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IN THIS ISSUE

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Depression tops list of attending problems for rehabilitation patients

Researchers advocate routine depression screening

A growing body of research establishes a link between rehabilitation and depression. There are many questions still unanswered, but researchers agree on one fact: If you work in rehab, you're going to have to deal with depression.

"Depression is for many people a first- or second-tier response to trauma," says **Greg Smith**, PhD, clinical rehabilitation psychologist and director of Progressive Rehabilitation Associates in Portland, OR. "Depression is No. 1 or No. 2 on anybody's problem list in a rehab program when they're dealing with chronic disabilities."

So it's not so much a question of if, but rather when a patient will begin to have feelings of depression. Patients go through a range of emotions that may start with disbelief and denial and move on to fear, anger, or depression once they begin to confront the true nature of their new limitations, Smith says.

"The way the rehab team functions is to say where is this person in the process of adapting and coping and learning to address this issue," Smith says. "Typically, patients will find themselves on antidepressants, but the medications are really adjunctive to the treatment. They aren't the treatment. The treatment should occur not only with the rehab psychologist but with the other team members as well. In a rehab setting, what we're looking for is assisting the person to adjust. It's a behavior-change strategy."

The rehab team should be looking for depressive symptoms all through the rehab process but should be particularly alert to emotional difficulties that rise as therapy decreases. The highest suicide rate in the United States is among quadriplegics and paraplegics, Smith says, and it usually happens as much as a year after injury.

"The more medically stable they are, the stronger they get, the more they wake up," he explains. "The therapy begins to diminish in frequency,

and they're kind of on their own; and it's at that point where they're at the highest risk for suicide. All the focus of attention had been on getting better, and now this is it."

Every rehab plan should have a behavioral aspect that is updated weekly or even daily as needed, Smith says.

It's not hard to understand why patients with sudden severe physical limitations might become depressed. But what if the depression is a biological reaction caused by the traumatic event itself? Researchers now believe that depression in stroke patients may correlate with the size and location of the lesion on the brain. The presence of a biological mechanism may explain why a recent study from the University of Iowa in Iowa City found that antidepressant treatment for stroke victims appears to reduce mortality, whether the patients are depressed.[1] "This finding suggests that the pathophysiological processes determining the increased mortality risk associated with post-stroke depression last longer than the depression itself and can be modified with antidepressants," the authors write.

Ricardo Jorge, MD, a co-investigator of the study who is a neurologist and assistant professor of psychiatry at the University of Iowa, says almost 68% of patients who received 12 weeks of antidepressant treatment were alive after nine years, compared with about 36% of patients who received 12 weeks of placebo.

Forty percent of patients develop a depressive disorder within two years of a stroke, he points out. There doesn't seem to be any association between the severity of the stroke and the severity of the depression.

Reasons for depression in stroke patients include:

1. Biological causes. Patients who develop depression tend to have a greater degree of atrophy in the brain, Jorge says.

2. Socioeconomic factors. Patients who are socially isolated with a poor social support network are more vulnerable to depression.

3. Genetic endowment. Certain personality types and reactions to stress can lead to depression.

4. Previous history of depression. According to Jorge, the causes of depression may vary along the course of the patient's recovery. "Those factors prominent in acute phases may not be so prominent in later phases. Biological causes may play a big role at the beginning, and lack of social support later on."

Whatever the causes, adequate treatment of depression leads to significant improvement in activities of daily living and cognitive function, he says. "Lack of motivation is one of the cardinal signs of depression. Depressed patients, in general, have less degree of involvement with every type of rehab effort. One of the reasons those patients don't recover in the same way is they don't participate in the same degree in the rehab process."

Jorge and his colleagues are exploring further the mechanism by which antidepressants seem to be increasing stroke patients' chances of living longer. They say it's possible the drug's action may be independent of depression. They also say giving antidepressants early after stroke potentially could prevent the onset of depression later.

But Jorge cautions that it's too soon to start prescribing antidepressants to every stroke patient.

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"Many rehab physicians have a very low threshold to start antidepressants, even if they are in doubt that the patient is really depressed. It's not easy to diagnose depression," he continues. "But we need more research, bigger studies, to be sure about the results and also to select the most adequate medications. Using antidepressants is not devoid of side effects. We don't have the empirical evidence to start treating every patient at this point. We need to be cautious."

