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INSIDE

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TRAIL rehab system offers patients an outside experience from inside hospital

Program developed by multidisciplinary team

It's sometimes not practical to arrange for transportation to take rehab patients to community settings where they can work on re-entry issues, so a Michigan rehab facility has found a solution that brings the outside world into the patient's rehab arena.

Called Therapeutic Rehabilitation Approach to Independent Living (TRAIL), the system was developed by a multidisciplinary committee that included representatives from most disciplines, including case management, social work, therapy, and administration, says **Stacie Bommersbach**, RN, MBA, program director for neurosciences and rehab at Genesys Regional Medical Center in Grand Blanc, MI.

"The team was looking at developing a community re-entry program and was exploring transportation such as bringing patients into the community of a mall," Bommersbach says.

"One thing we found out was that it's very complicated to get transportation these days within the rehab continuum," she says.

There are strict criteria regarding drivers and transporting patients, and the costs would affect the rehab facility's budget, Bommersbach says.

"Now that we're going into a new reimbursement system under the prospective payment system [PPS], we don't know what our financial picture looks like yet," she adds. "And we found that we'd be driving patients to a setting similar to what we already have here on the campus."

The team also began to realize that the hospital system already had facilities that are easy for families to coordinate and that include community-type amenities, such as three nature trails that lead through wooded areas, a Rite-Aid pharmacy, a gift shop, and three cafeteria-style restaurants.

"We have a medical equipment store in the atrium area, and we have a credit union with an ATM machine, and of course we have a hospital information booth, so the patient can practice asking for directions," Bommersbach says. "There's also a chapel."

Within the rehab unit there is an outside gardening and porch area near where the trails are located. Rehab patients also have access to an on-site beauty salon.

"Patients plant all of the flowers in the garden trough, and they do the watering and weeding," Bommersbach says. "It's a beautiful porch area with some chairs."

Add these features to the rehab's use of a fully furnished, transitional-living apartment where patients and families can spend a night or weekend prior to the patient's discharge, and there are a variety of community re-entry experiences available without rehab staff having to take patients off the hospital system's campus, Bommersbach adds.

Therapists can even assist patients in automobile transfers by using the rehab facility's four-door Cadillac car.

"We use it for both wheelchair and joint camp patients, but we don't use it for driving," she says. "If they have weight-bearing restrictions, we make sure that they are following those and that they are able to maneuver in and out of the car safely."

The stationary auto also is used to teach the family and patients safe transfer skills.

Once it became clear to the TRAIL committee that the hospital campus already had a plethora of community re-entry experiences, it was only a matter of adding a few extra items to the list. **(See story on how TRAIL works, at right.)**

For example, the rehab facility created a house door entry, including a few steps to walk up so patients can practice getting out of the car, walking to the steps and door, and entering the house.

"It's an actual door where you walk up two steps like you would be entering your house," Bommersbach says. "It has a door handle and lock that patients have to maneuver to get into the house, and it has a doorbell."

On the other side of the door are a few feet of floor space, walls, and windows. The backside of the door has a ramp that wheelchair-bound patients can use.

In all, the rehab facility's patients have been very satisfied with the community re-entry program, Bommersbach notes.

"We do patient/family satisfaction surveys, and 99% of our patients say they would recommend our rehab unit to other patients. We thought that was a pretty good statistic," she says. ■

Here's how TRAIL works for Michigan rehab facility

Rehab team makes most of re-entry program

The Therapeutic Rehabilitation Approach to Independent Living (TRAIL) has become an integral part of the inpatient program at Grand Blanc, MI-based Genesys Regional Medical Center's rehab facility.

The rehab facility uses various features of the hospital's campus as part of the community re-entry program for inpatient rehab patients.

"It definitely increases patients' self confidence and self-perception, especially with stroke patients," says **Stacie Bommersbach**, RN, MBA, program director for neurosciences and rehab.

"Simple tasks of going to the grocery store are not so simple anymore for these patients. The TRAIL program provides them with a true environment while they're still in the hospital," Bommersbach says, "so it doesn't seem as scary to them once they get out in the community."

The fact that patients are still within the hospital grounds while they're practicing their community re-entry is an added bonus to their need for security, Bommersbach adds.

