

Review & Commentary on Health Policy Issues from a Rural Perspective - March 1st, 2000

Large Urban Hospitals Double Down Rurals

From "Panel May Support Doubling Of DRGs" by Jonathan Gardner in *Modern Healthcare*, 1/31/00:

"In a move that could shift billions of Medicare dollars to teaching hospitals at the expense of small and rural facilities, a congressional panel may recommend that Medicare nearly double the number of DRGs it uses to pay hospitals for inpatient care."

"The current system of 491 DRGs, according to the Medicare Payment Advisory Commission, is that it does not adequately reflect differences in the severity of patients' illnesses that occur within a single DRG, resulting in overpayments to some providers and underpayments to others. Using as many as 900 DRGs, however, would make the payment system more sensitive to those differences."

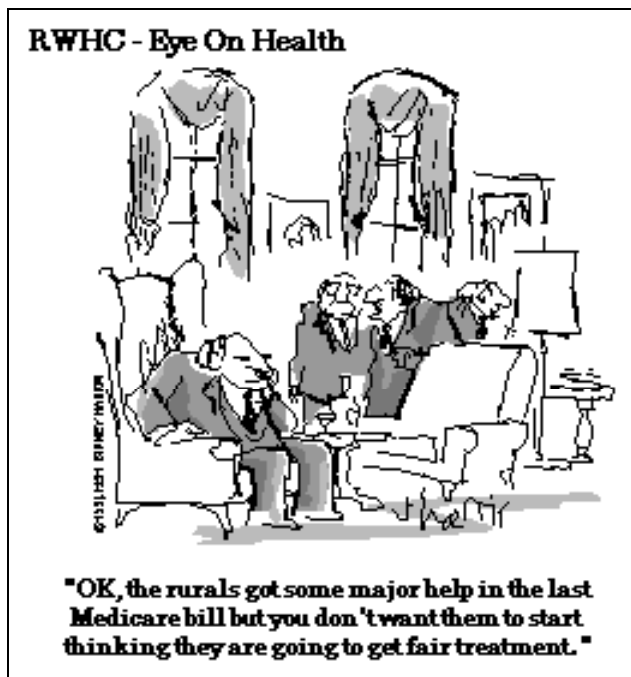
"Such a proposal would shift billions of dollars from hospitals that treat simple cases, such as small and rural facilities, to hospitals that treat highly complex cases, such as teaching facilities. Under the best scenario, rural hospitals as a whole would lose 1.5% of their total Medicare payments. Under the worst, they would lose 2.7%, and those that have fewer than 50 beds and receive no federal rural-health subsidies lose 5.1%."

"Teaching hospitals would gain between 0.2% and 0.5% under three scenarios outlined by MedPAC analysts."

"We are not hosts to our patients, we are guests in their lives." Don Berwick, M.D. 12/9/99
RWHC Eye On Health, 2/23/00

"MedPAC is aiming to make inpatient payments more accurate. Now each DRG encompasses a wide range of patients, for which hospitals receive roughly the same fee regardless of the severity of the patients' conditions."

" 'Something that has too much variance within a class overcompensates some and under-compensates others,' said MedPAC Chairwoman Gail Wilensky."



"The increase in the number of DRGs would allow for payments that are closer to hospitals' costs for more-severe and less-severe cases. As a result, the hospitals that tend to treat sicker patients, such as urban teaching facilities, would see increased payments, while those treating less-acute patients, such as smaller rural hospitals, would see decreased payments."

"Mary Wakefield, a MedPAC member and a rural health policy analyst at George Mason University raised concerns about the redistributive effects."

" 'I think there are some categories of providers that need some protection,' Wakefield said. 'We need to say first, do no harm to those providers receiving those special protections.' "

"National hospital groups are not commenting, although representatives said privately that the redistribution makes the proposal a politically tough sell at a time when rural providers are the cause celebre of the hospital industry's efforts to alleviate payment restraints imposed by the Balanced Budget Act of 1997."

