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INSIDE

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How will you measure up to the new CARF accreditation standards?

CARF wants to see corporate citizenship, credible budgets, yearly reports

Starting July 1, all organizations accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) must meet a new set of standards, regardless of what area of rehabilitation they are involved in. The new standards put a greater emphasis on business practices such as risk management, insurance, and performance issues, as well as on corporate citizenship.

"We're trying to address the arena of good business practices for the rehabilitation continuum," says **Christine MacDonell**, managing director of medical rehabilitation and emerging markets for the Tucson, AZ-based CARF. "People go into rehab because they're good caregivers, and not necessarily because they're good businesspeople. The new standards would actually be a great template for people just starting a business."

Previously, each type of rehab organization — from medical rehabilitation to assisted living to behavioral health to adult day services — had its own specific standards manual. "It was sometimes difficult for providers who cross over into multiple areas CARF accredits because they had to blend a lot of the standards. It was confusing and it often required a lot of man-hours," MacDonell says. "The new standards are clear, very practical, and they should be very helpful to the organizations."

In the works since 1999, the new standards were written with input from rehab providers and with an eye to ISO 9000 and Baldridge quality standards, MacDonell says. CARF hopes the practical nature of the standards will make it easier for organizations to commit to using them on an ongoing basis. "We want providers to use the standards all along rather than panic six months before the survey," MacDonell says. "There really shouldn't be so many peaks and valleys, but more of an ongoing look at whether the organization is continuing to meet the goals."

To encourage continuous use of the standards, CARF will begin this year to use the nine business practices criteria as the basis for interim

quality reports to be completed each year on the anniversary date of the organization's accreditation. CARF already requires that organizations use the standards for a minimum of six months before the survey, that surveyors have access to all data they need while on site, and that the organization sends CARF a quality improvement plan that addresses the surveyors' recommendations within 90 days of accreditation. The new yearly quality report now will be the fourth condition of accreditation.

The new standards manuals have enhanced information on risk management plans and insurance packages (*Criterion Nine*, Standards 57 and 58), MacDonell says. "We wanted to move in this direction because so many providers are getting difficult allegations in these areas, and they need to learn to be better prepared to handle risk effectively," she says. "You have to stay focused on the fact that you're there because of the people you serve, but the reality of running a rehab program is that it's difficult some days to remember that. When you have a managed care company that's not paying you, a personnel issue, or some other such issue, it detracts from the reason you're in business. The standards bring you back to your purpose and serve as a gentle reminder to focus on your patients so that both of you can be truly successful."

Good corporate citizens get long-term results

Another new emphasis is an item added to *Criterion Seven*: Leadership that deals with corporate citizenship (Standard 43g). "We've always had standards on corporate responsibility and ethical codes of conduct, but we haven't singled out the idea of corporate citizenship before," MacDonell says. "We want to see how the organization is performing in its community. If you're going to be successful in meeting the needs of the community, you've got to know what those needs are."

CARF defines corporate citizenship as "an organization's efforts, activities, and interest in integrating into, contributing to, and supporting the communities where it delivers services to better address the needs of the persons served." The standards manual lists several examples of these types of efforts, including educational events for schools on safety issues, active involvement in community organizations and service groups, and positions on local boards that address such issues as accessibility and housing.

"In a pediatric program, for example, if you're not advocating for those individuals and pushing for long-term changes, then the environment they go home to won't be supportive," MacDonell says. "If you can get that child well enough to go back to school but they can't go to the park because there's no disability access, then have you really accomplished your goal? Or if you can get someone back to work but they don't have accessible transportation, then their life really hasn't changed. Good corporate citizenship makes sure there's a durability to what rehab providers do. Anyone can be successful in a protected environment, but it's when the patients get back to the community that really counts."

(Continued on page 16)

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These CARF standards take effect July 1

Some standards new, some have changed

Not only are CARF's new manuals blended to be useful to each type of rehab facility, but there also are new standards in each area. Following are the standards (copyrighted by CARF in the 2003 Standards Manuals) that are new for every type of facility:

• Criterion Three: Information Management and Performance Improvement

— **Standard 12:** For business improvement, information is collected and analyzed from the following: strategic planning information; financial information; accessibility plans; resource allocation; surveys; risk analysis report; technology analysis; environmental health and safety reports; and field trends.