"It relieves their fears to know they're still in the hospital and someone to help them isn't far away, and it increases their learning," she says. "We're able to show them a different technique

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or different way of doing something that they wouldn't have thought of if they were home by themselves."

Bommersbach offers this example of how it works in the case of a stroke patient in his 40s:

• **Physical therapy:** The stroke patient and his family are faced with the reality that their lives will change dramatically, particularly if the patient had been the primary breadwinner.

The physical therapist (PT) will work with the patient on basic problem-solving tasks by giving the patient a task to withdraw money from his bank account at the ATM in the atrium. A family member will accompany the patient during this exercise. This will involve the patient having to learn his bank account password, then walk to the ATM and physically make the transaction. Next, the PT will have the patient take the money to the cafeteria to buy a cup of coffee.

"The physical therapist will always be with the patient and will evaluate the patient's cognitive level to see if the patient can remember the pass code, deal with multiple tasks, and follow directions," Bommersbach says.

The physical therapist also will set up a problem-solving scenario in which the patient will be given a prescription that is either real or fictitious to the pharmacy.

OTs supervise meal preparation

• **Occupational therapy:** Using the transitional living apartment, the occupational therapist (OT) will assess the patient's ability to cook a meal, beginning with taking items safely in and out of the refrigerator. The meal would be something simple like macaroni and cheese, and the OT will observe the patient to see if the patient remembers to turn on the stove to boil the water and then to turn it off when the noodles are finished.

For some patients, these meal preparation lessons may take place in the rehab facility's therapy gym where the patient can prepare a meal, under close supervision, for an entire family.

The OT also will observe the patient transferring in and out of the transitional apartment's bed, which is a regular bed such as what the patient will have at home.

"If the patient has one side that is weak, simple tasks of getting from the wheelchair to the bed or from the bed to the wheelchair can be practiced," Bommersbach says.

Likewise, the OT will monitor how the patient uses the apartment's bathroom, observing how the patient is able to transfer to and from the toilet, brush teeth, and attend to other basic activities of daily living (ADL), she says.

"It depends on how severe the stroke is," Bommersbach says.

If the stroke was less severe, then the OT will assess the patient's ability to return to work and ADLs. If the stroke was more severe, the OT will work with the patient and family in the transitional apartment, making certain the family members will be able to manage the patient on their own.

"We also evaluate whether the patient can be left alone for six or eight hours a day while family members work," Bommersbach says. "That's when we use the transitional apartment to see whether the patient can go to the bathroom alone safely or cook a meal without assistance."

Also, if the patient is left alone, can she get out of the house safely in the event of an emergency, or can she dial 911 for help?

"Those are the things we look at," Bommersbach says. "We try to do everything we can to keep patients as independent as possible."

So sometimes the rehab team will have a patient stay in the transitional apartment for the entire day, with therapists walking in and out, monitoring him or her.

• **Family consultation:** When family members are presented with information about how the patient did during these community re-entry exercises, they often will develop more realistic expectations of what will happen when the patient returns home.

"Sometimes families will realize that they are out of their realm, that it's too much and they can't manage it because the patient can't be left alone," Bommersbach says.

Therapists might have witnessed how the patient left the refrigerator door open or left the stove on, or perhaps the patient had become confused and began to walk aimlessly down the hallway, Bommersbach explains.

Also, the community re-entry exercises will give staff and family members a good idea of how continent the patient is under normal living circumstances and whether the patient truly can maneuver and transfer from and to the wheelchair.

The rehab staff and family members meet in weekly conferences during the patient's stay, and there is one last session before the patient is discharged.

"It's a conversation that starts out by the physiatrist saying, 'This is what we notice is going

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on,'" Bommersbach says. "Then the physiatrist will give recommendations to the family and we say that we'll work with them in any way we can and help them meet the patient's needs, but ultimately the family is responsible."

So if it's the staff's observation that the patient does not do well when left alone for long periods of time, the physiatrist will say that the home would not be a safe environment for the patient if he or she were left alone. The physiatrist would offer various alternatives, such as adult day care.

If family members resist advice, the staff would provide specific details of what they observed during the community re-entry exercises. ■

Obesity among elderly poses rehab challenges

New study highlights problem

A new study shows a link between obesity and poor nutrition among the elderly, highlighting a problem that is common in rehabilitation facilities, as well as other health care settings.

