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IN THIS ISSUE

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Congress calls for Medicare reform following HCFA's testimony

System is too complicated, say representatives

In a congressional hearing held late this summer, legislators heard testimony from representatives of the Health Care Financing Administration (HCFA), Office of the Inspector General (OIG), and various physician provider and medical technology groups as to how the complex rules put forth by HCFA affect coverage issues and provider complaints.

At the hearing, "Medicare's Management: Is HCFA's Complexity Threatening Patient Access to Quality Care?" Rep. **Michael Bilirakis** (R-FL), chairman of the House Commerce Subcommittee on Health and the Environment, called for a new and improved HCFA and noted that many members of Congress, from both parties, question whether HCFA can efficiently administer a prescription drug benefit.

Ranking minority member Rep. **Sherrod Brown** (D-OH), defended HCFA and reminded those in attendance that the organization does not operate in a vacuum and that Congress and its leaders share the blame for any of HCFA's problems.

HCFA hatches a plan for efficiency

Mike Hash, deputy administrator of HCFA, told the subcommittee of several recent HCFA initiatives designed to minimize Medicare regulations and strengthen the Medicare program's efficiency and fiscal integrity. Specifically, those initiatives include:

✔ launching a wide-ranging education program to help providers understand Medicare policies and proper billing procedures, and preparing providers for new payment systems as mandated by law;

✔ revamping advance beneficiary notices by using "plain language" to make the document user-friendly so beneficiaries can make better informed choices;

✔ developing compliance programs for providers and inviting public comment on such guidance;

✔ requiring all claims-processing contractors to establish toll-free lines for providers to call with billing questions;

✔ simplifying evaluation and management guidelines designed to reduce the documentation for physicians to justify their claims;

✔ studying error rates at the contractor level so that HCFA can focus on education and error prevention;

✔ establishing the Physicians Regulatory Issues Team to ensure that HCFA addresses how its policies affect practicing physicians.

(This information is courtesy of the National Association for Home Care in Washington, DC.) ■

Do you know how to play the hiring game?

Hire (and fire) the right way

Job loyalty is not what it used to be. There was a time, once, when people stayed in their jobs for eight years and longer. People expected to grow old and retire with a company. Those days are long forgotten for most of America's work force, and even those who haven't forgotten aren't playing by those rules any more.

With unemployment at record lows, just about anyone who wants a job can get one. What's the downside? It's harder to keep good employees when more lucrative positions are frequently in the offering. So just how do you get employees to stay with your company, even in an industry with notoriously long hours and low pay?

Will they? Can they?

It sounds obvious, but the best way to get an employee to stay and grow with your agency is to hire the right person for the job. It makes no sense to hire someone who has ambitions other than home care administration if that's all you have to offer.

The trick, of course, is making sure the person you are hiring and the job you are trying to fill are a good match.

Sue Romero, owner of Englewood, CO-based Susan Romero Consulting, advises would-be hirers to sit down with their staff and take stock of a position and the skills needed to succeed in it. Together, the "hiring team" should formulate a list of minimum skills that a successful applicant must have.

For example, if you're looking to hire someone as a home infusion therapist, the person should be able to demonstrate the ability to insert IVs and draw blood. For an office position, you may need to specify that the applicant should be able to type at least 80 words a minute and deal with multiple phone lines.

Those are the "can" skills, says Romero, and are the easiest to determine because they can be "pulled off a resume and clarified with technical questions in an interview."

It's the "will" skills that are harder to determine, notes Romero. "Will the person do the job? Does he or she have the right attitude for the job? These are the questions you need to be considering. You want to determine the success criteria of someone who already is successful in that job. What are the soft skills [an employee has that makes him or her successful]?"

Romero points to attributes such as a positive attitude, demonstrated initiative, and the ability to cope with on-the-job stress as "will" skills. Good indicators of whether a person will fit into the home care field are whether the applicant can handle unruly patients and whether the applicant will show initiative to take on work outside the immediate job description.

The right questions

It's important to determine the "will" skills in advance of an interview. "Remember that past behavior is an indicator for future performance," Romero says. "The interviewer will want to identify questions in advance that will elicit how the applicant reacted to certain situations in the previous job."

Romero uses an angry patient as an example. An ineffective method of determining whether a person will be able to cope with an irritated patient is to ask, "What would you do if your patient got angry with you?" Most people know enough to give at least a textbook answer. A better, more effective tool is to ask the applicant to describe how she handled an angry patient in a previous job.