“The relief package passed last fall increased payments to rural hospitals by \$800 million over five years and payments to teaching hospitals by \$700 million over five years.”

“Rural hospital representatives said they hadn’t seen MedPAC’s proposals and weren’t prepared to comment.”

“MedPAC is expected to recommend ways to refine payments in a report to be released in June. The report will address how to minimize the reimbursement shift caused by expanding the number of DRGs.”

Medicare Redistribution Must Go Both Ways

From “Rural Provider Group Seeks Payment Relief” by Jonathan Gardner in *Modern Healthcare*, 2/14/00:

“A week after hospital executives appealed for \$25 billion more in Medicare payments over the next five years, rural providers last week went to Capitol Hill asking Congress to make a series of smaller adjustments to Medicare payment policies. The National Rural Health Association asked Congress for an update in Medicare inpatient payments equal to a healthcare inflation index called to hospital ‘market-basket’ in the next two years. The NRHA represents hospitals, clinics and physicians.”

“The rural health association also wants Congress to alter the hospital ‘wage index’ used in part to adjust individual hospital payments based on the wage rates in different markets. The rural executives blame the wage index for lower margins in rural hospitals.”

“If congress follows through on that request, it could result in a redistribution of Medicare revenue from urban hospitals. The federal government often makes changes to Medicare reimbursement formulas on a ‘budget neutral’ basis, meaning the changes don’t increase or decrease total Medicare spending.”

Two Lobbies That Really Deserve Each Other

From “Drug and Insurance Companies Battle Over Medicare Benefits” by Robert Pear in *The New York Times*, 2/20/00:

“A fight between the pharmaceutical and insurance industries over how to expand Medicare to cover pre-

scription drugs is imperiling bipartisan efforts in Congress to offer drug benefits to the elderly this year. The dispute is being played out behind the scenes on Capitol Hill, as insurance lobbyists conduct briefings for Congressional aides to shoot down the ideas being floated by drug companies.”

“The disagreement creates political difficulties for Republican members of Congress, who have historically been close to both industries. It also complicates the work of Democrats, who have put prescription drugs high on their agenda for the year.”

“Drug companies, eager to avoid a big new government program, want insurance companies to offer drug coverage to Medicare beneficiaries, with federal subsidies to help low-income people pay the premiums. But insurance companies say they want nothing to do with such a venture, because they fear drug costs for the elderly will grow much faster than either premiums or the proposed federal subsidies. Insurers say the government will strictly control the premiums for such coverage, and they fear they will be blamed if a private drug-insurance plan fails to meet expectations.”

“For Congress to pass legislation over the objections of either industry would be difficult. Both have extensive networks of political contacts. Medicare finances health care for 39 million elderly or disabled people. It generally does not pay for drugs outside the hospital, even though drug therapy accounts for a rapidly growing share of all medical care.”



Vanishing HMOs Abandon Rural Residents

From "Vanishing HMOs Leave Rural Residents At Risk" by Maureen West in *The Arizona Republic*, 2/8/00:

"Seniors and the disabled are being stranded in Arizona's rural areas by evaporating HMO plans, leaving many unable to afford the drugs they need to treat their diseases and pain. While state and federal lawmakers scramble for an answer, many rural elderly are returning to urban areas so they can rejoin a health maintenance organization. Others can't afford the move or the higher urban living costs."

"Only a year ago, Arizona was a national model because of its numerous health-care options in rural areas. Today, seniors in only four of the state's 13 rural counties have access to an HMO."

"The Federal Health Care Financing Administration estimates that 30,000 Medicare beneficiaries in rural Arizona lost their HMO coverage this past year as five companies pulled out. Without an HMO Medicare program, many elderly and disabled people cannot afford ever-more-expensive prescriptions. Some are taking their medications half as often as prescribed to stretch out their supply. For many, that could mean greater health problems or premature death."

"Since December, the State Health Insurance Assistance Program has received 100 or more calls each day asking for information or help. 'Thirty to 40 percent of the callers are desperate,' said Martha Taylor, coordinator of the state office. 'They say, 'I have to sell my house or my car to pay for prescriptions.''"

