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INSIDE

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Have reservations when seeking perfect appointment reminder system

Search is not for the faint-hearted, but you can cut through the hype

When personnel at the Cleveland Clinic Foundation began the search for an automated appointment reminder system, little did they expect to navigate a labyrinth of contradictory claims within a surprisingly "cutthroat" industry, says **Carolyn McConnell**, operations analyst.

After all, she notes, with systems available for as little as $8,000, it's not as though the vendors are competing for big bucks. After more than a year of sifting through claims and counter claims and discovering the hidden costs of some systems, the Cleveland Clinic will pilot its new system the last quarter of 1999, with assessment and full rollout to follow. McConnell offers hard-earned advice to access managers involved in a similar search.

> **"[No-shows are] a huge problem — an awful lot of lost revenue and idle time, and we're paying people who aren't busy."**

While checking vendor references, McConnell says, she was surprised to discover that many health care organizations had no data on their no-show or same-day cancellation rates, thus rendering it impossible to measure any improvements a new system might make. To make sure this crucial information is available, she suggests an organized approach beginning with identifying the need for such a system and ultimately measuring its effectiveness before it's rolled out to the entire organization. **(See related story, p. 87.)**

When McConnell and marketing manager **Peter Miller** started looking for a centralized appointment reminder system for the Cleveland Clinic, there were already six such systems operating independently of each other in various departments, she says.

An e-mail survey on the no-show and same-day cancellation problem sent to administrators throughout the organization got an immediate and 100% response, Miller adds. "They were very interested, and they wanted to help and to learn about possible solutions."

The systems already in place represented the different departments' efforts to combat an 11% no-show rate for appointments. "We're a very large tertiary care facility with 11,000 employees and about 1.5 million patient visits a year," McConnell points out. "Although 11% is a relatively low no-show rate, it means that in our case, 160,000 people don't keep their appointments," she adds. "That's a huge problem — an awful lot of lost revenue and idle time, and we're paying people who aren't busy."

Some attempts to lower the rate — such as sending punitive letters, requiring deposits, or assessing fees for repeat offenders — proved less than effective, McConnell says. "It's difficult to collect the money, and if you do, what do you do with it? There's no accounting procedure in place for individual departments to take in money."

Solutions created new set of problems

The individual reminder systems spawned a new set of problems, she says. With some departments using the systems and others not, patients wondered why they got reminder calls for radiology appointments but not for cardiology appointments, she adds. "Much more often, the patient would say, 'I got four calls last night from the Cleveland Clinic.' A lot of people come from out of town and have multiple appointments," she notes. "By the third call, they're thinking we're pretty stupid. Even worse, if they get a reminder for one appointment and not the other, they think the second one's been canceled."

In addition, McConnell says, there is no uniformity to the systems. "Some use your name, others say, 'You or your family member have an appointment.' Some allow you to press a button saying you want to cancel, others don't."

Mailed reminders offered virtually no help, since they are sent only when appointments are made two weeks ahead of time, and most are scheduled only seven to 10 days in advance, she adds. The ultimate goal is to have a dual system, where the telephone reminder is a backup to the mailed reminder or supplants it for the shorter time frames.

Technical support for existing systems might come from down the street or from as far away as Alabama, McConnell points out, and sometimes problems weren't discovered until patients became very irate. In one case, a system flipped "a.m." and "p.m.," and no one found out until the wrong person got a call in the middle of the night and complained to "someone high up in our food chain," she adds.

After sitting in on a satellite clinic's meeting with the vendor it had selected for its own reminder system, McConnell says, she and Miller decided it was time to stop adding systems to the mix. They wrote a proposal for a centralized appointment reminder system and presented it to the foundation's marketing strategy task force, McConnell says. "They got it right away, that we needed to centralize, and said, 'Go find a vendor.'"