"You are looking for situational success

stories," says Romero. "You want to ask open-ended questions. You want [applicants] to tell you about a situation, to explain something. And get them to elaborate on why they responded as they did. It's so important to interview people toward the success criteria that you and your team decided on — the ones that you decided were important for your organization."

"If the person wants two weeks in Tahiti and a brass band escorting him to the airport, he's over the top. You want someone who gets recognition out of doing the job and would rather that recognition be private than public. This is a person who is close to self-actualization with respect to the job."

Romero cautions that the quantity of success criteria isn't the issue; rather, quality is. "You don't need a lot — maybe just three or four — but you want them to match the office and job culture."

Asking questions in today's litigious society can be intimidating for interviewers. How do you get the information you want and need without crossing any boundaries? **Henry Wolford**, owner of Wolford & Associates, a management consultant firm in Irvine, CA, says, "You're OK as long as you stay with job-focused questions. For example, 'Where you're working now, if you were in charge, what would you change?' You want to elicit from them the things they'd like to change and see if it fits in with your agency."

He also notes that it's important to ask skill-specific questions. If you are looking for someone who gets the greatest satisfaction from a job well done, ask the potential hire how she would like to be rewarded if she were to win a competition.

"If the person wants two weeks in Tahiti and a brass band escorting him to the airport, he's over the top," he says. "You want someone who gets recognition out of doing the job and would rather that recognition be private than public. This is a person who is close to self-actualization with respect to the job."

Wolford, like Romero, says hirers should start with the attitudinal skills and go from there, within reason. "The other things can always be developed," he notes.

When the applicant arrives, Romero advises looking for nonverbal cues to augment the person's responses. However, she encourages interviewers to carefully probe what they perceive as negative nonverbal cues, "so you don't make a wrong assumption."

As an example, Romero talks about the potential hire who sits in front of you with arms crossed. "If you're talking about a conflict in a previous job and she closes her body off, you might want to ask a 'feeling' question," Romero says. "Ask how she felt in that situation and get her to talk about it. Maybe she was uncomfortable and had problems dealing with it, or maybe she's just nervous and will loosen up. Or maybe she's just cold."

Romero says one interview is sufficient time to get to know the candidate, but she strongly recommends getting the person's potential supervisor to conduct an interview as well. Furthermore, she advises "having a peer interview with someone from another department but with whom the potential hire would be working. You want to get an evaluation of how the person will fit into the organization from a variety of people."

Drawing other employees into the interview process not only gives you a better rounded opinion of the job candidate, but does double duty in terms of getting your employees to buy into the job selection process. "[Employees] feel that they have some ownership in the selection process. They helped bring the person in so they are more likely to act as a mentor and help the person become successful in the new job."

According to Romero, everyone in the interviewing process should have some input. It's important, though, that the candidate be evaluated objectively according to the pre-determined success criteria. "When the interview is subjective, you are comparing the candidates to one another. You need to keep going back to the criteria and objectively look at it and evaluate each candidate toward that end," she notes. "You can even weight the criteria if it makes it easier."

After the hiring

There's more to keeping an employee than finding someone who is not only capable but willing to do the job. Wolford points out that "when you have unemployment rates as low as we do, you find not only that some people who shouldn't have jobs have them, but competitors are throwing lures into your organization to pull good employees away." How do you stop what Wolford calls "fishing in my employee pool?"

The Heave-ho Thumb

The disciplinary action process boils down to these five steps:

1. When an employee needs disciplinary action, give him a verbal warning and pull in your pinkie finger.
2. If the employee repeats the behavior or fails to improve, issue a written warning and pull in the ring finger.
3. If the behavior continues, issue another written warning. This time, pull in your middle finger.
4. If problems continue, give the final warning and pull in your index finger.
5. What you're left with is the heave-ho thumb. (The exceptions to the heave-ho thumb rule are an abusive or threatening employee — who should be dealt with more severely, according to company policy — and unions. In the case of a union, Wolford points out that there is a contractually specified process to be followed.)

Source: Henry Wolford, Wolford & Associates, Irvine, CA.

First, an employer needs to be aware of what keeps people at a company. There are basic physiological needs that must be met, and the higher people feel they rank on your "valued" scale, he says, the less likely they are to be pulled away to another firm.

First, Wolford says, are the basic needs of food and shelter. If you have an employee to whom you aren't paying a living wage, who can't afford a table, let alone to put food on it, he "will think of nothing else than getting a better job with more money. He will be gone the first chance he gets," he warns. "If you're not paying competitive wages, you'll always be behind the eight ball."