Assessment is critical

The first step, Jorge says, is to strive for correct assessment of depression. Patients in rehab facilities need an evaluation by a psychiatrist who has rehab experience.

At Burke Rehabilitation Hospital in White Plains, NY, all stroke patients get a depression evaluation, straight from a clinical investigator himself. **Pasquale Fonzetti**, MD, PhD, a neurologist and principal investigator in clinical neuropharmacology, is working with Jorge on a three-site depression prevention protocol.

So far, he has 10 patients enrolled in the study that seeks to confirm the results of Jorge's earlier study and lead to a new standard of care for rehabilitation hospitals around the country.

They are enrolling patients who are not depressed, starting them on a trial medication, and following them for 18 months to see if they develop depression or have other medical events. Patients who do develop depression are removed from the study and started on proper treatment. Another arm of the study will compare the effects of behavioral treatment with the antidepressant.

Burke Rehab patients are fortunate, Fonzetti says, to get the depression screening because of the clinical trials done there.

"But screening is not widely done unless a hospital is involved in clinical trials. It should be," he explains. "Depressed patients have less motivation to improve, less attention and concentration. Depression is a factor for [patients' conditions] to deteriorate instead of gradually improve. This is an issue that is well known to neurologists who work in a rehab setting, but other neurologists are not as aware of the problem."

Another area of disability in which there is not nearly enough awareness about depression is vision loss, says **Amy Horowitz**, DSW, senior vice president for research and director of the Arlene R. Gordon Research Institute at Lighthouse International.

Lighthouse is a nonprofit organization based in New York City that serves as a worldwide resource on vision impairment and rehabilitation.

"People absolutely do not know there is such a thing as vision rehabilitation. It's not like having a hip fracture and knowing you're going into rehab," Horowitz says. "They don't know there is anything that can be done or what's available, and therefore, they see the situation as hopeless. People do not have to expect vision loss or depression as a normal consequence of aging. A lot of people say, 'What do you expect? They're losing their vision; of course, they're depressed.' But that doesn't have to be the case. It's highly prevalent, but it's not inevitable."

Horowitz recommends that ophthalmologists routinely screen for depression, especially in patients with age-related macular degeneration.

"You speak to a lot of specialists and they say, of course, they see a lot of depression in their practice. They just don't do anything about it," she says. "It's important to acknowledge it and make the appropriate referral."

Lighthouse is in the data analysis phase of a five-year longitudinal study of the prevalence of depression in people with vision loss and its relation with disability over time. The researchers are looking at the impact of depression on rehabilitation and also the impact of rehabilitation on depression.

About one-third of people older than 65 who have vision impairment also suffer from depression, Horowitz says. That's a higher percentage than has been reported for elderly people in the community and also higher than the estimates for elderly patients with other medical conditions.

"One thing that is clear is that the relationship between vision impairment and functional disability is profound compared to other common medical conditions. It's comparable to stroke and arthritis. There is a strong relationship between disability and depression," she says.

"There's something unique about the subjective feelings about the loss of vision. It has a great deal of meaning to people over and beyond sometimes what kind of functional limitations it might cause. It's associated with feelings of dependence, fear, loss of autonomy," Horowitz explains.

According to research from the Lighthouse, depressed people are less likely to follow through with rehabilitation and have a bigger dropout rate. But in a recent study published in *Aging and Mental Health*, Horowitz and her colleagues reported that use of rehabilitation services led to

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a decline in depression over time.[2]

"When they do engage in services, they tend to receive fewer hours of service. Depression dulls the affect, dulls the ability to engage in activities of all sort, including rehabilitation," she explains. "Depression should never be left untreated. The ironic part is that rehabilitation can impact one's mental health status."

The key is determining how best to address this reciprocal relationship between depression and rehab. "For some people, you may have to deal with the depression before you deal with the rehabilitation," Horowitz adds. "For some, you may be able to deal with them concurrently. Which do you need to address first so you can improve both function and mental health? The goal of rehabilitation is not only to improve function but to improve one's adaptation to a disability."

There is evidence that rehabilitation cannot only alleviate depression but also can improve physical problems related to the disabling condition. A large randomized trial reported in the *Journal of the American Medical Association* last fall found effective depression treatment in arthritis patients led to less pain, enhanced functioning, and a better quality of life.[3]

The IMPACT study was a multisite study of depression care in 1,801 patients seen in their primary-care physician's office.