— **Standard 15:** To support information management and performance improvement activities, the organization has a written technology and system plan that includes hardware, software, security, confidentiality, backup policies, assistive technology, disaster recovery preparedness, and virus protection.

• Criterion Six: Human Resources

— **Standard 37:** The organization demonstrates recruitment efforts, retention efforts, and identification of any trends in personnel turnover.

— **Standard 39:** Annual performance management includes: job description reviewed and/or updated annually; promotion guidelines; job posting guidelines; annual performance evaluations for all personnel directly employed by the organization.

• Criterion Eight: Legal Requirements

— **Standard 45:** During the CARF survey, the organization provides for review of all reports from legal actions, regulatory agencies, and contractual relationships.

— **Standard 46:** The organization provides a synopsis report on any of the following that have occurred within the last three years: litigation; allegations of wrongdoing; malpractice; and violations of the codes of ethics.

• Criterion Nine: Financial Planning and Management

— **Standard 53:** There is evidence that the organization has established and maintains fiscal policies and procedures, including internal control practices.

Following are the standards that are new for some organizations:

• Criterion Three: Information Management and Performance Improvement

— **Standard 16:** If Internet access to the organization's services is provided, the organization provides for security of personal information; alternative access formats; accessibility and accommodations and a user-friendly interface; on-line information 24 hours a day, 7 days a week; personnel to provide instruction and guidance to accessing services provided by the organization; and connections or links with local service providers or affiliates for personal contact and information.

• Criterion Seven: Leadership

— **Standard 44:** An organization in the United States receiving federal funding demonstrates corporate compliance through a formal resolution on corporate compliance; written designation of a personnel member to serve as the primary point of contact for monitoring and reporting corporate compliance; procedures to guide personnel in responding to subpoenas, search warrants, investigations and other legal actions; and provision of initial and ongoing training on billing and coding procedures.

• Criterion Nine: Financial Planning and Management

— **Standard 54:** If the organization bills for services provided, a quarterly review of a representative sample of records of the persons served is conducted.

Following are the standards that have changed from previous manuals:

• Criterion Four: Rights of Persons Served

— **Standard 24:** One external inspection is conducted annually (previously this was done twice every three years) that provides: evidence that all locations owned, leased, operated, or rented by the organization or donated to the organization have been inspected by a designated compliance/safety officer; a report that identifies the areas inspected; recommendations for areas needing improvement; and an action plan for improvements to be made.

• Criterion Five: Health and Safety

— **Standard 32:** The organization defines a system to report critical incidents that includes the following (this list of incidents is new) as applicable: medication errors; incidents of seclusion or restraint; incidents involving injury from equipment, machinery or vehicles; communicable disease; infection control; violence or aggression; sentinel events; weapons; elopement and/or wandering; transportation; biohazardous materials; licit or illicit substances; and other areas as required. ■

Another change made under *Criterion Nine: Financial Planning and Management* could easily be missed but shouldn't be, MacDonell says. "We added the word 'credible' to the item [Standard 48] on preparing budgets with projections of revenues and expenditures," she says. "It's one thing to present a budget during a CARF survey, and quite another to make it actually happen after we leave."

New items also have been added to the list of corporate responsibility efforts (Standard 43), including policies on waste, fraud, abuse, and other wrongdoing that include a "no reprisal" approach for personnel reporting and time frames for investigation, as well as demonstrated corporate citizenship.

'CARF-ese' removed from standards

Rest assured that the new standards should make things easier in the long run, says **Bonnie Breit**, a CARF surveyor and president of BRB Consulting in Media, PA. The new standards are presented in a more logical format, and much of the "CARF-ese" has been removed in favor of businesslike language that's easier for a lay person to understand, she says.