Feeling safe and secure

Once the basic needs have been met, there is the issue of safety. This goes beyond the driver whose truck is kept in good working order or the nurse who is given safeguards to prevent against bloodborne pathogens. Job security plays a large role, too. "If employees are forced to work in poor sanitary conditions or deal with out-of-control management, they won't be lured away by more money. But if someone comes to them who has been in business for 100 years and has a stable company, they feel they will be safer at this other company and they will go there," says Wolford.

Belonging is another critical factor in keeping an employee loyal. It's a matter of whether the employee feels at home, explains Wolford. "In a situation where safety is taken care of, does the team consider me to be a part of it?" Closely related are esteem needs, he says. "It goes beyond feeling like part of the family. You can have a brother or sister, but if the other sibling is always being praised then there isn't that feeling of esteem that comes from being part of a family." This form of recognition, he says, can be doled out through rewards and commendations, but a simple pat on the back and a positive word is often enough.

Finally, there is the idea of self-actualization, explains Wolford. "This is when you have a person doing what he was born to do. If an employee has that general sense of self-worth, [no one can] steal him away."

When things go wrong

Both Romero and Wolford agree that a progressive discipline system is a must for any company. This system should go hand in hand with documentation so that in the event a disgruntled former employee comes back with a lawsuit, you will be able to prove why the person was let go, and the steps and changes that person was given to turn herself around.

Wolford likens the firing process to something he calls the "heave-ho thumb," a tool not to be whipped out at the first mistake or sign of trouble, he cautions. Still, when poor work habits or disciplinary problems have escalated beyond the acceptable levels, you can put the "heave-ho thumb" into action in a matter of five simple steps including verbal and written warnings. **(See box, above left.)**

He points out that these five steps are not written in stone. People can rectify behavior for some time and then begin their slide back down the slippery slope. "A number of things can cause a person to go bad: drugs, personal trauma," he says. "The trick is to use progressive discipline as a coaching tool. The person might respond to the

(Continued on page 105)

Coping with Depression: What You Need to Know

Major depressive disorder — often referred to as depression — is a common illness that can affect anyone. About one in 20 Americans (over 11 million people) get depressed every year. Depression affects twice as many women as men. Depression is not just feeling "blue" or "down in the dumps." It is more than being sad or feeling grief after a loss. Depression is a medical disorder (just like diabetes, high blood pressure, or heart disease) that day after day affects your thoughts, feelings, physical health, and behaviors. Depression may be caused by many sources, including family history and genetics, other general medical illnesses, certain medications, illegal drugs or alcohol, and other psychiatric conditions. Certain life conditions, such as extreme stress or grief, may bring on a depression or prevent a full recovery. In some people, depression occurs even when life is going well. Depression is not your fault. It is not a weakness. It is a medical illness. Depression is treatable.

CAUSES OF DEPRESSION

Major depressive disorder is not caused by any one factor. It is probably caused by a combination of biological, genetic, psychological, and other factors. Certain life conditions (such as extreme stress or grief) may bring out a natural psychological or biological tendency toward depression. In some people, depression occurs even when life is going well. Drinking too much alcohol or using drugs can sometimes cause depression. When drug and alcohol use is stopped, the depression usually goes away. Talk to your health care provider if you have a problem with drugs or alcohol. It can be treated. Remember, major depressive disorder is not caused by personal weakness, laziness, or lack of willpower. It is a medical illness that can be treated.

DIAGNOSING DEPRESSION

Before depression can be treated, it must be accurately diagnosed. Your health care provider will ask about symptoms, general health, and family history of general medical health and mental disorders. You also will be given a physical examination and undergo some basic laboratory tests.

HOW WILL I KNOW IF I AM DEPRESSED?

People who have major depressive disorder have a number of symptoms nearly every day, all day, for at least two weeks. The symptoms always include at least one of the following:

- ☐ Loss of interest in things you used to enjoy, including sex.*
- ☐ Feeling sad, blue, or down in the dumps.*
- ☐ Feeling slowed down or feeling restless and unable to sit still.
- ☐ Feeling worthless or guilty.
- ☐ Changes in appetite or weight loss or gain.
- ☐ Thoughts of death or suicide, suicide attempts.
- ☐ Problems concentrating, thinking, remembering, or making decisions.
- ☐ Trouble sleeping or sleeping too much.
- ☐ Loss of energy or feeling tired all the time.

Other symptoms include:

- ☐ Headaches.
- ☐ Other aches and pains.
- ☐ Digestive problems.
- ☐ Sexual problems.
- ☐ Feelings of pessimism or hopelessness.
- ☐ Being anxious or worried.