"Older adults with depression commonly cope with several chronic illnesses on a daily basis," explained principal investigator **Elizabeth H.B. Lin**, MD, MPH, in a news release about the study.

Lin is a family medicine physician at Group Health Cooperative in Seattle.

An estimated 15% to 20% of elderly folks in the community have depressive symptoms, but the prevalence of depression jumps to between 30% and 50% in elderly patients with medical conditions requiring rehabilitation. Those most frequently affected tend to be patients dealing with stroke, arthritis, and vision loss.

"This research suggests that we can lessen their pain, improve their outcomes, and enhance their quality of life by reorganizing primary care practices to better treat their depression. We did not use any magic bullet — no new medication or technology. We simply used existing treatments more effectively," Lin asserts.

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No double standard: CARF applies its own rules

New HR practices lead to excellence award

Have you ever been through a rigorous CARF accreditation survey and wondered if CARF walks the walk as well as it talks the talk?

The short answer is yes, CARF does apply its own standards, those that are not specific to medical care, internally.

Because it does it so well, the organization recently was named the 2004 grand prize winner of the Workplace Excellence Award of Greater Tucson, where CARF International is based. CARF (which accredits rehabilitation, employment, and aging service providers in the United States, Canada, and western Europe) was named one of the best places to work in Tucson and also one of Tucson's most progressive employers.

The award, sponsored by the Society for Human Resource Management, was given to the company that best exemplified human resource

practice. Not bad for a company that didn't even have a human resources professional position just three years ago.

And that gets us to the explanation of how CARF applies its own standards: It starts with **Brian Boon**, PhD, president and CEO of CARF. Boon's first order of business when he came to CARF three years ago was to begin an organizational assessment to identify areas that needed improvement. Human resources and utilization of technology popped up as two such areas. "There wasn't a lot of investment in the things that our standards demand of our accredited organizations around looking at long-term strategy, financial planning, and human resource planning," he explains. "We did all this because our standards say good organizations should do this. It's really living up to what you preach."

Boon says he was surprised to learn CARF had no official human resources position. "The function was being done through different assignments in the organization, but there really wasn't an HR professional. I said, 'I'm sorry. I've never worked in a company where we didn't have someone who was a human resources specialist,'" he adds.

Boon created the HR position and hired **Judy Forman** to be CARF's first human resources officer. Forman reports directly to Boon.

"I learned a long time ago that organizational success is very much dependent upon the people, not the suits and ties," he notes. "Having HR report directly to the president/CEO sends a signal that there aren't that many degrees of difference between the leadership positions and the frontline staff. I'll be on the phone with the disgruntled customer just like they will."

CARF also reviewed its HR policies and procedures, staff education and training, and awards and incentives programs. "What we've tried to do is make our organization more responsive to our external environment. In order to do that, we had to invest in our people," Boon says.

Changes CARF made include:

- employing a corporate balanced scorecard to monitor progress;
- holding a quarterly president's forum to share information with staff about company goals, financial results, organizational events, and employee satisfaction survey results;
- investing in a new technology platform and training staff to use it;
- integrating HR objectives into the company's strategic goals;
- making awards to individual employees for significant contributions;
- giving goal-sharing rewards for team efforts in achieving budget objectives and balanced scorecard indicators.

According to Boon, while most of the CARF standards are written for the medical rehab field, there are many that CARF can apply to itself.

"We look at strategic planning and financial planning and resource planning. We now have a five-year integrated strategic and financial plan. We use the standards as our own benchmark," he says. "One of the standards says to collect information on an ongoing basis regarding the people you serve. We have customer satisfaction data that we look at every quarter in front of our staff so they can see what's working and what's not. The accessibility standard — we had a university come out and test to make sure our own work environment was accessible to persons with disabilities."

The new efforts are paying off. In 2002, CARF did 1,446 surveys. In 2003, CARF was able to complete 1,898 surveys with no extra staff at the same time it rolled out the new computer system. Even with those challenges, CARF saw an 89% customer satisfaction rate in the last half of the year, up from 86%. Results of employee job satisfaction surveys also have increased.

According to Forman, employee involvement in the organizational changes has been a key to success.

"We've focused on communication of business strategies so people are not working in the dark," she says. "Employees have been allowed to make suggestions. People can see what their role is and why we're doing these things because they have the bigger picture."