"Looking at your business practices like this is going to keep you on the cutting edge," Breit says. "You need to be aware of the business side of delivering care. That's one of the benefits of CARF accreditation and this particular new standards manual. Organizations know they should look at how they're doing, but they're not always clear on how they should do it. If you're not doing the business piece, you're not going to be here to deliver the clinical piece. The effort spent on the new standards speaks highly of CARF's commitment to help organizations stay on the cutting edge so they can keep being here." ■

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Health care gearing up for smallpox vaccination

Focus on education, pre-screening of volunteers

The first stage of smallpox vaccination has begun, even before the doses are released or a final plan formulated. Across the country, hospitals are educating health care workers about smallpox and the vaccinia vaccine.

It's impossible to know how many health care workers will decline the vaccine due to concerns about adverse events. But already, nurses have shown a patriotic commitment to fight bioterrorism: More than 2,900 have expressed interest in becoming part of the National Nurses Response Team, a group co-sponsored by the American Nurses Association (ANA) and the U.S. Public Health Service, both in Washington, DC.

The team's mission is "to vaccinate and administer chemoprophylaxis in the case of use of a biological agent," says **Cheryl Peterson**, RN, a senior policy fellow at the ANA. "We have a number of nurses who are concerned because they want to help.

"What we're seeing is that many nurses did not feel equipped to respond on Sept. 11. They didn't feel they could do anything. If they did respond, they weren't utilized well," she says. "We're seeing a lot of nurses who are saying, 'I want to be able to respond.'"

Otherwise, health care workers' unions have heard surprisingly little from their members who may be asked to take the vaccine. That underscores the need for education to make sure workers know what health issues, such as eczema and other skin conditions, might make them ineligible for the vaccine.

"Once they start vaccinating people, the phone's going to be ringing off the hook; by then, it will be too late," says **Bill Borwegen**, MPH, director of occupational health and safety for the Service Employees International Union (SEIU) in Washington, DC.

At Memorial Sloan-Kettering Cancer Center in New York City, **Kent Sepkowitz**, MD, director of hospital infection control, has begun educational sessions to help health care workers decide if they should receive the vaccine. "I've been impressed that most workers are of a mind to volunteer and take their chances. It seems like the right thing do," says Sepkowitz, who also is associate professor of

medicine at the Weill Medical School of Cornell University, also in New York City.

He is encouraging a conservative approach to vaccination, starting with small groups of vaccinees and closely monitoring adverse events. Congress removed one hurdle to the vaccinations by addressing an aspect of liability: A provision added to the homeland security bill states that the federal government will assume liability for serious adverse effects of the vaccine. Those administering the vaccine cannot be held personally liable for adverse events, and those suffering from the effects can receive compensation but not punitive damages.

As the nation moved closer to smallpox vaccination, the Centers for Disease Control and Prevention (CDC) released new educational resources. On-line continuing education training on the vaccine and its potential adverse effects now is available on the CDC web site at www.bt.cdc.gov/training/smallpoxvaccine/reactions/default.htm. The site includes images of normal reactions and adverse reactions, such as eczema vaccinatum, in which the vaccinia virus becomes implanted in the diseased skin and produces numerous lesions.

Contraindications could affect thousands

The most important aspect of the training involves the contraindications, screening, and reporting of complications of the vaccine. For example, CDC recommends against vaccination for those who have a history of eczema or who have other skin conditions, including acne and contact dermatitis, or those who have close household contacts with those conditions. That exclusion alone could affect thousands of health care workers.

The Association for Professionals in Infection Control and Epidemiology in Washington, DC, has an on-line course and templates for bioterrorism preparedness (www.apic.org). **Judith English**, RN, MSN, CIC, chair of APIC's Bioterrorism Work Group and director of infection control at the National Naval Medical Center in Bethesda, MD, lauded CDC's educational efforts.

"Those real concerns are being addressed. [Health care workers] know they need to self-select out if they are personally at risk or if their significant others are at risk," she says.

In its Smallpox Vaccination Clinic Guide, the CDC provides a sample screening form and screening information. This information was developed to help state and local governments plan for widespread emergency vaccination following an actual case of smallpox. However, it provides a useful tool to educate health care workers about the vaccine. (More information is available at www.bt.cdc.gov/agent/smallpox/response-plan/files/annex-3.doc.)