Having surveyed more than 21,000 people, ages 65 and older, the Geisinger Medical Center's Clinical Nutrition Research Center in Danville, PA, found that more than 70% were overweight for their height, with a body mass index (BMI) over 25. Thirty percent were obese, with BMIs of 30 or above, says **Christopher Still**, DO, director of the Center for Nutrition and Weight Management at the Geisinger Medical Center in Danville.

"In rehab, we see mainly geriatric patients, and a percentage of them are overweight or obese," notes **Theresa James**, MHS, supervisor of inpatient therapy at Geisinger Wyoming Valley Medical Center in Wilkes-Barre, PA.

"We usually find that they have other health factors that we have to take into consideration, such as high blood pressure, diabetes, and limitations on activities," James says.

"So in the clinic we're seeing people who are not used to being active, and we're trying to encourage them to be active," James adds. "That's hard for them to adjust to, physically and emotionally."

The cohort studied included an elderly rural Pennsylvania population, but probably is representative of elderly people living in the United States, Still says.

Contrary to the popular image of the frail, malnourished elderly person, this was not the case. Only 2% of the people studied fell into that category, with BMIs of less than 18.5. Three times as many people as were underweight were found to be morbidly obese, with BMIs of greater than 40.

"The big problem in the elderly is obesity," Still says.

More striking was the discovery that even among those elderly people who ate more than enough calories and who took vitamin supplements, there was a lack of proper nutrition.

Investigators looked more closely at a representative sample of about 200 people. They conducted home visits, collected blood work to analyze for nutritional status, obtained medical histories (including a list of medications and supplements they used), and assessed them for depression and mental capacity.

They found that women who had the higher BMI numbers and waist circumferences also had the highest nutritional risk. They had an inadequate intake of fiber, folate, vitamin B6, vitamin B12, magnesium, iron, and zinc.

These are the same patients that rehab facilities might see following a stroke, orthopedic surgery, or another type of injury.

Focus on nutrition, not weight loss

One way to improve the outcomes for obese rehab patients is to include a dietitian or nutritionist on the rehab team.

Madonna Rehabilitation Hospital in Lincoln, NE, has two full-time and one part-time dietitian dedicated to rehab. A fourth dietitian works with the nursing home unit, says **Sharon Balters**, PhD, LMNT, manager of medical nutrition therapy and a registered dietitian.

"I agree that obesity is an epidemic, and it's a risk factor in many health problems in America,

including high blood pressure, osteoarthritis, and type II diabetes," Balters says.

However, when an obese patient is an inpatient in a rehab facility, that is not the right time to encourage the patient to begin losing weight, Balters adds.

"Our philosophy is that now is not the time to do that magic diet and lose weight while a patient is recuperating here in rehab," she says.

"The patient has just had knee or hip surgery, and while weight probably is cause or factor in their need for surgery, they've just had some blood loss and have gone some days without eating since their appetite is down, and so we've got to improve their nutrition," Balters says.

Using good nutrition to head off infection

Balters meets with patients to encourage them to eat enough nutritional foods, because if they were to deprive themselves of calories and nutrition, their surgery sites could become infected.

Sometimes physicians will forget that the healing process requires a higher caloric and nutritional intake, and they'll instead talk with these patients about weight loss. That's where a dietitian on the rehab staff can help by letting rehab physicians and therapists know how important it is to put the weight-loss issue on the back burner for now, Balters says.

"We will talk to patients about the future and will say that they're welcome to come back as outpatients to talk about a healthy, low-calorie diet," she explains. "We say, 'It'd be nice, but not until you're healed.'"

With cardiac rehab patients, a dietitian might advise rehab staff to keep the patient on a regular diet until the person's appetite is improved, instead of switching immediately to low fat or low sodium.

"Heal first, and then get started on life changes and learning how to eat healthy and exercise," Balters says.

Another consideration is that rehab patients who are obese will need a higher calorie intake because of their excess weight, says **Erin Krist**, RD, LDN, dietitian with Cape Fear Valley Medical Center in Fayetteville, NC.

"When I do a follow-up, if they're eating better I will recommend a lower-calorie diet and give them nutritional education," Krist says. "Once I know they are eating better and once they have adjusted to being here, I can talk to them more, but when they first were admitted they were so worn out and didn't even have the energy to eat, which is another challenge."