Staff receive a weekly electronic newsletter and frequent e-mail communication, and they participate in all-staff forums that range from the quarterly meeting to impromptu 15-minute discussions in the lobby. Employees have also participated in focus groups to make suggestions for change. One employee group developed a value statement for

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CARF called RESPECT, which stands for respect, excellence, stewardship, partnership, communication, and technology.

"The feeling was that we should have an internal value statement as well as an external one," Forman says. "Another thing that came out of it was people thought they had good communication within their department but that communication could be improved between different customer service units. They said we'd be better placed if we looked at each other as internal customers."

CARF launched an intensive customer service program to deal with that issue. Each staff member went through 18 hours of training. "If we're going to deliver excellent external customer service, our delivery chain is only as strong as our weakest link," she continues. "We even developed a customer service excellence slogan that said let's focus on what we can do, not why we can't do it."

CARF also beefed up its employee recognition programs. About a dozen employees receive the annual president's award for making a significant contribution above and beyond the scope of their jobs. One winner, for example, negotiated faster, more reliable copy machines and saved CARF $20,000 a year in leasing costs in the process. CARF also pays cash bonuses to employees if the company reaches certain levels on the balanced scorecard. Managers receive $50 per year per staff member to use for departmental recognition in whatever way they choose — group lunches, gift certificates, movie tickets, and the like. Individuals also can qualify for merit pay increases.

"It's a good balance between the team piece and the individual contribution," Forman says. ■

Providers welcome new admission guidelines

AAPM&R forms task force on medical necessity

After months of gloom and doom surrounding the 75% rule and the draft Local Medicare Review Policies (LMRPs) on inpatient rehabilitation admission, rehab advocates say they finally see a glimmer of hope. Not a big bucket of sunshine — the 75% rule and the draft LMRPs still are on the table — but a welcome ray of hope, nonetheless.

The American Medical Rehabilitation Providers Association in Washington, DC, sees a positive alternative in a new local coverage determination document released by AdminaStar Federal, says **Carolyn Zollar**, JD, AMRPA's vice president for government relations. AdminaStar is the Medicare fiscal intermediary for Indiana, Illinois, Kentucky, and Ohio.

When three other fiscal intermediaries — Riverbend Government Benefits Administrator (Tennessee and New Jersey), Blue Cross and Blue Shield of Georgia, and Veritus Medicare Services (Pennsylvania) — released their draft LMRPs in the fall, rehab providers worried the policies would be a disaster for inpatient rehab. **(See *Rehab Continuum Report*, November 2003, cover story.)** Providers said the proposed narrow criteria for admitting patients to inpatient rehab would shut many patients out of services they need and even force some rehab hospitals to close.

While the previously released LMRPs were virtually identical, the AdminaStar document takes its own tack on the issue of what types of patients should be admitted for inpatient rehabilitation.

According to **Bruce Gans**, MD, chief medical officer at the Kessler Institute for Rehabilitation in West Orange, NJ, that's a good thing.

"The AdminaStar document has absolutely no relation to the other documents, and it was clearly not just a minor variation or derivative of one commonly produced document. It's a totally different approach," says Gans, who is also the president-elect of the Chicago-based American Academy of Physical Medicine and Rehabilitation (AAPM&R).

Fiscal intermediaries began producing local coverage policies for inpatient rehab after a 2002 program memorandum from the Centers for Medicare & Medicaid Services gave them the responsibility for auditing inpatient rehab claims.

With all the differing opinions coming from the payer side, the AAPM&R has decided to officially weigh in on inpatient rehab admission. The organization has formed a task force of eight physicians and four consultants to establish its own professional recommendations of what are the appropriate criteria for determining medical necessity for admission into an inpatient rehab facility, Gans says. Over the next six months, the task force will review the existing documents and what little literature exists on the topic and try to articulate the standards and criteria to which rehab hospitals should be held.

He maintains that fiscal intermediaries really don't need a local coverage document, but if they must have one, the AdminaStar version is the best.

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"The Medicare 110 benefit policy regulations are quite clear and quite readily usable to assess a patient's appropriateness for admission by anybody who knows and understands rehab," he says.

Gans, who says he found the Riverbend LMRP to be a "disturbing document" that couldn't possibly have been written by physicians with rehab experience, says the AdminaStar document does appear to have been written by people with knowledge of medical rehab. "It approaches the whole concept of how to identify what patient is appropriately cared for in inpatient rehabilitation settings from the perspective of rehab. It recognizes the purposes of admission are for function and that need for admission doesn't always correlate well with diagnosis," he adds. "That is one of the problems that has been identified with the other approach and how attendant it is on the notion of diagnosis. What the field has said all along is that it's not medical diagnosis that determines appropriateness but rather functional need and potential benefit from the kind of resources that are available at a rehab hospital."