Thus began an intensive, yearlong analysis that included the vendors already on campus and several others, she says. The search addressed issues under the following two categories:

1. Cost

McConnell and Miller discovered that start-up costs, including hardware and training, for an appointment reminder system range from $13,000 to $80,000. "But we found out that if [vendors] were low on the front end, they were high on the back end," McConnell notes. "How they charge is critical."

Some vendors charge by the batch, meaning the customer pays a certain amount for, say, 5,000 calls per month. One vendor who was on the high end in upfront costs charged a flat rate for monthly maintenance, so over time, that vendor likely would cost less. In most cases, she suggests, the flat rate is best. "With a time-specific contract, those charging by transaction fee could come back later with a higher processing fee, and you're already hooked.

"We tried to figure out what the costs would be if you were making 130,000 calls a month," she adds, which is an estimate of the number of reminder calls that would be generated by the foundation. "Depending on how you figure it,

it was $12,000 a month or $21,000. Now we're talking maintenance costs approaching $200,000 a year."

2. Standard functionality

Under this category, McConnell and Miller looked at the following features:

- **Voice quality**

"With some vendors, a person at the facility must record the message, while others have a voice library and 'splice and dice' sentences together," she notes. Good voice quality was high on the list of priorities for the clinic's system. "We wanted to know, 'Does it sound human or computerized?'"

- **Call blocking**

Another important question was whether calls could be blocked at the department and individual level. Call blocking would allow the organization to prevent calls from going to, for example, psychiatric patients. And, McConnell adds, if patients request that they not receive the automated calls, those patients' names can be eliminated from the call list. This also relates to the issue of patient privacy, she points out. "You don't want to embarrass anyone or put anyone in danger or in an awkward situation by making the call."

- **Database filtering**

McConnell says she was surprised to find that the appointment reminder system of one of the largest vendors did not filter the database to determine if, for example, one patient had multiple appointments the next day. Its system would simply call the patient for each appointment, an alternative that was not acceptable, she says. Other systems had the capability of making one call and listing either the first appointment scheduled or the times of all appointments that day, McConnell adds.

- **Bi-directional capacity (outgoing and incoming messages)**

At one of the foundation's health centers, McConnell says, half of all calls are requests for lab results or prescription refills. To significantly free up the telephone, therefore, the system must provide for incoming as well as outgoing calls.

- **Interactive response options**

How interactive the system could be was another concern. Some systems allow the patient, upon receiving the reminder call, to press a button saying he or she would like to cancel the appointment, while others do not, she notes. Another question is, "Can the patient be connected directly to a real person?"

Here are some questions to ask regarding the system's operational and technical aspects, McConnell suggests:

- How much manual intervention is required to make this system run the way you need it to? Must someone push a button to start it, or does it happen automatically?
- Is there network connectivity? Can you connect the unit to the network, download or e-mail reports where they need to go, and eliminate paper reports?
- Where is the vendor in terms of product development? Is it a Windows or a DOS system? What version of software is the vendor on? What new products are in the works? Most vendors are working on Web-based applications, McConnell notes. "If you're working with one who isn't, that might be a concern."
- What is the maximum number of calls inbound or outbound that can be handled in a day? How many dedicated phone lines do you need? ■

Measure first, then pilot automated reminders

Check vendor claims, interview references

Before implementing an automated appointment reminder system, it's important to measure your organization's no-show and same-day cancellation rates so you can see if the new system helps, suggests **Carolyn McConnell**, operations analyst for the Cleveland Clinic Foundation.

That's the first step of a process that includes identifying issues, gathering data, selecting a solution, building a consensus, and then selecting a vendor, she says. **(See tables, p. 88.)** "Then there are product demonstrations, contract negotiations, time lines, and setting up a pilot. Then, there is post-implementation assessment. Otherwise, how do you know the system works?"

The assessment should be done after the pilot, she emphasizes, not after rolling out the system to the entire organization.