Many questions still unanswered

Even as more information emerges about the vaccinia vaccine, many questions remain unanswered. Data on adverse effects of the vaccine come from immunization that occurred more than 30 years ago, Sepkowitz notes. Today's population — including cancer patients and individuals with HIV infection and other immunosuppressant conditions — is more vulnerable to accidental transmission of the live virus from injection sites. Two federal expert advisory panels have stated that precautionary measures such as covering the site with gauze and a bandage would prevent transmission.

Sepkowitz reviewed the literature on nosocomial transmission of vaccinia, encompassing 12 articles published between 1907 and 1975. The 62 individuals who acquired vaccinia from nosocomial transmission all had underlying skin disorders. Most cases involved children, some of whom were in different cribs or even different wards from the source case, and the mortality rate was 16%.

"The route of transmission is still puzzling to everyone," he says. But by taking a slow and cautious approach, hospitals can successfully vaccinate health care workers without putting patients at risk, Sepkowitz adds. "I think that flexibility is the key. You start conservative and slowly gain confidence."

Meanwhile, advocates for health care workers are looking for job protections as well as education and screening. "Who's going to protect people from discrimination if their employer says, 'We want you to be vaccinated?' Most people are going to be reluctant to say no; but if they say no, are they going to be protected from discrimination?" Borwegen says. "We would argue if people want to be reassigned because they don't want to be in a job that requires smallpox vaccination, they should be allowed to transfer into a job with the same pay and benefits."

Borwegen and others want to know who will pay for medical treatment for workers or their family members who suffer adverse effects. They

also want reassurance that education and vaccination will occur during paid time.

"We have more questions than we have answers," Peterson says. "I really think some of these questions need to be addressed by the [Bush] administration or there needs to a dialogue about them among the stakeholders." ■

Patients want quality, quantity time with PTs

Research shows patients care less about wait times

Conventional wisdom — and indeed, much literature — supports the idea that satisfied patients are impressed with short waiting times, good parking, convenient locations, and sophisticated equipment. But a new study looking at patient satisfaction with physical therapy clinics found that what patients really care about is the quality and quantity of time they spend with their therapist.

According to the study, published recently in the journal *Physical Therapy*, patients rate first in importance the amount of time the therapist spends with them, along with the therapist's listening and communication skills and the therapist's willingness to give clear explanations of treatment.[1] The quality of patient-therapist interaction counts for much more than high-tech medical hardware, accessible parking, and convenient location and office hours. Researchers surveyed a sample of 1,868 worker's compensation patients from clinics in 17 states in an effort to measure the effectiveness of a patient satisfaction survey instrument the authors developed.

Study findings defy conventional wisdom

"Based on the current literature regarding customer satisfaction, as well as conventional wisdom, we asked questions about things like parking, location, equipment quality, things that arguably would be of interest to a consumer," says **Paul Beattie**, PhD, PT, OCS, clinical associate professor in the department of exercise science at the University of South Carolina's School of Public Health in Columbia. "We found that none of those things correlated significantly with the overall satisfaction with care. The big things were that they wanted to have quality time with the therapist and to have that person answer their questions, provide information, and spend adequate time with them.

"Our primary objective was to develop an instrument and determine its measurement properties," Beattie says, "but when I saw these results, it was almost astonishing. It was a very strong relationship, and I think it's significant in terms of practice."

The waiting time issue might be the most surprising. "As a patient, you may say that a lengthy waiting time was worth it if the therapist really paid attention to you, answered all your questions, and provided high-quality care," Beattie says. "On the other hand, you could go to a palatial clinic where you are quickly moved through without adequate time or attention from your therapist, and you're going to be dissatisfied with that experience."

Maximizing income, minimizing time

Diminishing reimbursement and increasing demands for patient care, which face all health care providers in today's market, motivated the researchers to do the study. "There has been a trend in many clinics to try to maximize income by seeing more patients and using care extenders to get more patients in, and that often results in decreased one-on-one time between the patient and the therapist," Beattie says. "One of the messages from the study is that as we progress through this wacky health care delivery system we have now, everybody on the team needs to come up with strategies to maximize the time with patients to remain competitive."