"In Bullhead City, where Taylor recently talked about medical coverage, a small crowd was expected but more than 1,500 elderly showed up."

"... **but not with my money.** Many of the attendees at last week's American Hospital Association meeting in Washington support coverage for the uninsured-- just as long as they don't have to pay for it."

"We didn't get healthy seniors, but the sickest of the sick -- people in the middle of chemotherapy, seniors with limbs missing, those hooked up to oxygen tanks -- all wanting to know where they could turn for help," said Taylor, who wishes she had more answers. Ida Ramirez, 64, of Lake Havasu City, who has multiple sclerosis, would move to Maricopa County if she could. "But where could I afford to live there?" she asks."

"Ramirez moved to Lake Havasu City when her husband died and her income dropped. She lives in a mobile home that once was their weekend retreat. Now, it is all she can afford, and she has a loan on it."

"On advice from the state help program, Ramirez applied for a public assistance program through a pharmaceutical company that makes her MS drug affordable. Last week, she learned she was among the few applicants who were accepted. She can pay \$900 for a year's supply of the drug, which normally would cost almost \$11,000 a year."

"That leaves her with an additional \$162 in monthly prescriptions she can't afford. For now, she will take her cholesterol and thyroid pills every other day, and skip her pain pills and muscle relaxants."

The Governor's Rural Summit 3

Sign up for *TGRS3--Setting the Action Agenda for Rural Wisconsin's Future* to be held at Stoney Creek Inn and Northwoods Conference Center in Mosinee on Tuesday, May 2, 2000. The Summit will feature facilitated roundtable sessions to identify the top rural issues in Wisconsin, as well as opportunities to develop strategies to work on the issues together. Participation is limited to 160 persons; to reserve a slot, contact Kelly Haverkamp, Wisconsin Rural Partners, Inc. at (608)592-2550 or wirural@tds.net

"An estimated 14 percent of Arizonans are 65 and older. But in rural counties, the number is 25 percent. 'You are going to see a slowdown in the migration of seniors to rural areas,' said Bob Tippet, head of economic development for Lake Havasu City, where two of every five residents are over 55. It lost both its HMO providers last year."

"The Arizona Commerce Department last month began encouraging more retirees and senior-related industries to locate in rural areas. 'It used to be by moving to rural Arizona you could make your money go further,' said Cindy La Rue, director of the Commerce Department's Office of Senior Industries. 'This could change the profile of persons moving to rural Arizona -- only those who are healthier, wealthier and younger would be able to move there.'"

Not Exactly Walking The Talk

From "Outliers--Asides and Insides," *Modern Healthcare*, 2/7/00:

"... **but not with my money.** Many of the attendees at last week's American Hospital Association meeting in Washington support coverage for the uninsured-- just as long as they don't have to pay for it."

"One speaker, Rep. William Thomas (R-Calif.) asked audience members how many of them had em-

ployer-sponsored coverage. Almost everyone raised his or her hands.”

“Thomas then asked attendees to keep their hands raised if they would be willing to pay more for their coverage so other people could get coverage. Many people lowered their hands. That’s surprising, since the AHA supports expanded coverage for the uninsured.”

Employees To Get Health Plan Choice & Cost?

From “Companies Consider Letting Employees Handle Their Health-Benefits Decisions” by Ron Winslow and Carol Gentry, *The Wall Street Journal*, 2/8/00:

“After long relying on managed-care companies as their weapon against health costs, U.S. employers are considering a fundamental change in strategy: turning the fight over to their employees.”

“While most health-benefits decisions now are negotiated between companies and health plans, a growing number of employers are looking for ways to retreat from their middleman role and let workers make their own benefits decisions -- and bear more responsibility.”