About four years ago, McConnell notes, the Cleveland Clinic began generating a quarterly mainframe production report for every department on the no-show and same-day cancellation data. So when the organization began looking for an appointment reminder system about a year

High-Level Activities

Identify issues	Gather data
Investigate solutions	Gather data
Select a solution	Build consensus
Review products/vendors	Client referrals
	Product demonstrations
	Secondary analysis
Select a vendor	Negotiate contract
	Set general time lines
Develop implementation plan	Select pilot
	Implement pilot
	Assess pilot
	Determine rollout sequence
Rollout	
Post-implementation assessment	Does product work as anticipated?

ago, the information with which to make a comparison was available.

Taking the names of vendors whose systems already were in use in various foundation departments and adding a couple of new ones to the list, she and marketing manager Peter Miller started their search, she says. In addition to interviewing the five vendors on key issues **(see cover story)**, they obtained three references for each and devised seven groups of questions for those users, McConnell says.

That wasn't as straightforward a procedure as it sounds, she notes. "In the beginning, every one of the vendors said they had a contract with Johns Hopkins [University in Baltimore], but when questioned closely, they said the contract wasn't signed yet. You really have to pay attention to this kind of thing."

Selecting a Vendor

General

What specific products are being used from (this vendor)?

What has the overall patient response been like?

Have any privacy-related issues come up?

What hidden costs have you discovered? Are your monthly maintenance fees fixed or variable?

Are you currently in a pilot status? If so, is scheduled rollout planned?

Technical

How responsive to your needs is the vendor?

Have there been many technical problems?

If there a lot of down time?

Are reports in a file format (downloaded) or print?

How do you use the reports generated from these systems?

Are they easy to use?

Product Type: Appointment Reminder Calls

Prior to installation of this system, how were appointment reminders handled?

What has the impact of this system been on your no-show and same-day cancel rates?

Is your reminder call product in use at the institution level? Or is it decentralized?

Do you use the "recall" feature?

Do you use the patient inquiry feature?

Has the use of this product resulted in substantial time savings for you? Greater convenience for your patients?

Source: Tables on this page are courtesy of the Cleveland Clinic Foundation.

Sometimes the vendors would say who their clients were but would not give contact names, she says. "One continually gave references to parts of their system we weren't interested in — one that was only for prescription refills and another for checking account balances. We cut them."

The foundation was particularly interested in a vendor with a program for presenting the system to patients in a favorable light, she notes. "Many don't have [a plan for gaining patient buy-in], so this helped us make our choice."

In the end, McConnell says, she added up the pluses and minuses for each vendor and picked the one who had the majority of features she thought necessary. Among these were good voice quality, good reports from references, and the functional capability for call blocking and two-way interfaces, she adds.

She also made sure the chosen vendor served other clients of similar size and structure to the foundation, McConnell says. Another organization, however, might be better served by a vendor that specializes in smaller operations.

Some vendors claim a 50% reduction in no-show volume with the use of their products, she notes. "I've seen 25% reduction personally [with systems in various foundation departments], but part of the issue is that we have different units with different delivery systems. If the patient population knows there is just one system that will call, we will have better results."

She'll have a chance to measure those results when the Cleveland Clinic pilots its new system the last quarter of 1999, with assessment and full rollout to follow.

Even with costs of $200,000 a year, she says, an automated reminder system is an economical way to combat missed appointments. "If a machine is calling 5,000 people a day, what's the equivalent in employees it would take to do that?"

(Editor's note: Look for a report on the implementation of the Cleveland Clinic Foundation's automated appointment reminder system in a future issue of Hospital Access Management.*)* ■

Need More Information?

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Focus gives newfound respect to access role

'There's no magic,' just hard work, consistency

Focusing on good customer service was a tradition at Albert Einstein Medical Center in Philadelphia when **Anthony Bruno**, MPA, became director of health care access management two years ago, but the challenge he faced was making the philosophy work in the access department.

"Impressive customer service has been a breakthrough objective for the Einstein Healthcare Network," he says. "From the top down, everyone is looking at it in their areas and trying to develop strategies."