Beattie recalls that in the late '90s, when he worked in a large orthopedic practice in upstate New York, there was a gradual demand to see more and more patients. "Pretty soon, I was clearly seeing more patients than I felt like I could do and provide quality work. And yet I was told that was the nature of practice in the current millennium," he says. "So when I saw the results of this study, it really confirmed my own bias and my own observations that patients don't like it either."

The problem of increasing patient volume is particularly difficult in physical therapy, Beattie says, because the treatment is so time-intensive. He suggests to his students and the clinics with whom he consults that they look at ways to lower overhead expenses such as administrative costs,

office space, and equipment. "Physical therapists can be quite successful in a low-overhead environment," Beattie says. "They also need to look at how much time is allotted to each patient. At what point, by reducing patient time to increase revenue, do you ultimately wind up hurting your business?"

This is a purely theoretical exercise unless you have objective data to measure patient satisfaction, which historically has been difficult for physical therapy clinics in the absence of instruments specifically designed for them. Because patients come for frequent visits over a short period of time and tend to stay longer at each visit than they would at a typical physician visit, the satisfaction surveys used by other providers may not be appropriate. Several recent instruments, including the one designed in this study, can alleviate that problem, as long as therapists realize the importance of making the effort to measure satisfaction, the authors say.

"In the United States, physical therapists are really under the gun. They're having to see a lot of people, and the documentation has become absurd," Beattie says. "People hesitate to start to do anything else they feel will detract from their already stressed-out time with patients. The trick is to administer the survey during non-patient-care time, such as when the patient is getting ready to leave. I think most clinics really want to measure patient satisfaction, but they just don't know how to do it."

Satisfied patients follow regimes better

High patient satisfaction also benefits the clinical side of the practice. "Patients who are satisfied come back, and they refer others to your clinic, but they also are more likely to follow through on their therapeutic regime," says **Roger Nelson**, PhD, PT, another survey author and chairman of the department of physical therapy at Lebanon Valley College in Annville, PA. Nelson also is vice president of Expert Clinical Benchmarks, part of King of Prussia, PA-based MedRisk Corp., which is offering the survey instrument to physical therapy clinics. "Physical therapists have a unique responsibility. We teach patients how to get better themselves. It does no good to only do the exercises while they're in the office. They have to do it at home as well."

Physical therapy providers might balk at the extra time and effort it would take to measure satisfaction, but they should consider it in order to ensure their long-term viability, says **Mary Beth Pinto**, PhD, another of the study's authors and an assistant professor of marketing in the School of Business at Penn State Erie in Erie, PA. "If we think of health care as a free market, if patients really have the opportunity to choose providers, then they're not going to go to people who don't demonstrate caring. In the long run, these people are going to have problems," she says. "To be a successful health care provider, you have to function as a business that cares about its customers. Service is the key."

The marketing literature is filled with evidence that customer satisfaction is multidimensional, Pinto says, and that's true for health care just as in business. But the difference is that the environmental issues don't seem to be as important in a health care setting as they are in a lawyer's office. "A lot of people don't have the technical ability to evaluate the services. So when I go into a lawyer's office, how do I know I'm getting a good divorce? Well, I look around for cues that suggest this person is going to give me a good divorce. If I see folding chairs, what am I going to think?" Pinto says. "But what we found in this study is that it's not the most important thing for physical therapy clinics. The most important thing is the therapeutic alliance, the patient-provider interaction."

Another key point to remember is that physical therapists will probably define quality differently from their patients. Therapists might think in terms of the quality of the specific treatment

Here are the top 10 ways to satisfy PT patients

The following items from a patient survey instrument created and copyrighted by MedRisk, Inc., had the highest correlation to patients' overall satisfaction and desire to return to the physical therapy facility:

- PT answers my questions
- PT explains my treatment
- PT listens
- PT is courteous
- PT spends enough time
- PT gives detailed instructions
- PT advises me
- Office staff is courteous
- The office is clean
- Up-to-date equipment

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given, but consumers don't know how to judge that because they don't have the medical knowledge or training. Patients are more likely to judge the physical therapist's attitude or the way questions are answered. And since patients are the ones with the pocketbooks, their opinions are the ones that are likely to ensure the ongoing success of the practice, according to another of Pinto's studies.[2]

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Joint Commission looking for outcomes measurement

How do you know education is effective?