There is no doubt, however, that morbidly obese patients can pose significant challenges to rehab staff, and there may be little a dietitian can do for the duration of these patients' stay.

For example, Cape Fear once had a patient in her 40s who weighed more than 300 pounds. Admitted for a spinal cord injury, the woman was bedridden and was unmotivated to leave her room or transfer to a wheelchair, Krist recalls.

Education can reinforce weight loss

As difficult as it is to provide rehab therapy to such a patient, Krist initially could not put her on a low-fat diet because the woman was having eating problems and needed to maintain her usual caloric intake in order to regain her strength. However, Krist provides nutritional education to such patients before they are discharged, and patients' efforts to lose weight can be reinforced by the rehab facility's outpatient dietitian.

"Anytime I do a diet education, whether the patient is new or about to be discharged, I say, 'Don't worry about these things while you're here — these are for when you get home,'" Krist says. "I try to get feedback about what they typically like to eat at home and what their problem areas are."

Krist also will explain the different food groups and how some high-fat, low-nutrition foods are often substituted for more nutritionally rich foods.

"Everyone asks for recipes, and I go through the standard diet and then give them my name and number to call me later," Krist says. "I've had a few call-backs with minor questions."

The rehab team can be instrumental in nudging obese patients toward a healthier diet.

"Whether it's the psychologist or the dietitian, we need to show them we understand that it's difficult to lose weight," Balters says. "Sometimes, if patients really want to change, I may say that I'll let them come back after the inpatient stay for one visit, but then we'll have to charge them after that."

The team also could be a problem if therapists and nurses are not educated about the importance of a strong caloric and nutritional diet during the rehab experience, Balters says.

For example, Madonna Rehab had one patient

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who had lost a leg and was being fitted for a prosthesis. During his initial days as an inpatient, the man had lost weight, and it was important for the staff to encourage him to eat enough calories to heal his wound, Balters explains.

But then he began to gain weight steadily and was becoming overweight, as he had been before he lost his leg.

"People tend to go back to their usual weight, and normally that is good, but in his case, he needs strength in his arms to lift himself because he has an above-the-knee amputation," Balters says.

Holding on to extra pounds will make it that much more difficult for him to find a permanent prosthesis, and it will make ambulation painful. However, it's not a good idea for the rehab team to discourage him from eating after so many weeks of telling him to eat more, Balters says.

Balters learned that one nursing shift had been vocal about how much food he was ordering, and she asked them to tone it down, telling them that this wasn't the time to talk with him about his weight. She told them the patient was eating fine in terms of healing, and now they needed to watch out for the overeating, but to do so more tactfully.

"We're trying to be positive with him when we see him drinking a diet pop instead of regular pop," Balters says. "The therapist may say, 'Isn't that diet pop good? That's the kind I like.'"

Or a nurse could compliment him on his having ordered only one or two desserts with a meal, instead of three or four, she adds. ■

Washington state takes aim at ergo hazards

Rule moves forward despite opposition

Even as the U.S. Occupational Safety and Health Administration (OSHA) backs away from ergonomics regulation, Washington state is moving forward as a model for tougher action. A new rule that becomes effective this month will require employers to identify "caution zone jobs" and to reduce the hazards of musculoskeletal disorder injuries.

Lifting 75 pounds or more once a day qualifies as a caution zone job. That means hospitals must analyze and reduce the hazards of jobs that involve patient transfer. **(See "WMSD Hazard Sample Worksheet," pp. 79-80.)**

"The standard requires that employers reduce exposure to the hazard below the hazardous level or to the degree that it's economically or physically feasible to do that," explains **Michael Silverstein**, MD, assistant director for industrial safety and health at the Washington State Department of Labor and Industries in Olympia.

Business coalition opposes rule

So far, the Washington rule has stood up to political pressure to quash it. After a review by a Blue Ribbon Panel on Ergonomics, Washington Gov. **Gary Locke** directed the state Department of Labor and Industries to stay on course with implementation but to delay enforcement for two years. A business coalition that includes the Washington State Hospital Association has filed suit, seeking to overturn the rule.