In fact, the Philadelphia-based organization's reputation in that regard was one of the reasons he wanted to work there, Bruno points out. "Wendy Leebov, the vice president of human resources, has been a national spokesperson for customer service since the '80s."

His mission became manifesting that idea in access management, he says. Not the least of his motivations was to bring respect and recognition to what historically has been one of the most undervalued parts of any health care organization. "It's so terribly important, in an era of downsizing and people losing their jobs, to express the extreme value that patient access has."

Bruno's effort — a five-faceted approach to developing impressive customer service — garnered him the 1998 Einstein Award for Customer Service and "has really put our department on the map," he says. "There's no magic. It's just hard, conscientious, consistent ways of working with staff." The improvements happened, Bruno adds, by breaking the process into these directives and devising specific ways to follow them:

- **Recognize and anticipate customer expectations.** With this goal in mind, Einstein came up with innovations ranging from a preadmission services brochure with free parking pass to a single patient consent form and a wireless registration system. A patient handout titled, "Read any good insurance cards lately?" explains that financial penalties might be incurred by not following the precertification requirements specified on the cards and offers the phone number for financial counseling for further help. On the back is an insurance requirements checklist. **(See patient handout, p. 91.)**

• **Define staff behavior expectations.** To meet this objective, the access department developed a mission statement outlining its responsibilities and goals. Job tasks for registrars and financial counselors are clearly outlined. In addition, access employees are asked to complete and sign a form indicating their commitment to "delivering continuous impressive customer service." In making that commitment, the employees list specific behaviors they will integrate into their jobs to achieve the goal.

• **Educate/train staff.** The department implemented two new forms of communication to achieve this objective, explains **Marina Zeccardi**, manager of administrative services for health care access management. "Code Green," named for its financial focus, is a quarterly newsletter that goes to access staff both at the hospital and at registration sites throughout the network. "Although these employees are not under our control, they deal with the same issues," notes Zeccardi, who writes the publication with the help of the patient accounts department.

Printed on green paper, the newsletter emphasizes that access staff "are not really registrars, but front-end billers." It notifies staff of insurance name changes and computer system updates and is a forum for questions and answers. Educational features include, for example, explaining the difference between a preferred provider organization and a health maintenance organization.

"Hot Off the Presses" is a one-page notice to all registration areas of items that need immediate attention. "It may be that we just found out we have a new financial class," Zeccardi says. Another message alerted employees that entering the effective dates for patients' insurance on a registration needed special attention because of year 2000 complications. "It's an eye-appealing, fun way to approach serious information."

The "What's Hot Hotline" is a dedicated telephone line staff can use to find out about new programs, code changes, and upcoming meetings. A recent message, Bruno says, informed employees that a new laser jet print system was going live that day. Other educational efforts include a physician office staff orientation breakfast, and the assignment of individual employee mail slots for memos and other correspondence.

• **Demand consistency.** Outpatients at the Albert Einstein Medical Center carry a Patient Flow Card on which staff record the patient's arrival and departure times at various ancillary departments. "This is the patient's 'passport' as they arrive at different services," Bruno says. "We use it to guide the patient, but also to do a quality review. If we want to get through preadmission in less than two hours, it takes a team effort."

On the back of the Patient Flow Card is a customer service survey, which asks such questions as, "Were you greeted in a friendly manner?" and "Did you receive service in a timely manner?" The cards are given to patients when they arrive for an appointment and collected before they leave.

To promote accuracy, Zeccardi randomly spot checks patient registration forms. **(See spot-check form, p. 92.)** "We look at what was right and what was wrong," she notes. The employee who did the registration gets a copy of the review, as does the manager.

• **Reward staff with recognition.** To recognize employee efforts, Bruno instituted an annual health care access excellence award, with the recipient honored at a ceremony during health care access personnel week, held the second week in April in conjunction with the National Association for Healthcare Access Management observance. Special events throughout the week include an employee breakfast, an international foods luncheon, raffles, and a white elephant swap meet.