Patient education managers should make outcomes measurement a high priority, says **Barbara Moore**, MPA, CPHQ, an instructor at the Amarillo (TX) Veterans Affairs Health Care System. These measurements are important when seeking funding for a new program or resources as well as renewed funding. Administrators want to know if the programs are worth funding and if they are effective, she explains.

The Oakbrook Terrace, IL-based Joint Commission of Accreditation of Healthcare Organizations wants to see outcome measurements as well. "When the Joint Commission came here in the spring, their No. 1 patient education question was, how do you know your patient education is effective?" says Moore.

To gather outcome data, managers first must determine what outcome they want to achieve. For example, if many patients who are seen by physicians at the health care facility have high cholesterol, a class might be implemented to teach them how to lower their cholesterol. In that case, the goal of the class, or desired outcome, would be to lower patients' cholesterol.

Don't make measures too global

When selecting an outcome measure, select something clearly defined that either happens or doesn't, says Moore. "If you are too global, then it might be difficult to collect the data. So you need to be very clear and precise. You also need to think about outcomes that will happen on a regular basis," she says. If outcomes are infrequent, it takes too long to accumulate enough numbers to analyze the data.

There are many examples of clear and precise outcomes. For example, if a program to teach new mothers to breast-feed their babies has been implemented, a patient education manager might measure how many women who are discharged successfully can nurse their newborn. Or perhaps people coming in for surgery are not prepared. The effectiveness of a pre-surgery education program could be measured by looking at the increased number of patients now prepared for surgery as a result of the teaching.

Ideally, a baseline measure should be taken at the beginning of the program so there are numbers to measure the outcome data against. "One of the mistakes that a lot of people make is they leap right into a program, and they haven't taken much of a measurement prior to the implementation of that program," says Moore.

It also is important to define the population that the expected outcome will come from, she says. For example, if the effectiveness of a class that teaches patients to lower cholesterol is being measured, then everyone who attends the class is the population.

Determining how to collect the data is important as well. It sometimes can be collected from

charts. To determine if an outpatient class is effective in teaching patients to reduce cholesterol, the figures would have to be collected from the physicians.

The final step once the numbers are collected is to analyze the data, says Moore. To make this process simpler, don't just count the number of patients who reduced their cholesterol following the class, but figure a rate of those patients who lowered their cholesterol from month to month, such as 2% or 10%, she advises. In this way, percentages can be compared from month to month.

"Once you have your measurement or rate, you have a lot of options on how to analyze the data," says Moore. One way is to plot the data along a line from month to month to see if the program is achieving the desired outcome.

"It is really important to know where you began before the intervention started, and in that way you can support your case that your intervention was directly related to the outcome," she says.

Comparisons help to show that the educational intervention is effective. The most basic comparison is with the baseline measurement, says Moore. However, comparisons can be made between surgical units and other institutions with similar types of patients as well. "You need to make sure that the way you count patients and the way you are figuring those rates are similar enough to justify what you are doing," she cautions.

Be sure to present clear message

When presenting findings to top management, give them the whole picture but make sure that the tool used, whether a chart or a graph, has a clear message, advises Moore. For example, 60% of patients who attended the class lowered their cholesterol.

The process of gathering data to support patient education programs isn't too complicated. "Think carefully about the outcome measure, take a baseline, find a comparison, and watch it over a period of time. Don't try to draw conclusions too quickly," Moore advises. ■

Theme days fight stress inexpensively, easily

Rehab facility zeroes in on workplace fun

Thomas Jefferson said we have an inalienable right to pursue happiness, but for many people that pursuit doesn't take place at work. Unless, of course, you happen to work at Roosevelt Warm Springs Institute for Rehabilitation, the comprehensive rehabilitation facility founded by Franklin Delano Roosevelt in Warm Springs, GA. Imagine working for an employer that lists "having fun in the workplace" as one of its institutional values.