If you have had five or more of the symptoms including at least one of the symptoms marked with an asterisk (*) for at least two weeks, you may have major depressive disorder. See your health care provider for diagnosis. Sometimes a few symptoms can go on to become major depressive disorder. Other forms of depression are milder, but persistent or chronic. Chronic symptoms of depression also need treatment.

ANOTHER FORM OF DEPRESSION

Some people with depression have well-defined mood cycles. They have terrible "lows" (depression) and inappropriate "highs" (mania) that can last from several days to months. In between the highs and lows, they feel completely normal. This condition is called bipolar disorder or manic-depressive disorder. Bipolar disorder affects about one in 100 people. Just as eye or hair color are inherited, bipolar illness in most cases is inherited. It can also be caused by other general medical problems, such as head injury, or neurologic or other general medical conditions. Use this list to learn the symptoms of mania and to check off any you might have.

- ☐ Feeling unusually "high," euphoric, or irritable.*
- ☐ Needing less sleep.
- ☐ Talking a lot or feeling that you can't stop talking.
- ☐ Being easily distracted.
- ☐ Having lots of ideas go through your head very quickly at one time.
- ☐ Doing things that feel good but have bad effects (spending too much money, excessive sexual activity, foolish business investments).
- ☐ Having feelings of greatness.

☐ Making lots of plans for activities (at work, school, socially, or sexually) or feeling that you have to keep moving.

If you have had four of these symptoms at one time for at least one week, including the first symptom marked with an asterisk (*), you may have had a manic episode. Tell your health care provider about these episodes. There are effective treatments for this form of depression.

WHAT SHOULD I DO IF I HAVE THE SYMPTOMS?

Too often people do not get help for their depression because they don't recognize the symptoms, have trouble asking for help, blame themselves, or don't know that treatments are available. Family practitioners, clinics, or HMOs are often the first places that people go for help. Those health care providers will help you find out if there is a physical cause for your depression, treat the depression, and refer you to a mental health specialist for further evaluation and treatment. If you do not have a regular health care provider, contact your local health department, community mental health clinic, or hospital. University medical centers also provide treatment for depression.

WHAT TYPE OF TREATMENT WILL I GET?

The major treatments for depression are antidepressant medicine, psychotherapy, and antidepressant medicine combined with psychotherapy.

HOW WILL TREATMENT HELP ME?

Treatment reduces the pain and suffering of depression. Successful treatment removes all of the symptoms of depression and returns you to your normal life. The earlier you get treatment for your depression, the sooner you will begin to feel better. As with other medical illnesses, the longer you have the depression before you seek treatment, the more difficult it can be to treat. Most people who are treated for depression feel better and return to daily activities in several weeks. Because it takes several weeks for treatment to work fully, it is important to get treatment early before your depression gets worse. As with any medical condition, you may have to try one or two treatments before finding the best one. It is important not to get discouraged if the first treatment does not work. In almost every case, there is a treatment for the depression that will work for you.

WHO SHOULD SEE A MENTAL HEALTH SPECIALIST?

Many people with depression can be treated successfully by their general health care provider. However, some people need specialized treatment because the first treatment does not work, because they need a combination of treatments, or because the depression is severe or it lasts a long time. Many times, a second opinion or consultation is all that is needed. If the mental health specialist provides treatment, it is most often on an outpatient basis (not in the hospital).

PEOPLE WHO TREAT DEPRESSION

The following health care providers can treat depression:

- **General health care providers**
  - — Physician: A medical health care provider who has some training in treating mental or psychiatric disorders.
  - — Physician assistant: An individual with medical training and some training in treating mental or psychiatric disorders.
  - — Nurse practitioner: A registered nurse with additional nursing training and some training in treating mental or psychiatric disorders.

The health care providers listed above can refer you to one of the health care providers specializing in mental health listed below:

- **Mental health specialists**
  - — Psychiatrist: A physician who specializes in the diagnosis and treatment of mental or psychiatric disorders.
  - — Psychologist: A person with a doctoral degree (PhD or PsyD) in psychology and training in counseling, psychotherapy, and psychological testing.
  - — Social worker: A person with a degree in social work. A social worker with a master's degree, often has specialized training in counseling.
  - — Psychiatric nurse specialist: A registered nurse, usually with a master's degree in psychiatric nursing, who specializes in treating mental or psychiatric disorders.

(Note: The term "health care provider" is used to describe any general health care provider or mental health specialist listed above.)