Efforts to promote and monitor customer service are varied and ongoing, Zeccardi points out. The department has conducted telephone surveys to determine if employees answer the phone according to a prescribed script. "We had a listing of all [access] extensions and did it once a month for four months, picking two or three phone numbers in each location," she adds. "That's simple, something anyone can do. Sometimes we tend to think broad instead of getting down to the nitty-gritty."

At the end of 1998, she says, the department participated in a networkwide "secret shopper" campaign. "A representative from another department would come in unannounced, pretending to have an appointment," Zeccardi adds. The secret shopper rated the experience. "Our [results] were very positive," she notes. ■

Need More Information?

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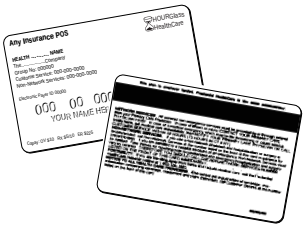
Read any good insurance cards lately?

This is a serious question, because if you do not know what is written on your insurance card, it may cost you money...



Today, many insurance companies have special instructions that may require patients to contact the insurance company before or at the time of an admission (including emergency admissions) or before or at the time of registration for other hospital services.

These special instructions are called different names:
Pre-certification or Prior Authorization.

If you card indicates that your insurance company must be called for authorization, you or a family member should contact the insurance company within a 24-hour period.

The staff at Albert Einstein Medical Center is here to help you. If you have any questions about your insurance during your stay at the hospital, please telephone our financial counseling department at 456-8083 for assistance. Also, please remember that insurance companies can issue severe financial penalties for non-compliance with authorization requirements, so...

Please read both sides of your insurance card today!

Also, please take a moment to read the ***insurance requirement checklist*** *printed on the right.*

Thank you,
Healthcare Access Department

Source: Albert Einstein Healthcare Network, Philadelphia.

✓ Insurance requirements checklist

If you are going to be receiving health care services, to assist you as you sort through the process of complying with your insurance company's coverage requirements, please read the following list of questions:

- ☐ Have you read the front and back of all insurance cards issued to you by your (or your spouse's) employer?
- ☐ If pre-certification is required, have you made arrangements to contact your insurance company?
- ☐ If you have contacted your insurance company regarding pre-certification, have you given your health care providers your approval number?
- ☐ Are you aware if your health care provider's charges will or will not be covered by your insurance company?
- ☐ Does your policy require a deductible charge? If so, what is the amount?
- ☐ Does your policy require a co-payment charge? If so, what is the amount?
- ☐ Does your policy require a second medical opinion? If so, have you obtained the second opinion?
- ☐ Does your policy require that you have a referral form for health care services? If so, have you obtained your referral form and given it to your health care providers?
- ☐ Does your policy require a claim form? If so, have you completed the form for submission to your health care providers?
- ☐ If you are scheduled for surgery, is your surgery related to any type of accident? If so, have you given all of the accident-related information to your health care providers, such as how, where, and when accident occurred?
- ☐ Are you covered by more than one insurance plan? I so, have you submitted all insurance information to your health care providers? This will include: name of plan, address, telephone number, ID number, subscriber's date of birth, and completed claim and/or referral form(s).

If you have any questions regarding your insurance requirements and/or coverage during your stay at the hospital, please call our financial counseling department at 456-8083 for assistance.

Spot Check

To: _____

As a part of our departmental commitment to quality improvement, the attached reservations/registrations/admissions have been ***spot checked*** for content accuracy. Each data field has been reviewed with the following results:

- ❑ No errors found in any transactions
- ❑ ____ Billable/Insurance errors found
- ❑ ____ Demographic errors found
- ❑ ____ Physician Information errors found
- ❑ ____ Diagnosis or Procedure error found

Total Items Reviewed: _____ Total Errors Found: _____

Corrective Action Needed:

- ❑ No corrective action needed.
- ❑ Corrections already made; however, errors need to be reviewed and will be forwarded to management staff.
- ❑ Update system with correct information.
- ❑ Document revisions by printing copies of all screens involved or by initialing all highlighted errors on the attached sheet(s).