"I'm not aware of other rehab facilities that have fun as an institutional value," says **Carolyn McKinley**, executive administrator of services at Roosevelt Warm Springs, which offers both medical and vocational rehabilitation. "We made a conscious decision to make having fun a workplace value. We believe that, particularly in a health care environment, with all the stress and all the sadness that oftentimes takes place in our patients' and students' lives, we all need to have a little fun. The fun is not at the expense of what we're doing, but to augment what we're doing and to make it even better."

The Institute put some teeth in that intangible goal recently when staff members began coordinating monthly theme days designed to lighten up a stressful environment. In 2001, the state-run facility moved from the Georgia Department of Human Resources to the Georgia Department of Labor, says **Martin Harmon**, the Institute's spokesman. "There was a lot of uneasiness among the staff about the change; it was a big transition for everybody," he says.

Add that to the stress every health care facility faces — nursing shortages, competition, budget constraints, reimbursement issues — and you have an environment ripe for a little levity. McKinley says the theme day idea popped into her head one day when she was walking through one of the units talking to the nurses. The more she thought about it, the better it sounded, and before she knew it, staffers were planning a luau for the first theme day. After a day of flowered shirts, flip-flops, a pineapple piñata, and a Hawaiian menu, the theme day idea was a hit among the nearly 500 staff members.

"It was amazing how people responded," McKinley says. "Everybody was talking about it. It was a great way to engage not only our staff but also our patients and our students.

The therapists really took the idea to another level by gearing their activities for the day to the theme. We were still doing what we needed to do, but in a fun, creative way."

The luau turned into a series of monthly theme days, including a Halloween carnival, the 1950s, Mardi Gras, St. Patrick's Day, Western day, and a "Woodstock" event complete with a concert put on by employees with musical talents. New themes planned for 2003 include Harley Davidson, hillbillies, hats, and international day.

"We had limbo contests, costume contests, cake walks, and Elvis impersonators, just to name a few," says **Rhonda Fuller**, McKinley's executive secretary and the first theme day chairman. "We crowned a Mardi Gras king and queen just like in New Orleans, we played staff two-hand touch football, and we did it all without taking away from any of our basic programs and services. In fact, our patients and students probably enjoyed it more than anybody. It was a lot of fun, and it was great to see virtually all of our direct caregivers — nurses, therapists, doctors, technicians — enjoying themselves by simply taking part."

Fuller organized a group of "theme day ambassadors" consisting of a staff member from each department to help plan and carry out each event. Fuller estimates she spent no more than a day's worth of time each month and no more than $2,000 total for the year's events.

"I worked in the private sector for 15 years, and there was never fun in the workplace. Coming to a place that does have that, I do feel different," Fuller says. "I feel more valued, because they do care about the stress you're under. They do take the time to encourage people."

McKinley says that this type of activity is especially effective in rehabilitation. "One of the reasons the theme days have so much impact in a rehabilitation environment is because patients are here for an extended stay. We develop relationships with our patients and their families, and the theme days enhance those relationships that we already have."

The theme days provide a welcome bright spot in what is a stressful time for patients. "Patients depend on us, and it's important that we remain upbeat and optimistic," McKinley says. "Many of these patients will never be the same again. They're facing permanent changes in their physical and functional activity levels as well as societal, emotional, and social factors. Nothing else in recovery matters if you don't address that emotional component. We want them to leave here feeling they are still important, whole people, regardless of any disability."

The theme days have been an inexpensive, no-hassle way to plug into the Institute's goals. "We decided this was a way to reinforce our commitment to our organizational values, to relieve a little bit of stress and bring a little lightheartedness into the workplace," McKinley says. "It really has done a great thing for the morale here. It has carry-over even on the other days. This is part of our culture, part of what we believe in. It's a way to solidify the camaraderie between the staff and the patients and students we serve." ■

Need More Information?

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Licit drugs a threat to worker wellness

Illicit drugs are not the only problem

An exclusive focus on illicit drug use by employees is causing the nation's health professionals to overlook another major threat to worker health and safety: licit drug use.

That's the stark assertion made by **Rick Lippin**, MD, FACOEM, a medical planner based in Southampton, PA. Lippin, who is trained in futurology, forecasts megatrends in medicine. (For example, in 1985 he correctly forecast that the application of the infectious disease model to occupational medicine would, in most cases, fail.)