PREPARING FOR YOUR FIRST VISIT

You can help your health care provider diagnose and treat you by giving as much information as possible about your health. General medical history, physical examination, and basic laboratory tests can help your doctor learn if a general medical disorder is the cause of your depression. About 10% to 15% of all depressions are caused by general medical illness (such as thyroid disease, cancers, or neurologic diseases) or medicines. Once these conditions are treated, the depression usually will go away. If you have a general medical illness and feel depressed, it is important to tell your clinician. Sometimes depression is a reaction

to a life-threatening condition. Getting help during a difficult time in your life may help you to cope with your general medical illness. An episode of depression begins when symptoms of depression start and ends when the symptoms are completely gone. If your first episode of major depressive disorder occurred after age 40, a thorough medical evaluation is important.

SEVERE? MODERATE? MILD?

For each type of depression there is a treatment that works best. You should talk with your clinician about your depression and the best treatment for you. In general:

- **Severe depression** is present when people have nearly all of the symptoms of depression, and the depression almost always keeps them from doing their regular day-to-day activities.
- **Moderate depression** is present when a people have many symptoms of depression that often keep them from doing activities that they need to do.
- **Mild depression** is present when people have some of the symptoms of depression and it takes extra effort to do the activities they need to do.

TREATING DEPRESSION

Depression is usually treated in two steps.

- **Acute treatment.** The aim of acute treatment is to remove the symptoms of depression until you feel well.
- **Continuation treatment** (continuing the treatment for some time even after you are well) is important because it keeps the episode of depression from coming back. Depending on the type of treatment you have, your chances of staying well for six months on continuation treatment are extremely good.

In cases of recurrent depression (three or more episodes), a third treatment, called maintenance treatment, is used. In maintenance treatment, you stay on the treatment for a longer period of time. The purpose of maintenance treatment is to prevent a recurrence of the depression. With maintenance treatment, the chances of staying well are also extremely good.

HOW TREATMENT WORKS

Treatment for depression works gradually over several weeks. With medicine, most people see some benefits by three or four weeks; with psychotherapy alone, it can sometimes take longer. There is a very good chance that your first treatment will work well for you. If treatment is not effective after a certain amount of time, it can be changed or adjusted. There are other treatments to try, and your chances for effective treatment are still very good.

CHOOSING A TREATMENT

You and your clinician can work together to find the best treatment for you. In choosing which acute treatment is best for you, you should weigh the chances of getting better against the chances of possible harm, as well as the expense of the treatment offered and the costs of the depression (time from work, effect on personal relationships, etc.). Here are some questions you may want to ask when discussing treatment:

- What are the chances of getting better with this treatment?
- What are the possible risks and side effects of treatment?
- What are the costs of treatment?

WHY DEPRESSION MUST BE TREATED

Even though some people are able to struggle through an episode of depression without treatment, most find that it is much easier to get some help for their pain and suffering. It is important to get treatment for your depression because:

- Early treatment may help to keep the depression from becoming more severe, or chronic.
- Thoughts of suicide are common in depression, and the risk of suicide is increased when patients are not treated and the depression recurs. When depression is successfully treated, the thoughts of suicide will go away.
- Major depressive disorder usually comes in episodes lasting six to 12 months. In between the episodes, most people feel better or are completely well (without symptoms).
- Between episodes, about one out of four people with depression will still have some symptoms and trouble doing their daily activities. These people, if not treated, have a greater chance of having another episode of depression.
- Treatment can prevent recurrences of depression. The more episodes of depression you have had, the greater the chance that you will have another. About half of the people who have one episode of depression will have a second. Without treatment, after two episodes, the chances of having a third episode (recurrent depression) are even greater. After three episodes, the chances of having a fourth are 90%.

IF YOU HAVE CONCERNS ABOUT YOUR TREATMENT

If at any time you are worried about your treatment or you don't think that things are going well, tell someone about your concerns. You can talk to your clinician, ask for a second opinion, or talk to someone you trust. Health care providers and mental health specialists are interested in your concerns and will help you. This may mean getting a second opinion or even finding another clinician.

TAKING CARE OF YOURSELF

When you are depressed, it is important to:

- Pace yourself. Do not expect to do all of the things you were able to do in the past. Set a schedule that is realistic for you.
- Remember that negative thinking (blaming yourself, feeling hopeless, expecting failure, and other such thoughts) is part of a depression. As the depression lifts, the negative thinking will go away, too.
- Avoid making major life decisions during a depression. If you must make a major decision about your life, ask your clinician or someone you trust to help you.
- Avoid drugs and alcohol. Research shows that drinking too much alcohol and use of drugs can cause or worsen a depression. It can also lower the effectiveness of antidepressant medicines or cause dangerous side effects.
- Understand that it took time for the depression to develop and it will take time for it to go away.
- There is some evidence in milder cases of depression that exercise can be helpful in reducing symptoms.