“The idea is driven by a confluence of forces: the backlash against managed care, the popularity of 401(k) retirement plans, the rise of Web sites that help consumers make decisions -- plus a recent resurgence in health costs despite the efforts of managed care. Behind the trend, too, is a growing feeling that the nation’s vast health-care market won’t work with full accountability until patients themselves hold the purse strings. ‘Let the consumers be the gatekeepers,’ says the health-benefits director at Honeywell International Inc., Brian Marcotte. ‘Long term, it has to be the consumer who drives efficiencies.’ ”

“Putting employees in the driver’s seat won’t happen overnight. Policy makers and companies will have to wrestle with daunting questions on such issues as tax-code changes, shortcomings in data on quality of care, and affordable coverage for high-risk patients.”

“But some of the obstacles are wearing away. One that is fading is the long-held view that health-benefits decisions are just too complex to be left to consumers. In addition, it’s possible that Congress or a court ruling will expose employers to legal liability in malpractice cases, something that could spur some companies to look for an exit strategy from the health-benefits busi-

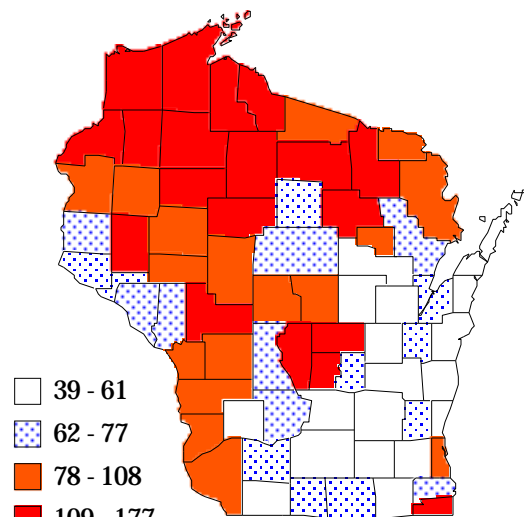
ness. The bottom line: Some employers have now embarked on an experiment that, while still in its early stages, is likely to change the health-care system as radically in the coming decade as managed care did in the last.”

“In one new strategy, employers provide a set amount of money for each employee’s health benefits, thus capping the company’s costs. Employees use the amount to purchase a health-insurance plan, picking from a wide menu ranging from no-frills managed care to a traditional fee-for-service plan. Those who want more-generous coverage than can be bought with the company contribution can pay the difference themselves. By analogy with pensions, this approach is known as a ‘defined contribution’ health-benefits system.”

“Not everyone applauds this trend, though. Some fear that employers just want to wash their hands of health benefits and push more costs onto employees. And even some supporters worry it could go too far. Kenneth Abramowitz, a Sanford C. Bernstein analyst who is an ardent advocate of consumer choice, blanches at what he calls the ‘Yellow Pages’ approach: telling an employee, ‘Here’s \$5,000 and the Yellow Pages. You figure it out.’ ”

“Moreover, a similar movement fizzled once before, says Charles Blanksteen, vice chairman of Active Health Management Inc., a Web-based company in

Rurals & Milwaukee Lead Uneven BadgerCare (CHIP) Enrollment



Percent of Expected Enrollment
as of 1/00, divided into quartiles
State Average = 80%

Data: WI Medicaid & Marshfield Clinic, 2/00
Graph: RWHC 2/00

New York. As a consultant in the 1980s, he designed defined-contribution systems for several companies. But health-care costs rose faster than company contributions and became too much to bear for lower-income employees, who eventually dropped their insurance. At that point, Mr. Blanksteen says, "The companies blinked -- and had to pony up more money."

"Employers on the leading edge of this movement say they have no intention of taking a cut-and-run policy."

"For one thing, with the labor market tight, employers are loath to tamper too much with their benefit programs. Xerox met a storm of employee protest after news reports suggested it was planning a Yellow Pages strategy. The company says it doesn't plan to change health benefits further until there is something that would offer employees more flexibility and more value."

"For another, many companies known for innovation in health-care purchasing remain convinced that their clout is crucial to changing the market, and they want to keep their hands in, not only to control costs, but also to pressure doctors and hospitals to improve the quality of care."