Please take all corrective action noted, sign and return form within **four working days** from the date of issue. If you have any questions, please contact your manager immediately.

Date Issued:_____ Reviewed By:_____

Date Returned _____ Employee Signature: _____

Please make a copy of this form for your records.

Source: Albert Einstein Healthcare Network, Philadelphia.

'Fact-based management' trusts data, not anecdotes

Satisfied employees called key to success

Managing by fact, not by anecdotes, is key to success in today's health care environment, says **Edsel Cotter**, CHAM, vice president of general services for Grant/Riverside Methodist Hospitals in Columbus, OH. Put another way, Cotter says, "In God we trust. All others bring data."

With that in mind, his organization developed a model called "fact-based management," which applies this philosophy to leadership, work force, process management, patient/family-focused care, and measurement.

The results of this management model are tied to the organization's quality, service, financial status, and quality of work life, which in turn are recorded on a "score card" that is distributed throughout the hospital. **(See related story, p. 94.)**

Communicate the big picture

Leadership in fact-based management has to do with understanding and communicating the big picture, Cotter says. That means focusing on solid information rather than anecdotes — "not putting out fires, but looking at data," he adds.

In Grant Medical Center's emergency department (ED), for example, employees were complaining about workload, high patient volume, and lack of coordination, and they were blaming various people or departments.

Drawing on fact-based management, the hospital put together a multidisciplinary team to study the situation, Cotter notes. "[The team] started tracking when a lab test was ordered, and when the results came back, how long before a patient was taken up for an MRI and when the patient came back, when a bed was requested and how long before a patient was told he or she could leave the ED for a bed.

"That information was brought forth to the executive staff, who were told, 'Here's the root cause, here are the facts about what's causing it, and here are the actions we need to take,'" he says.

The human resources aspect of fact-based management focuses on "creating, improving, and promoting systems, programs, and processes which enable us, the system, to be viewed as the employer of choice," Cotter says. "We want to create an environment of well-trained people who like to work here."

Most employees today don't consider their jobs to be the most important aspect of their lives, which makes "quality of work life" a crucial element of the management equation, he points out. "Work is part of making life outside of work possible and pleasant."

That's why variable staffing — "having the right number of people at the right time in the right place" — falls under this piece of the management model, Cotter says. The hospital also has a program for selecting and tracking employees and matching them to a job for which they're more suited. "Sometimes people just need change."

It's also his organization's practice to empower employees "to do the job, to take risks, to do what satisfies the customer" without waiting for the boss to give the word, he adds.

"We view our work as a set of processes that are critical to our customers," he says. "We align our core processes, care of the patient, with operational patient care processes." That involves everything from the care administered by the nursing staff to the processes involved in getting food to the patient.

Under fact-based management, there is an owner of each process, he says. "The process owner is the person downstairs who gets the order request for a medical item needed on the patient care floor and sees that the item gets to that particular nursing unit.

"[He or she] makes sure that the process works from the time the item is ordered until it gets upstairs, as opposed to handing off [the responsibility] to a lot of different people. That person has to know what it took from start to finish to fill that order."

Under the patient/family-focused care part of fact-based management, the hospital looks at its internal and external customers, who ultimately define and determine the success of the continuous improvement processes, he explains. "This allows us to deal with the requirements of customers and provide a framework for anticipating their needs and meeting those needs."

For example, when satisfaction surveys indicated that patient food was not up to par — that hot items weren't hot and cold items weren't cold — the hospital looked at the problem through process improvement, Cotter says. "Plates were not staying warm in their covers, and we determined that we needed to replace the warmers. The complaints dropped off."