As of July 1, employers in the state's highest risk industries, including nursing homes, must begin identifying hazards and providing education to employees about ergonomics. Hospitals must meet those requirements beginning July 1, 2003. By July 2004, they must reduce the hazards. However, fines and citations for failure to comply won't be issued until two years later.

"Even the largest hospitals have several more years before there would be a possibility for a citation or a fine. There is plenty of time for those programs to be fine-tuned," says Silverstein.

Yet hospitals that are struggling financially may

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WMSD Hazard Sample Worksheet

WAC 296-62-05174 Appendix B: Criteria for analyzing and reducing WMSD hazards for employers who choose the Specific Performance Approach.

For each "caution zone job" find any physical risk factors that apply. Reading across the page, determine if all of the conditions are present in the work activities. If they are, a WMSD hazard exists and must be reduced below the hazard level or to the degree technologically and economically feasible (see WAC 296-62-05130(4), specific performance approach).

Awkward Posture				
Body Part	**Physical Risk Factor**	**Duration**	**Visual Aid**	Check (✓) here if this is a WMSD hazard
Shoulders	Working with the hand(s) above the head or the elbow(s) above the shoulder(s)	More than 4 hours total per day		❑
	Repetitively raising the hand(s) above the head or the elbow(s) above the shoulder(s) more than once per minute	More than 4 hours total per day		❑
Neck	Working with the neck bent more than 45º (without support or the ability to vary posture)	More than 4 hours total per day		❑
Back	Working with the back bent forward more than 30º (without support, or the ability to vary posture)	More than 4 hours total per day		❑
	Working with the back bent forward more than 45º (without support or the ability to vary posture)	More than 2 hours total per day		❑

WAC 296-62-05174 Appendix B: Criteria for analyzing and reducing WMSD hazards for employers who choose the Specific Performance Approach.

Awkward Posture (continued)				Check (✓) here if this is a WMSD hazard
Body Part	**Physical Risk Factor**	**Duration**	**Visual Aid**	
Knees	Squatting	More than 4 hours total per day		❑
	Kneeling	More than 4 hours total per day		❑ ❑

Source: Washington State Department of Labor and Industries, Olympia.

(Continued from page 78)

not be able to afford to buy all the lifting devices on the time line expected by the Department of Labor and Industries, contends **Beverly Simmons**, executive director of the hospital association's workers' compensation program in Seattle.

"We believe in those [ergonomic] principles and we're acting upon them," says Simmons. "[But] we feel that until hospitals are appropriately compensated [in reimbursement], it's going to be very difficult for any sort of compliance to happen unless it's voluntary."

However, Silverstein counters that voluntary programs are ineffective.

"I think employers are going to find it pretty confusing under the program the federal government has announced," he says. "The agency is saying no one is required to meet those [voluntary] guidelines. On the other hand, they will be issuing citations under the general duty clause.

"If I'm not responsible for following these specific guidelines, what does it mean to be responsible for maintaining a workplace that is free of recognized hazards?" he says. "It's kind of a guessing game. The agency is not telling them ahead of time what they could be cited for."

MSDs cost more than $410 million

The Washington Department of Labor and Industries began work on an ergonomics rule in 1998, in response to the grim statistics of musculoskeletal disorder (MSD) injuries. More than 52,000 workers' compensation claims each year involve MSDs, making it the largest category of injuries and illnesses affecting Washington workers. The department estimated that the total annual direct cost of MSDs exceeds $410 million.

Yet in a department-sponsored survey, 60% of employers reported they had taken no efforts to reduce workplace MSD hazards (WMSD). The department adopted the rule in May 2000.

"L&I estimates that the ergonomics rule will prevent 40% of work-related MSD injuries and 50% of work-related MSD costs once all the elements of the rule are fully effective," the department reported, though adding the caveat, "These are average figures and actual reductions will vary by workplace and by industry."

The department identified the top 12 industries with the highest work-related MSD injuries. Nursing homes made the list; hospitals fell in the second-highest category. The implementation of the rule requires the top 12 industries to comply a year earlier than other employers, and it gives small employers — those with fewer than 50 employees — extra time.

The department also developed demonstration projects and assistance programs. But employers can decide how to set up their ergonomics programs and reduce hazards.

"We've tried to strike a balance between being specific enough so that employers know when they have to do something and when they're finished, and being flexible, so employers don't face one-size-fits-all obligations," says Silverstein.