The AdminaStar document (go to: www.amrpa.org/PDF_Files/Inpatient_Rehabilitation_IAC_Jan_Mar.pdf) does not include a listing of diagnoses appropriate for inpatient rehabilitation but instead asserts, "The need for inpatient rehabilitation is more dependent on the effects of a patient's injury or illness [impairments, functional deficits, achievable goals] than on the precipitating cause [diagnosis]."

The document summary states that inpatient rehabilitation will be considered medically reasonable and necessary as long as:

- There is a reasonable expectation of measurable improvement that will be of practical value to the patient within a predictable and reasonable period of time.
- The patient requires the active and ongoing therapeutic intervention of at least two disciplines, one of which must be a therapy, acting in a coordinated fashion.
- The patient requires and can tolerate at least three hours per day of skilled therapy at least five times per week.
- The therapy cannot be provided in a less intensive setting.

The AdminaStar document probably would not force hospitals to change the way they admit patients. "But it would relieve a lot of the anxiety that we feel when we admit somebody who we know needs our care and services but we know puts us in jeopardy of having a denial," Gans says. "That's the good news. Each case needs to be judged on its own merits. You can't develop a blanket guideline that automatically could be applied to people."

But overall, both the 75% rule and the LMRPs should be stopped, he says. Gans sees two different questions to be answered:

1. How do you define a rehab hospital in contrast to an acute care hospital? "That actually has very little to do with the attributes of the individual patient and mostly to do with what the facility does, what the services are, what the resources are like," he says.

2. How do you determine which individual patient belongs in that setting? "That's a job for the local coverage determination. There are specific attributes that should be defined. The AdminaStar document shows it's not impossible. Now somebody has published a model that is really close to being right. It should be quite a usable tool for the fiscal intermediaries but also for the field," Gan adds. ■

Integrating acupuncture improves care, profits

Occ-health program incorporates it into PT

Integrating acupuncture with conventional physical therapy and work hardening has been both a medical and financial success for Good Samaritan Occupational Health Services in Avon, MA, according to its medical director, **Robert P. Naparstek**, MD. The on-site acupuncture program was initiated in January 2000.

"I had always wanted to do this," explains Naparstek, whose first exposure to acupuncture

was as a rheumatology/immunology fellow in 1983-84. "The medical center was downtown near Chinatown. I met interesting people from Hong Kong and Taiwan, who invited me go downstairs to their storage room, where I met their cousin, who was a renowned master in acupuncture." When patients left, he adds, it would be with smiles and bows, and they often left their canes behind.

"Since then, I have always wanted to have the opportunity to do some integration [of acupuncture] with occupational health," Naparstek notes. From time to time he sent patients to acupuncturists, and some of them were able to get off of drugs like Percocet. "I did not do any formal measures, but I noticed anecdotally that there was improvement," he reports.

In 1995, Naparstek became medical director at Good Samaritan's occ-health services. And in 1999, he became involved with the New England School of Acupuncture, a prominent institution in the region. "I felt it was now or never. I had significant autonomy, so I got an acupuncturist I had met through the school to come talk with us about integrating it into our program, and what kind of MMI [maximum medical improvement] we could reach with acupuncture." After that, he says, "I just basically did it."

The setup was fairly simple. Naparstek brought in the acupuncturist, **Nicole Stockholm**, MAc, LicAC, of the New England School of Acupuncture, to see patients on Tuesdays and Thursdays. The rest of the team comprised Naparstek and Good Samaritan's physical therapist.

The facilities were fairly large, with two rooms devoted to acupuncture. "We gave Nicole all the support she needed, the rooms, heat lamps — we'd even buy her needles," he notes. "In other words, we'd cover all the overhead and then we'd split the money."

Most of the patients came from corporate clients. About 50% were workers' comp cases; the rest of the patients were billed direct. Acupuncture was not covered by their insurance, but the fees were reasonable — $86 for the initial visit and about $40 per follow-up visit. "The total cost of an average course of acupuncture is less than that of an MRI," Naparstek points out.

Factors such as strength and range of motion were measured regularly to assess patients' progress. "Patients' healing rates improved, he notes. "Acupuncture was clearly making a big difference in terms of numbers of lost days and getting people back to work."

