the subject at a pediatric hospital medicine meeting in Tampa.

"When the family isn't present, the [care] plan seems reasonable to the team, but for some reason it won't work," maybe because there is some issue with the patient that the team didn't know about. But later when the intern tries to get consensus on an alternative plan, "the resident has gone to continuity clinic and the attending has gone somewhere else, so the poor intern is trying to get everyone to agree on a plan when the team has scattered. A conversation that could be completed in person in 10 seconds can take the intern an hour or more to resolve." With family-centered rounding, Dr. Tamura said, "we avoid that 90% of the time by having everybody there so we can have this discussion and resolve those issues at the time."

**Building a Team**

At Seattle Children's, the FCR team includes the attending pediatrician; all of the house staff—residents and interns, and medical students if they're on the team; a team coordinator; a care coordinator who makes home care arrangements; a nutritionist; and a pharmacist, who can be very helpful with specific cases.

"We had one patient who had a urinary tract infection that was very hard to treat," Dr. Tamura said. "We had pharmacy [with us] on rounds, and we said to them, 'Look at the options and tell us what's reasonable and get back to us with answers.' Them being there means they understand what we're really grappling with."

Team coordinators are not clinicians, "but they help the team get prepared by making patient lists and letting the team know how many patients there are to round on. As we move through rounds, they call the nurses ahead of time so they know we are coming. They know the most efficient route through the hospital."

Having a care coordinator on rounds to help create a discharge plan with the family can also help prevent having the plan fall apart on discharge day, said Dr. Tamura, who is also assistant professor of pediatrics at the University of Washington. "We can make sure the family feels comfortable with the discharge plan and is confident they can do all that we are asking them to do."

Making an FCR program work requires buy-in from hospital management, Dr. Tamura said. Before FCR, "people were used to showing up whenever and having the residents at their beck and call, and you just can't run a family-centered rounds program this way. We created a system where attending physicians have standard rounding times, but it wouldn't have worked if they weren't told that they had to be there. Someone at the top has to say that."

**Getting Past Hurdles**

But although family-centered rounding has benefits, there are also disadvantages, according to Dr. Tamura. For one thing, he has found that at his hospital, it adds time to rounds. "It takes an extra 3 minutes a patient, which doesn't sound like a big deal until you have 20 patients," he said. "We are continuing to work on making sure there is time to round with all the families."

Despite all of the challenges, Dr. Rascoff said she loves involving families in rounds. "One thing people worry about is the teaching component," she said. "Due to time constraints, we don't have as much time to do formal teaching with medical terminology, because we're trying to make it parent friendly. But what you are teaching that's essential are communication skills for residents and medical students, like how to console a parent who breaks into tears when you start talking about why their child came into the hospital. That's incredibly valuable." ■