The rule passed muster with the Blue Ribbon Panel of experts, which concluded that the rule, its enforcement directive, and its procedures "provide a foundation for fair and consistent enforcement." The panel also stated that "the rule itself is clearly written, and together with the educational materials, enforcement policies and procedures, is understandable."

That is a vastly more positive outlook than the reaction to the failed OSHA standard, which was rescinded by an act of Congress. A National Academy of Sciences panel reviewed the scientific literature and concluded that ergonomic interventions would reduce the risk of work-related MSDs. But several provisions of the OSHA standard, including pay and benefit guarantees, sparked controversy, even from those who otherwise supported ergonomics regulation.

The Washington Department of Labor & Industries also hopes to smooth the transition to enforcement by supporting demonstration projects, providing educational assistance, and conducting test inspections.

"By the time we actually do real inspections, we're going to have a very well-trained group of inspectors," says Silverstein. "Both the business and labor communities are going to have a very good idea of what to expect. I'm very concerned that we conduct ourselves in a fair and consistent manner."

Cost/benefit flawed, opponents say

Those efforts will not be enough to make the ergonomics regulation a fair one, a business coalition asserts. More than 230 business organizations, companies, and individuals joined together to form Washington Employers Concerned About Regulating Ergonomics (WE CARE).

The coalition asserts that the regulation is not

based on sound science and that the department's cost-benefit analysis is flawed.

The Washington State Hospital Association, which sponsors a Zero Lift program, doesn't question the benefit of ergonomic intervention. But following the standard will require more resources than the labor department acknowledges, says Simmons. Many hospitals can't afford to hire consultants to help with implementation and don't have available staff to dedicate to the project, she notes.

"We believe industries should be taking a hard look at this and implementing what they can in ergonomics," Simmons says. "[Hospitals] can do it bit by bit, but they can't do it all at once."

(Editor's note: For more information, see the Washington Department of Labor & Industries ergonomics web site at www.lni.wa.gov/wisha/ergo/default.htm.) ■

Include psych evaluation in initial treatment plan

It's cheaper to deal with problems sooner

You've probably had clients with traumatic injuries or illnesses who just didn't get better during the rehabilitation process — even when there was no physical reason for it.

When patients fail to make progress even though the physical evidence says they should, there may be underlying psychological issues, says **Laurence Miller**, PhD, director of psychological services for Heartland Pain and Rehabilitation in Lantana, FL.

"[Many] will call for a psychological assessment as a last resort, when the patient isn't progressing and they're pulling their hair out and can't figure out why the patient isn't getting better," Miller says.

Psychological management costs less

But it's quicker and cheaper to deal with the problems early on, he adds.

"Studies and research have found that the inclusion of psychological management in any type of rehabilitation ends up costing less in the long run," Miller adds.

Most payers don't routinely include psychological components in their treatment, but from the standpoint of patient care and expense reduction, it's cheaper up front, he says.

He recommends a baseline psychological evaluation as part of any treatment plan to determine whether the patient could benefit from psychological services, biofeedback, or behavior modification.

"The less time since the injury, the smaller problems you'll see. If you wait until later, you'll have a firmly entrenched professional patient who is dejected and demoralized, and they can be much harder to treat and tough to handle," he adds.

Miller recommends a psychological component in the rehabilitation treatment plans for all patients rather than waiting until the last minute.

Assess recovery at six months

"I don't believe everybody has to have extensive psychological treatment, but they should have an upfront psychological evaluation to see what role psychology can play in their recovery," Miller adds.

Whether a patient is experiencing chronic pain from a herniated disk or is recovering from a stroke or a spinal cord injury, he or she can expect to return to some semblance of stability within the first six months, Miller says.

"If at six months, a patient is continuing to experience severe problems that can't be traced to a physical cause, ask the primary care or secondary care provider what is going on," he advises.

When you read the reports on the patients, look for indicators such as "the patient is not exerting maximum effort" or "the patient is not meeting his goals," Miller adds.

Physicians don't always understand the nuances in psychological disorders. They may not know if the patient is malingering or if the symptoms are psychological, he says. That's why it's important that the patient's psychological function be evaluated by someone with mental health expertise.

If you refer a patient for a psychological evaluation, call it stress management, not psychotherapy, Miller advises.