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He cites one case in particular to illustrate the important role acupuncture has come to play in treating patients. This particular patient worked for a nearby company that makes black electric tape. He regularly carried 50-pound barrels of toxic powder that easily can be inhaled, dumped the power, mixed it, and put it into special kilns.

"He was an immigrant from Portugal — uneducated but intelligent, a low-wage individual who was a heavy smoker," Naparstek recalls. "He was complaining of pain in his left arm. Because he was left-handed, he moved the barrels more with his left arm, so I felt it was logical to look for an ergonomic cause. But I could not isolate a tendon, bursa, muscle, or joint as the source of pain."

His next thought was a possible cardiac problem, since the patient was a smoker. "I even sent him to our cardio department for a stress test, but *that* was normal," he says.

Finally, the patient visited with the acupuncturist who interviewed him along with Naparstek. "He finally confessed that he had been under a lot of stress — he had lost his wife to breast cancer and was feeling very sad and overwhelmed," says Naparstek.

In the type of acupuncture Stockholm practices, there are a number of points associated with emotions and meridian lines. "She said the patient was terribly *Yin* deficient, and his lung meridian was profoundly blocked — that there was *Chi* stagnation, which she says is almost always associated with grief," Naparstek recalls.

She began treating him, and he got "unbelievable relief [within two to three treatments]," he adds. "He started crying for the first time; he *really* grieved."

The patient ended up having nine to 10 appointments, went through the work hardening program for two weeks to regain strength, and then was back to full duty.

"Acupuncture really does tend to stimulate the emotional issues associated with injury," says Naparstek. "People who are injured feel humiliated at work and become angry. Once they

started talking about it and getting acupuncture, they no longer had symptoms."

Naparstek says he also is using acupuncture for his chronic patient resolution (CPR) program. "This is for chronic workers' comp cases, where people have been out three to five years. We assert that managed care has not worked, and we make a deal with the adjusters: 'Give us six months, and we promise to state an MMI.' This really suspends managed care for six months."

In CPR, acupuncture is a key part of the program, being used in combination with aquatic physical therapy, medical office visits, work hardening, and clinic psychology. "We treat them as aggressively as we can and then reach an MMI," he says. "We have had 30 people moved back either to full-time work or permanent modified duty, and acupuncture has played a huge role."

Naparstek is having some success with the insurance representatives, but there's still work to be done. "I tell adjusters it will reduce future risk and free up reserves. That appeals to some, but others just do not want to give up authority," he says.

Using acupuncture in physical therapy (PT) and work hardening also benefits the insurer, he adds. "These stories are great examples of how dealing with emotions can help heal injury, push a person out of PT faster, and close the claim. I argue with the insurance companies that this something that is ridiculously cheap, and it *works*."

It also can help prevent the large number of iatrogenic gastrointestinal bleeds that result from overprescribing anti-inflammatory agents, asserts Naparstek.

"Acupuncture is cheap, it's safe, and it works," he points out. "Hopefully, because we have reams of data on this, we will be able to publish our experience in the near future." ■

Going from good to great is Studer program's goal

It's all about service excellence

Aligning with the health care customer service model of the Studer Group — whose Road Map to Excellence is guided by five pillars: service, quality, people, finance, and growth — was a natural fit for Providence Health System, says **Patricia Weygandt**, manager of access services at Providence Milwaukie (OR), one of three system hospitals in the Portland, OR, area.

"It's all about service excellence," she adds. "The pillars of the [Gulf Breeze, FL-based] Studer Group come very close to our strategic priorities."

What's striking about the Studer program, and gives it more substance than the average customer service initiative, Weygandt contends, can be summed up in one word: accountability.

"It's a change in culture, and it requires buy-in from everybody within the health system," she says. "It's not just, 'This is a good idea,' and maybe you do it and maybe you don't. It requires the complete support of all levels of leaders."

Information on the company's web site (www.studergroup.com) describes how it has applied to health care the concepts in the book *Good to Great* by Jim Collins, which is about the momentum created by the power of continued improvement and the delivery of results.

Under the Studer plan, Weygandt says, every member of the organization is asked to sign a service commitment and receives a star pin to wear as evidence of that commitment. Providence Hood River — also located in Oregon — was the first system hospital to adopt the program, with some modifications, she notes, and the three Portland-area facilities began implementation in late November and early December 2003.