With hospital score card, there are 'no rumor mills'

Quality, service, finances measured

Grant/Riverside Methodist Hospitals in Columbus, OH, looks at its status each month with a "score card" distributed throughout the organization, says **Edsel Cotter**, CHAM, vice president of general services.

In addition to the organizational score card, individual departments fill in score cards geared to their specific concerns, adds Cotter, who also is senior operation officer for Grant Medical Center.

The card is made up of four quadrants, formed by drawing a cross, and with the quadrants headed, from top left, "quality," "service," "financial," and "quality of work life," Cotter explains. Each quadrant is filled with whatever information the organization, or the department, believes is the most appropriate measure of its status in that area.

In its quality quadrant, the organization tracks 13 different clinical items, including the number of patients who are in the emergency department (ED) longer than six hours, the number who leave the ED before completion of treatment, the neonatal mortality rate, and the cesarean rate.

In the service quadrant, the hospital includes data from the latest report by South Bend, IN-based patient satisfaction measurement firm Press, Ganey Associates, he says, including scores from the inpatient, outpatient, and ED surveys. "We show a baseline for each of those scores, and where we are now."

Individual departments measure, for example, feedback on the laundry service or the food service, plugging in new numbers every month, Cotter adds.

The financial quadrant shows where the organization is in relation to its budget, with data on revenue and expenses. "We want to keep our monthly operating margin at 3%," he says. "If we're not meeting that, we want everybody to know."

There is a quadrant for "quality of work life," he notes, because of the importance of employee satisfaction in today's health care environment. Staff now are less interested in money than in going home on time, having weekends off, whether they like the boss, and other "quality of life" concerns, he points out.

Grant/Riverside surveys employees quarterly on such issues as whether they believe management is doing a good job and whether they are happy with their own job benefits, Cotter says. Numeric data from that survey are included in the score card, as is the employee turnover rate, he adds.

"If the quality of work life is good, the turnover should slow up. We also track the employee suggestion program — how many suggestions we're getting, and how many of those are approved and enacted," Cotter says.

Score cards are handed out at management meetings, posted, and distributed to employees, he says. As a result, "employees say they know what's going on. The more employees know, the better off we are. There are no rumor mills." ■

The hospital's physicians, in their satisfaction surveys, said they wanted different items on patient charts. "We had a team look at the items that the physicians said would help them," he says. "The result was that we made some changes, including establishing critical pathways, which is something third-party payers also requested."

Measuring the processes to check for improvement is another important part of the model, he points out. In one instance concerning the patient transportation department, the ancillary clinical departments were complaining that patients were not arriving on time for tests. At the same time, patients who had finished the procedures were having to wait too long for return transportation.

Rather than listening to anecdotal information, the hospital installed a computerized measurement system in the transport department, he notes. "When nursing calls down, it's logged in, and the request goes to the first available person. We've gained all kinds of efficiencies and can transport more people on time."

Grant Medical Center began fact-based management in March 1999, he says, which meant "changing the whole cultural game. Before, when somebody said to us, 'How do you manage?' everybody had a different answer. Now we have the same focus." ■

HCFA regs require notice at admission

The Health Care Financing Administration (HCFA) has announced new patient protections in standards to protect the health and welfare of hospitalized patients. The new regulations require that a hospital provide a patient or family member with a formal notice of their rights at the time of admission. The six basic patient rights specified in the regulations are:

- notification of the patient's rights;
- exercise of those rights in regard to care;
- privacy and safety;
- confidentiality of the medical record;
- freedom from restraints used in the provision of medical and surgical care unless clinically necessary;
- freedom from seclusion and restraints used in behavioral management unless clinically necessary.

The patient rights protections are part of Medicare's revised Conditions of Participation requirements that hospitals must meet to participate in the Medicare and Medicaid programs. The interim final regulations will be published July 2 in the *Federal Register* and will be effective 60 days from that date.