"But if they are resistant to it, it's not something you can force down their throats," he adds.

There are a number of reasons why patients fail to get better when all the medical evidence says they should. They may be depressed and

lack the will and motivation to meet their goals, or they may not have a clear goal in mind. In some cases, the providers may set the goals too high for patients to meet, setting them up for failure, which further demoralizes them and stops their motivation.

Or they may have a hidden agenda that impedes progress. For instance, a workers' compensation patient may be anticipating a large financial settlement. A patient may be angry at the system because he got hurt at work and the only way to get back at his boss or the job is to remain impaired. Or, the patient may subconsciously enjoy being in a dependent role that allows him or her to manipulate other people.

When a patient isn't getting better to the extent that you think they should, make an assessment and decide if it's related to the injury, or to psychological aspects, such as the family or the larger social situation, Miller says. ■

Staff morale low? Money's not necessarily the answer

Top predictors of satisfaction listed

Want to make your employees happy? Surprisingly, it's probably going to take something that is free, readily accessible, and easy to add: "Communication, communication, communication," says **Mel Thompson**, president and chief executive officer of Data Management & Research, a Franklin, TN-based research firm specializing in health care quality and satisfaction surveys.

Administrators often are good at making sure operations are efficient and quality care is being provided, but that mission isn't always articulated to employees, Thompson maintains. "You can have best technical abilities around, but it may not be communicated," he says.

Administrators should be the creators and champions of the facility's mission, Thompson advises. "They can be great operators, but if they don't do the other, employees don't get a sense of belonging, of being a part of something that's quality, and understand their role in carrying out the cause," he says. "They just become an assembly line worker, and people didn't get into health care for that purpose."

Without a "champion of the cause," recognition doesn't matter, because people don't know what they're being recognized for, Thompson maintains.

Thompson's firm analyzed 750 responses to an employee satisfaction survey. Here were the top predictors of employee satisfaction, in descending order of importance:

Sense of belonging proves important

• **Morale/yourself.** "When people are thinking of morale, they're thinking of things such as their sense of belonging, the work itself, communication, and customer service — how well it's being provided," Thompson says. "We really want to be a part of an organization that is really providing quality of care, and my morale is affected by how we're doing that."

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• **Morale/others.** It isn't clear why the morale of others showed up in the survey results, says Thompson.

"The assumption is that in a large setting, your morale may not have as much effect on you as what you see happening to everyone," Thompson says. "Size may be the difference."

• **Overall service.** This item reflects the perception of overall quality that the entire center provides, Thompson says. The intent is for there to be a general perception by the staff of quality overall service, he explains. For example, if you have a technician who is one of only a few performing a particular procedure in the country, tell your entire staff so they can share in the pride, he suggests. "Even if you're not working on it, you're a part of it by being there," Thompson says.

• **Sense of belonging.** "In a hospital, you could get lost in the mix," Thompson says. Communication is a key part of this factor, he says. "I need to know that what I do is truly contributing to this organization and the quality of care I provide," Thompson says. To feel that, employees need recognition, he adds.

Tell employees their role is important

• **Value of the work.** This item includes how well it's communicated that an individual employee is playing an important role, Thompson says. "For example, is it communicated that you know your role and how it fits into the scheme of providing overall quality?" he asks.

• **The work itself.** This item relates to the particular duties of the staff person, Thompson says. It is different from the "value of my work." The "value" predictor is related to staff members considering themselves important to the organization, Thompson explains.

• **Communication.** At the hospital level, it's not just communication by the supervisor that matters, but communication by the high administration level, Thompson says. When patients provide a positive comment about a particular staff member in the satisfaction survey, the comment can be posted for everyone to see. For an employee to feel their work is valued, it's important to recognize all employees, not just individuals, Thompson says.

• **Pay for job.** It is unusual for pay to show up as an predictor of employee satisfaction, Thompson says. "Usually pay only shows up on a location-by-location basis when other key drivers are really a problem," he says.

• **Support of supervisor.** This factor is important because employees' perceptions regarding satisfaction and how they feel about their supervisors are interconnected, Thompson says. "The supervisor may be the communicator and everything else," he says. What the most important thing for a supervisor to do? To truly listen to their concerns, their issues. If it all possible, make changes. ■

Need More Information?

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