You can get information about other ways to help yourself during episodes of depression **from the organizations listed on p. 105.** Your public library also has books about depression.

TALKING TO OTHERS ABOUT DEPRESSION

When people have major depressive disorder they often have difficulty at work, at school, and with family. With treatment, almost everyone returns to their normal life. Some jobs (where the safety of others is involved) require that you report treatment for medical illnesses (including depression). You and your clinician should talk about how and what to tell your supervisors, teachers, or friends.

YOUR FAMILY AND FRIENDS

Ask your friends for their support, understanding, and patience during your depression. It may be helpful to talk to your friends about your feelings and treatment, and to spend time with friends in social activities. Keep the names and phone numbers of people that you can talk to and ask to help you. Some people find it difficult, almost a burden, to interact with people during this time. If you feel this way, do whatever lifts your mood and makes you feel better. If you find yourself alone and unable to interact with others, tell your clinician. Many people find that family members are very supportive and helpful, especially those who have received education about depression.

YOUR CHILDREN

Parents often worry about whether depression is inherited. Most children of people with depression will not get this illness. Overall, research shows that only about one in seven children with one parent who has had several episodes of major depressive disorder or bipolar disorder will develop major depressive disorder. Another one in seven children with one parent who has bipolar disorder will develop bipolar disorder. If you have questions about your child's mental health, talk to a clinician.

FINDING HELP

Depression is a serious illness, but it can be successfully treated with the help of a health professional. If you think you are depressed, there are many places to get the help you need. You can:

- Call your family physician or other health care provider.
- Call your local health department, community mental health center, hospital, or clinic. They can help you or tell you where else you can go for help.
- Contact a local university medical center (many have special programs for the treatment of depression).
- Contact one of the national mental health groups. **(See box, p. 105.)** They can refer you to a health professional where you live. They can also give you more information about depression, provide you with books and pamphlets, and tell you about support groups where you live.

ADDITIONAL RESOURCES

In addition to the organizations listed on p. 105, the National Institute of Mental Health has free publications about depression for persons of all ages, including teenagers and the elderly. Write: Depression Awareness, Recognition, and Treatment (D/ART) Program, Department GL, Room 10-85, 5600 Fishers Lane, Rockville, MD 20857. Telephone: (80) 421-4211.

FOR MORE INFORMATION

The information in this article was taken from the *Clinical Practice Guideline on Depression in Primary Care*, Vol. 1 and 2. The guideline was developed by a private, non-federal expert panel of physicians, psychologists, psychiatrists, social workers, nurses, counselors, and people who have depression. The development of the guideline was sponsored by the Agency for Healthcare Research and Quality (AHRQ) of the U.S. Public Health Service.

To receive additional copies of this article in booklet form or the depression guidelines, call (800) 358-9295. Or write:

AHRQ Publications
Clearinghouse
P.O. Box 8547
Silver Spring, MD 20907

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first warning and improve, and then you go back to square one. It's a two-way street. A person can go halfway down the path and then come back. Some people improve permanently; some people improve temporarily; and some people you will have to let go."

The progressive discipline system may be on a longer timetable for more senior employees than for newer ones, says Romero, but it's important that in either case you inform the employee that you are documenting your performance concerns and that failure to perform the required changes could lead to termination.

Before you take that step, Romero suggests you "step back and figure out what happened. 'Did I communicate my expectations? Did I provide adequate training? Can he handle the technical skills?' If you have given someone a fair shot, then you need to move forward quickly and with discipline."

Mental Health Resources

National Alliance for the Mentally Ill
2101 Wilson Blvd., Suite 302
Arlington, VA 22201
Telephone: (800) 950-6264
Web site: www.nami.org

National Depressive and Manic Depressive Association
53 W. Jackson Blvd. Room 618
Chicago, IL 60604
Telephone: (800) 82-NDMDA
Web site: www.ndmda.org

National Mental Health Association
National Mental Health Information Center
1021 Prince St.
Alexandria, VA 23314-2971
Telephone: (800) 969-6642
Web site: www.nmha.org

National Foundation for Depressive Illness Inc.
P.O. Box 2257
New York, NY 20116-2257
Telephone: (800) 248-4344
Web site: www.depression.org

(For more information on depression and related conditions, see patient insert on depression, pp. 101-104.)