HCFA carved out the patient rights section from the larger proposed revision of the hospital Conditions of Participation regulation, published as a Notice of Proposed Rulemaking on Dec. 17, 1997, so the patient protections could be expanded as soon as possible.

"By carving out this section, HCFA will be able to move more quickly to hold all hospitals that participate in Medicare and Medicaid accountable for protecting patients' rights, and for the inappropriate use of restraints and seclusion," HCFA administrator Nancy-Ann DeParle said in a prepared statement.

The new patient rights protections build on HCFA's improved enforcement of quality of care in hospitals, DeParle said. The proposed protections will apply to all participating hospitals, including acute, psychiatric, rehabilitation, long-term, children's, and alcohol-drug hospitals.

These rights include the right to be free from restraints and seclusion in any form when used as a means of coercion, discipline, convenience, or retaliation. Other rights include the right to privacy and confidentiality.

Patients and families who have any concerns about the quality of care provided at a hospital may contact the state survey agency or HCFA regional office to find out whether the hospital has been cited for a violation of the patient safety requirements.

The new patient protections also make consistent the standards used by HCFA and the Joint Commission on the Accreditation of Healthcare Organizations to ensure only appropriate use of restraints and seclusion. HCFA adopted the same approach and time frames for monitoring the use of restraints and seclusion developed and enforced by the Joint Commission when it accredits hospitals and behavioral health facilities.

HCFA's regulations also contain new requirements on staff training so health care workers who have direct patient contact will learn the appropriate and safe use of seclusion and restraints. ■

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NEWS BRIEFS

HHS training seniors to spot fraud, abuse

In the latest move in its fraud and abuse campaign, the Department of Health and Human Services (HHS) has announced 41 grants totaling $7 million to expand a program that recruits and trains retired professionals to identify waste, fraud, and abuse in the Medicare and Medicaid programs.

The Senior Medicare Patrol Project grants, including 29 new and 12 renewed grants, will be distributed among 38 states, as well as Washington, DC, and Puerto Rico. They are administered by HHS' Administration on Aging to teach volunteer retired professionals such as doctors, nurses, accountants, investigators, law enforcement personnel, attorneys, teachers, and others how to work with Medicare and Medicaid beneficiaries.

Volunteers work in their own communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services, according to a statement from HHS secretary Donna Shalala.

The Senior Patrol project is part of the administration's broad initiative to combat waste, fraud, and abuse in Medicare and Medicaid, including extensive efforts by the Health Care Financing Administration, which administers the programs, and by the HHS Office of Inspector General and the Department of Justice.

Savings for this effort, including program and payment integrity improvements, total more than $38 billion since 1993. In addition, convictions and other successful legal actions stemming from anti-fraud and abuse efforts have increased more than 240% during this period.

The HHS Inspector General's toll-free hotline has received more than 50,000 tips warranting follow-up, the HHS announced. In addition, HHS earlier this year joined with the American Association of Retired Persons (AARP) in an outreach effort to AARP members to help identify possible waste, fraud, and abuse by examining Medicare statements. ▼

'Smart card' project said to be biggest ever

The nation's largest-ever "smart card" pilot, designed to manage health information and simplify administration of North Dakota's health and food benefits, has been unveiled by Gov. Edward T. Schafer.

The Health Passport Project, announced June 10, was to be rolled out over the next four months across three Western communities. It is designed to illustrate how electronic health cards can be used to improve information sharing and administrative efficiency among public and private health care providers.

Funded by federal health and nutrition agencies and other partners, it is the first effort by states to develop a multipurpose, standard smart card that can be used by many programs within a state and, eventually, across state lines. Siemens Information and Communication Networks of Boca Raton, FL, designed the trial project, and Open Domain of San Ramon, CA, is programming the smart cards.

The first application of the Health Passport will be focused initially on pregnant women, mothers, and children in the pilot communities enrolled in a number of public health programs. ■