"The budding trend to let employees handle their health-care benefits just as they do their retirement money comes as consumers' role in their own health care is growing anyway. For instance, drug companies, to dodge managed care's attempts to curb use of expensive medicines, increasingly advertise directly to patients. And within managed care, employers have had to offer employees more choices because of resistance to restrictions." "Patients have a lot more to say about their health," says Ingersoll-Rand's Ms. Powers. "Whether we want it or not, this is how the market is going."

"Still, most people see only a gradual transition to greater consumer control -- perhaps over the next decade -- as policy makers, the market and employees themselves get used to the idea. One major hurdle is the tax code. Many experts believe that shifting the tax deduction for medical costs to employees from employers is a prerequisite for a fully consumer-driven system."

"Another legal issue could accelerate the idea: Legislation or a court decision that would allow employers to be sued over the consequences of their health-plan decisions. Congress is weighing such a measure, and a related issue is pending before the Supreme Court."

Child Booster Seat Tips & Talking Points

- Traffic crashes are the leading cause of death for children of every age from 6 to 14 years.
- Most kids riding in child safety seats are improperly restrained.
- Parents often don't realize they need to alter the type of child safety seats they use as children grow.
- When children outgrow convertible seats, at around 40 lbs., they should be restrained in booster seats until they are big enough to fit in an adult seat belt, at about 80 lbs. and 4'9" tall.
- A child under 80 lbs. is generally too small for an adult seat belt.
- The lap belt rides up over the stomach and the shoulder belt cuts across the neck.
- In a crash, this can cause critical or even fatal injuries.
- According to a NHTSA study, after age four, restraint use falls from 91 percent to 69 percent.
- Over 47 percent of fatally injured children ages four to seven are completely unrestrained.
- Only 6.1 percent of booster size children are estimated to be using a booster seat.
- Child safety seats -- including booster seats -- are very effective in saving children's lives during crashes.
- With so many child safety seats, seat belts, and vehicles on the market today, it can be very difficult to properly install a child safety seat.
- Parents should have their child safety seats inspected by a trained and certified technician in their community.

Call 1-800-424-9393 to find the name of your state's child passenger safety coordinator or visit:
<http://www.nhtsa.dot.gov/people/injury/childps/>

"Adding new liability for companies could prompt some to scuttle their health-benefits programs and send employees into the market to fend for themselves. Says Margaret O'Kane, head of a managed-care accrediting organization called the National Committee for Quality Assurance: 'If employers find themselves in the path of the trial lawyers, I think you can expect a massive bailout.'"

Consumers Will Use Data About Providers

From “Do Consumers Use Information to Choose a Health Care Provider System?” by Roger Feldman, Ph.D., in *RESEARCH BRIEF* of the University of Minnesota School of Public Health, 2/00:

“Accurate information about price and quality is essential for consumers to make informed choices in a managed competition framework. To help employees make choices, some employers are providing comparative information on health plans. This study reports on the use of information by employees in the Buyers Health Care Action Group (BHCAG), a purchasing coalition of two dozen employers in Minneapolis that offers a self-insured point-of-service plan to about 250,000 employees.”

“BHCAG contracts directly with multiple health care provider systems, each built around a network of primary care physicians (who can belong to only one system) and affiliated specialists. Care systems are grouped into three cost tiers, with the employee’s out-of-pocket premium based on the tier that includes his or her system. Care systems are paid according to a fee schedule based on each system’s bid for an employee of ‘baseline risk,’ with adjustment for the system’s actual enrollment mix.”

“Employees can move freely among cost tiers once a year, at ‘open enrollment.’ All BHCAG employers provide comparative information on health plans in the form of a *Performance Results Book* that reports the results of a consumer satisfaction survey. Most employers also provide additional types of information—such as kiosks, newsletters, internal communications, and educational sessions.”

“We found that use of employer-provided information is positively related to education and years of residence in the Twin Cities. Older and low-income workers were more likely to use information from advertisements. Certain information sources tend to be used together—most notably, information from the employer and information from friends.”