"You want to document specific facts and occurrences and dates, and if it's only a verbal warning, you want to make a note of what was said, and the date and time. This way the person you're firing can hardly say she didn't know it was coming. Anyone with $10 and a [phone number of an attorney] can file a lawsuit," Wolford points out. "People get sued because they go around year after year writing up perfunctory performance reviews. They are putting up with a lot of garbage and then one day they blow up and fire the employee. Then, when [employers] go back to look into the files, there are only glowing reviews."

Romero has found in her experience that sometimes the person about to be fired is relieved. "I've heard a few people say, 'Thanks. I know this job isn't for me, and I'd like to move on,'" she says.

Firing an employee can be stressful for everyone involved. Other employees are not oblivious to the signs of trouble, and the stress only escalates when the process is drawn out. "Too many times, managers are so hesitant and self-blaming that they spend more time beating themselves up for employee problems than dealing with [them]. It's important that the employee in question comes through the process with her self-esteem intact, so you want to move quickly, but fairly, through the process," she says.

Romero encourages all managers to conduct an exit interview. If they feel too uncomfortable to do it themselves, she urges getting someone in human resources or even an outside consultant to do it. "Oftentimes, the stated reason a person is leaving is not the real one. Once you get to the root of the problem, then you can start altering your selection criteria to adjust for this," she says. "Maybe you aren't interviewing for the right criteria and, therefore, [employees] aren't fitting into your company culture.

"There will be turnover. It's guaranteed," she continues. "But you can try to minimize some of the interviewing stress and better your chances to hire right the first time."

[For more information, contact:

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NEWS BRIEFS

What's the latest in mergers and acquisitions?

HCA — The Healthcare Co. in Nashville, TN, has sold two of its hospitals to Florida-based companies. The first, 278-bed Miami Heart Institute and Medical Center, was sold to Miami Beach-based Mount Sinai Medical Center for $75 million.

The second was sold to Adventist Health System in Winter Park, which purchased the 339-bed Winter Park Memorial for $62.2 million. Winter Park Memorial has been owned since 1994 by a joint venture of HCA and not-for-profit Winter Park Health Foundation. It is possible that with profits from the sale to Adventist, HCA turned around and bought the foundation's interest in the hospital for $47.2 million.

University news

In university news, the clinical operations of Georgetown University Medical Center in Washington, DC, have been acquired by MedStar Health in Columbia, MD. In exchange for $95 million and the assumption of Georgetown's $80 million debt, MedStar was given a long-term lease on the Georgetown clinical enterprises, which include the 535-bed hospital, a community physician network, and a faculty practice, along with two medical office buildings and a parking lot.

Duke University Health System in Durham, NC, has also undergone some changes and has announced a definitive agreement to sell its five-year-old managed-care subsidiary, WellPath Community Health Plans, to Coventry Health Care in Bethesda, MD, for $25.5 million. WellPath, which has about 152,000 members and annual premium revenue of about $230 million, lost $12.8 million in the fiscal year ended June 30, 1999, and $4.6 million through the first eight months of fiscal 2000.

Twenty-seven-bed Randolph County Hospital and Health Services in Winchester, IN, has been purchased by Central Indiana Health System (CIHS) in Indianapolis and renamed St. Vincent Randolph Hospital.

Indianapolis-based CIHS is the regional holding company of Ascension Health in St. Louis. CIHS' flagship hospital, the 621-bed St. Vincent Hospitals and Health Services, had been managing the Randolph Country hospital for the past 18 months.

St. Joseph sold to HMA

Catholic Health Initiatives in Denver has sold its Lancaster, PA-based hospital, the 256-bed St. Joseph Hospital, to Naples, FL-based Health Management Associates (HMA) for an undisclosed sum. The sale makes HMA, which also owns the 116-bed Community Hospital of Lancaster, the owner of two of Lancaster's three hospitals and puts it in control of more than 43% of the city's acute-care beds.

The bankrupt company Charter Behavioral Health Systems in Alpharetta, GA, has announced the sale of its 66-bed Charter Louisville (KY) Behavioral Health System to United Medical Corp., which is based in Windermere, FL. Although the terms of the deal have not been disclosed, United expects to receive approval from the U.S. Bankruptcy Court. Among United's other holdings are 94-bed Ten Broeck Hospital and two psychiatric hospitals, all in Louisville.