There are two reasons that licit drugs pose such a serious threat, says Lippin: "No. 1 is the increase in usage. No. 2 is the failure of our professionals to adequately address their impact on performance, especially in terms of the CNS [central nervous system]. This, by extrapolation, moves into the area of health and safety."

Medical review officers (MROs, an occupational medicine subspecialty) have an excessive

focus on legal drugs, but not enough of one on licit drugs, Lippin says. "While some mechanisms within MRO training do emphasize the impact of licit drugs, it is not nearly enough," he says. "The reason for that is a corruption in the licit vs. illicit mentality. We are carrying out the policies of a society of leaders obsessed with illicit drugs. We're so obsessed with marijuana and cocaine, but we have a huge number of workers walking around with prescribed drugs that are impacting on their performance. But we don't measure performance; we look for drugs in the urine. "

A triple threat

Lippin sees the threat coming from three distinct types of licit drugs: analgesics, psychotropics, and sedating antihistamines.

In the area of analgesics, he points out drugs such as Tylenol with codeine or Percocet. "You and I could very easily verify that the use of those two meds in the last 10 years among workers has significantly increased," he says. "Workers are aging, they're in more pain for a lot of reasons, and they're taking more pain relief medications. And they're trying to work through that pain because they're afraid of losing their jobs."

However, he notes, there have been a number of studies on the impact of narcotics on performance. "If you pull out the PDR [Physician's Desk Reference] on those two pills and look at the side effects, drowsiness is clearly one, as are impaired cognition and impaired motor abilities," says Lippin. "Does that make them the devil? Not necessarily, but if you drive a truck or work around machinery, it might."

In the area of psychotropics, over the last 10-15 years, there has been a huge prescribing shift of physicians from anti-anxiety agents to stimulants, and also to antidepressant medications, he says. "The number of active workers in this country estimated to be on drugs like Prozac, in my opinion, is way under-reported," Lippin claims. "In essence, it's like the elephant sitting in the living room that no one is talking about. Not that these drugs don't help people, but they do have side effects."

In other words, he says, we have to take a good hard look at the use of these drugs by workers in safety-sensitive jobs. "You've got to look at what Zoloft, for example, does to performance functions," he advises.

Sedating antihistamines can be both bought over the counter and prescribed. "The pharmaceutical industry has responded by coming up with nonsedating antihistamines, and these should be used liberally," Lippin advises. "But some physicians prescribe sedating antihistamines because they are cheaper. People gobble these up over the counter during allergy season in particular, and they walk around drowsy. But if you talk to a typical occ-med professional, they're not looking for that."

What we should do

Lippin recommends that health professionals take several steps to help offset the potential threat posed by licit drugs.

"We should do a much better job, even though we're not required to by DOT [Department of Transportation] or other agencies, to take a complete medication history," he says. "We should aggressively pursue discussions with patients [about licit drug use] and record whether or not they are experiencing CNS side effects."

Second, he says, occupational health professionals should lobby for change, both on the micro and macro level levels, for agencies like the DOT to be more inclusive of the whole licit drug issue. "The FAA [Federal Aviation Administration] has formularies that list certain drugs, and they do a better job than the average industry. After all, they don't want pilots to make errors to the point where they crash and kill hundreds of people," says Lippin. "They have testing panels and procedures in place that are much more aggressive in terms of licit drugs. I hold them up as a potential model for DOT and others to follow."

Last but not least, he says, we need to move

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away from policing urine to assessing performance. "We should support the research of those companies that are trying to replace drug testing with CNS performance testing," he declares. "Even fatigue is a safety hazard. Fatigue, stress, it doesn't matter — what matters is the person's brain is not functioning. That's the whole problem with drug testing; it misses this."

In 20 years, the futurist predicts, this focus on drug testing will be looked back on as a major tragedy in the history of American medicine. "We will be looked upon as having abandoned professional ethics — not looking at safety and health, but instead becoming pseudo-cops," he warns.

"We are an arm of the drug czars, instead of being practitioners worried about whether our workers are safe and healthy." ■

Need More Information?

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