A three-tiered rollout of the program started with manager education and was continuing this year with an employee forum, or seminar, on service excellence, Weygandt adds. "It will take from one year to two years to get it fully implemented."

Highlights of the program, she says, include the following initiatives:

- **Leader rounding.** Using a rounding log, managers go to employees and ask a series of questions, she says. "We ask if there are any co-workers they would like to recognize, and why, and if there are any physicians they'd like to recognize, and why. Then we ask, 'Is there anything I can do that will help you with your job?'"

The form on which these responses are recorded also has a place to indicate action taken by the manager, she says. "Every manager is expected to do one rounding a week, and then the logs are sent to administrators, who keep a record."

Weygandt notes, for example, that she rounded on one of the emergency department registrars, asking the employee, "What's going well down here. Is there anyone I can recognize?"

The registrar immediately gave the name of a

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nurse, citing her compassionate attitude, and then listed four physicians who always are supportive of admitting staff, as well as a co-worker and another nurse.

Asked if there was anything that could be done to make her job easier, the registrar mentioned that the department's insurance eligibility software was not working properly. Weygandt wrote personal notes to those mentioned, citing the specific reason for the thank-you, and followed up on the software service request.

• **The 5-10 rule.** Within 5 feet, employees are expected to make eye contact with and greet whomever they meet — co-workers, physicians, or patients. Within 10 feet, they are expected to make eye contact and smile. Those who've made this commitment are given a "smile" button to wear.

At Providence Milwaukie, Weygandt says, "We have all noticed a real difference in the hallways and throughout the hospital as people have acknowledged patients and co-workers. People who before would put their head down and look away are now saying 'hello' or 'good morning,'" she adds. "Those who are a little reticent can't help but respond."

Asked if a required greeting might seem artificial to some, Weygandt notes, "If it is artificial, then people need to examine their attitudes and why they're here. That's how culture change happens. It's amazing how contagious it is. You see a light in patients' and families' faces when they are recognized and acknowledged."

• **Managing up.** "This means positioning someone or something in a positive light," she explains. "An example would be to say to a patient, 'Dr. Smith is your physician. He's a very good surgeon. You're in great hands.' You can almost always think of something positive, even if it's about equipment. You can say, 'We've just installed an MRI that is the best in the field."

To contrast, Weygandt points out, "Managing down" would be to tell employees something such as, "Management won't get us the equipment we need," or "I called the doctor three times about your pain, but he won't call back."

Because it's such an ingrained habit to consciously or unconsciously pass the buck to avoid being blamed, she continues, managing up is the most difficult practice for staff to implement consistently.

Follow-up — as in the seven thank-you notes generated by one employee — is imperative to the program's success, she emphasizes. "If you don't follow up, it's just so much lip service. If it doesn't translate into action, it's just one more program that will fall by the wayside."

Although the follow-up described above was more extensive than the norm, Weygandt notes, there is no question the Studer program represents a major time commitment. "It's worth it," she says. "It's part of what we need to do to turn us from a good hospital to an excellent hospital. Many times people are happy with good, but we're not."

Program practices yet to be rolled out, she says, include identifying the level of each employee's performance as either a 5 (highest), 4, or 3, with appropriate feedback given, and instituting telephone calls by nurses to all patients following discharge. The idea behind implementing the program in phases, Weygandt explains, is to "hardwire the behavior change for at least three months and then move on to the next step. [That way], it becomes part of the everyday routine." ■

Ergonomics program gives a lift to morale

Hospital survey shows satisfaction

Ergonomics is more than a way to lift patients. As Butler (PA) Memorial Hospital found, it can lift morale and employee satisfaction as well.

The challenge is to overcome negative perceptions and convince staff that hospital administration is serious about reducing injuries, says **Karen Bosley**, RN, manager of the employee health service of the western Pennsylvania hospital.

In a five-question survey, she found employees did not feel they had adequate training or equipment. The survey indicated employees believed injuries were not a high priority to hospital administration. As a consequence, employees paid little attention to the ergonomic devices the hospital provided. "We found we had employee reluctance to take the time to either use the equipment or get additional staff [to help with a lift]," Bosley adds.

During the following year, the hospital spent $80,000 on equipment, developed a training program, and initiated an incentive program to reward employees who complied.