Regional Medical Center and University of Tennessee Bowld Hospital, both in Memphis with 383 and 111 beds, respectively, have approved a merger to create a single facility.

If the merger goes through, the consolidated hospital is expected to be operational within three years. It would be housed at the downtown

COMING IN FUTURE MONTHS

- Coping with depression (in Spanish)
- A legislative look back
- Breaking their fall
- When caregivers say no
- Winter preparedness

Memphis campus of Baptist Memorial Hospital, whose owner, Baptist Memorial Health Care Corp., plans to move out of the facility and shift services to its east Memphis campus and other hospitals in the Memphis area. ▼

DC Medicare providers say no new members

As of Aug. 8, residents of Maryland, Virginia, and Washington, DC, became ineligible to join Oakland, CA-based Kaiser Permanente's Medicare+Choice plan.

Permanente, the nation's largest Medicare HMO provider, made this decision based on the fear that it would not be able to handle the flood of seniors in the area who are being dropped by other HMOs. Three HMOs in the Washington-Baltimore area — CareFirst Blue Cross and Blue Shield, Cigna Corp., and United Healthcare Corp. — announced that they will pull out of the Medicare program by the end of the year, leaving a combined 50,000 beneficiaries looking for new coverage and leaving Kaiser the only Medicare HMO in the area. ▼

2001 Medicare physician fee schedule released

The Health Care Financing Administration (HCFA) has released the proposed 2001 Medicare physician fee schedule which would make several changes to physicians' Medicare payments, among them a refinement of the resource-based relative value units used in the payment formula.

Cardiac surgeons, neurosurgeons, ophthalmologists, and thoracic surgeons can expect to see a small decrease in their Medicare payments, while gastroenterologists, nephrologists, radiologists, and radiation oncologists can look forward to a slight increase.

General practitioners and plastic surgeons would see virtually no change. The final fee schedule will be released on or before Nov. 1, and will go into effect on the first of next year. For more information or to see the proposed schedule, visit www.hcfa.gov. ▼

Alzheimer's may be related to high-fat diet

Researchers at Case Western Reserve University School of Medicine and University Hospitals of Cleveland have found a possible link between a person's likelihood of developing Alzheimer's disease and a high-fat diet during early and mid-adulthood. This link is strengthened in people who carry a gene variant called the ApoE-e4 allele, or apolipoprotein E, a key protein involved in the transport and disposal of cholesterol.

The group's findings were released at the World Alzheimer Congress 2000 in Washington, DC, in June.

The study examined foods eaten by 304 men and women (72 with Alzheimer's disease and 232

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healthy people), and found that of people ages 40-59 with the ApoE-e4 allele, those who consumed the highest fat diets were seven times more likely to develop Alzheimer's disease than people with the gene marker who ate lower fat diets. People with the gene marker whose consumption of fat was less than 35% of their calories had a fourfold increased risk of developing the disease compared with those with no e4 and lower-fat diets. In contrast, people with the ApoE-e4 allele who had diets in which more than 40% of the calories came from fat had a 29-fold increased risk of developing Alzheimer's disease compared with people who ate high-fat diets and did not have the e4 allelle.

For people ages 60 and older, those who were ApoE-e4 carriers and consumed a similar high-fat diet had a 12-fold higher risk of developing Alzheimer's than those who ate a high-fat diet and did not have the e4. In people ages 20-39, the combination of ApoE-e4 and a diet with more than 40% of calories from fat raised the risk of Alzheimer's by almost 23 times compared with those with high-fat diets and no ApoE-e4. ▼

HFMA announces fall home health seminar

The Healthcare Financial Management Association (HFMA) has released the dates for its Fall 2000 seminar series. Among the topics: "Compliance, Coverage and Cost Reporting for Home Health Agencies Under the New Prospective Payment System."

The seminar will be offered October 18-19 in New Orleans. Register on-line and save $50: www.hfma.org. For more information, call (800) 252-HFMA (4362). ▼

AAH welcomes new board of directors

The newly formed American Association for Homecare (AAH) has announced its inaugural 2000 board of directors. The executive committee of the incoming board consists of:

- chairman — Donald White, Associated Healthcare Systems;
- vice chairman — David R. Savitsky, Staff Builders;
- secretary — Joel C. Mills, Advanced Home Care;
- treasurer — Lawrence Higby, Apria Healthcare Group;
- immediate past chairman — Mario LaCute, Seeley Medical. ■

CE objectives

After reading each issue of *Hospital Home Health*, the reader will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that the profession encounters in home care and integrate them into daily practices. ■