Visible support for ergonomics was evident from administration. Injuries declined by 33%, and related medical costs were reduced by $123,000. Just as important, however, was the change in attitude, as demonstrated in a post-implementation survey. "It's absolutely amazing," she says. "Now people think administration cares. They know they've gotten education. They know we've got equipment."

Ergonomics now has become one aspect of the hospital's efforts to be an "Employer of Choice" — a hospital that has an edge in recruitment and retention. Butler Memorial actually began to investigate ergonomics because of concern over several serious injuries. It was not just the cost that concerned Bosley; although at $400,000 in workers' compensation, the cost was significant.

"We identified employees who had been injured previously, whose quality of life had been [permanently] changed." Employees had undergone back surgery, including fusions and diskectomy, due to work-related injuries, she says.

"They're still working here, but they are not able to do the job they were doing before," Bosley points out. "They are RNs who will probably never be able to go back to the nursing job they did before. Most of them are in nonpatient care-related jobs, such as data collection or staff education. We didn't want any other person to have to go through that. We wanted to see what we could do to prevent future injuries."

In July 2001, the hospital's safety committee decided to create a subgroup to investigate the injuries and develop a plan of action. The committee included Bosley, the safety officer/risk manager, an ergonomist, an employee educator, a floor nurse, the physical therapy director, and the systems improvement manager.

The causes identified by the team are common ones: Employees used poor transfer and lifting techniques. The hospital had no policy defining safe lifting techniques. It lacked adequate equipment. Employees needed patient assessment tools to define when equipment should be used, and employees were reluctant to take the time to use equipment or get additional staff. Bosley and her colleagues wrote a policy and developed patient-assessment algorithms. But they knew that was just the first step.

The safety team sought strong administrative support as well as employee buy-in. She and her colleagues were able to get a commitment for $80,000 to purchase equipment — and the team agreed to be accountable for results. They assured administrators they would achieve a reduction in lifting injuries by at least 25% and a savings of $100,000 in related costs. "We really were adamant

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that we could do it," Bosley stresses. "We asked for this money and asked for a chance to prove that we could make a difference."

The survey of 1,500 employees provided a way to measure another outcome: employee satisfaction. The safety team was very hopeful it would improve after the intervention.

Staff and managers were an integral part from the start of the program. Employees helped evaluate and select the lifting equipment. They acted in a video that became the training tool for the lift devices. Supervisors added ergonomics to their annual staff competency testing. Additionally, the hospital's ergonomist went to office workstations to make adjustments and improve comfort.

They also faced a common challenge: How do you keep employees motivated to use the equipment? Bosley uses an incentive program to reward staff who were observed using lifts, Hover mats, gait belts, or other ergonomic items. Employees receive $5 gift certificates for pizza, ice cream, movie theaters, and other local stores, along with a congratulatory note.

"It wasn't a great deal of money, but it's made a tremendous impact," explains Bosley, who estimates she spent about $1,000 on the incentives. "People really do appreciate that they've been noticed." She adds that she was pleased recently when she learned of two employees who followed the appropriate lifting policy when a patient lost her balance and began to fall. The nurses eased her gently to the floor. Then, instead of manually lifting her, one stayed with her while the other got a lift. "They didn't put their own backs at risk. The patient wasn't injured, and neither were the employees. It's a win-win." ■

NEWS BRIEF

IOM recommends more diverse health work force

A recent report from an Institute of Medicine (IOM) panel recommends strategies for achieving greater diversity among health professionals, a goal that would lead to improved access to care for racial and ethnic minority patients.

The report says health profession educational institutions should improve their admissions policies and practices to better recognize the value of diversity and culturally competent care, improve the institutional climate for diversity, and affiliate with community-based health care providers to attract and train a more diverse and culturally competent work force.

It also recommends academic accreditation bodies enforce diversity-related standards and include underrepresented minorities and other experts in cultural competence and diversity. In addition, the report says Congress and state and local entities should increase funding and support for programs effective at enhancing diversity.

At an IOM briefing on the report, **Lonnie Bristow**, MD, former president of the American Medical Association, pointed out that the "educational pipeline ruptures long before minority students have an opportunity to access higher education, let alone training in a health field."

Ray Grady, chairman of the Institute for Diversity in Health Management, said the report "focuses on issues that are essential to ensuring a diverse health care work force, [and] tapping into this diversity can only enhance the high quality of care that our hospitals and health care workers provide to patients every day."

To see the IOM report, go to: www.nationalacademies.org/morenews/. ■