“Most previous research has found that employees do not trust information from their employer and do not rely on this information to make health care choices.

“Our study shows that this generalization is not always accurate. BHCAG employers appear to have created a program that motivates employees to use employer-provided information. The BHCAG approach emphasizes the *Performance Results Book* and other forms of communication. It is not clear whether the success of this approach depends on the other design features of the BHCAG system, including standardized benefits and an incentive for employees to choose low-cost care systems.”

Virtual Healthcare Becoming Reality

From “How Will The Internet Change Our Health System?” by Jeff Goldsmith, *Health Affairs*, January/February 2000:

“Although health care institutions may resist the influence of network computing, eventually, the Internet is likely to accelerate the ‘virtualization’ of health care plans and systems and help to eliminate much of the clerical burden in caregiving and insurance. The core processes in health care-interactions between physicians and patients—are likely to be rapidly and profoundly affected.”

“Health care providers and systems are staggeringly inefficient at assimilating and processing information and at converting that information to knowledge. Part of the problem is that the core knowledge base of health care, biomedical science, is expanding at a geometric rate, driven by \$40 billion a

year in public and private sector research and development (R&D) spending. Also, more variability and uncertainty at the point of service exists in health care than in any other service in our economy. Although this variability does not completely defy capture, standardization, and manipulation by information systems, the technical and organizational problems associated with this process are daunting.”

“As if this variability were not complicating enough, more complex, highly trained, and difficult people (namely, health professionals) collide at the point of service than is true in any other service in our economy. Each health profession has its unique view of the patient’s needs, its own language, and an intensely

**Wisconsin Health & Educational Facilities Authority
Annual Conference, March 30th, Waukesha**

Call 262-792-0466 for more info on these sessions:
Assessing the Benefits of Public vs. Direct Debt Placement
Understanding the Tax-Exempt Financing Process
Trends in Long Term Care

What Investors are Looking for in Healthcare Bonds
Useful Technique Like Off Balance Sheet Financing
Enhancing Your Investment Guidelines & Returns
Economic Trends & Their Impact on the Health Sector
What’s New at WHEFA with Financing Assistance?

territorial view of its involvement in the care process. This has created a balkanized information architecture, in which each profession has its own data system that processes and records for payment the services it provides.”

“The present information environment in most health care institutions is dozens of functional computing systems (such as pharmacy, clinical laboratory, billing, and accounts receivable) running different programs written in different languages on different hardware. A depressingly large fraction of these processes are mediated by paper (medical records, prescriptions, telephone message slips, and bills)-incontrovertible evidence of an early 1970s information environment.”

“Some health care organizations are adopting enterprisewide information systems, with a single patient identifier, a single patient record, and a common application set. As J.D. Kleinke has noted, the growth and development of enterprise systems in health care has been deeply troubled. Vendors must shoulder part of the blame for promising solutions they cannot readily deliver; however, the difficulty health care organizations have had in shifting from functional to enterprise computing is, in major part, inherent in the complexity of the organizations themselves.”

“Indeed, it would be inaccurate to describe most health care organizations as enterprises. What they really are is collections of professions loosely and uncomfortably housed in the same physical structures. A coral reef is such a structure, much more a colony than a sentient being. As a consequence, systemic innovations are adopted very slowly. Passive resistance to change is compounded by a corrosive suspicion produced by the failure of past IT applications to materially improve productivity or processes of care.”

“Clement McDonald and colleagues compared computer networks to a rain forest canopy, where arboreal creatures (physicians) can gather fruit (information on patients and clinical problems) effortlessly by moving across the canopy (data network) without having to climb each tree (separate data systems). (The image of troupes of monkeys screaming and throwing fruit at one another is almost irresistible.)”

RWHC Seeking Telecommunications Consultant to evaluate the capacity and needs of up to eight rural hospitals as part of Wisconsin’s Critical Access Hospital implementation process. For purposes of this proposal, telecommunications is understood to include all technology relevant to the electronic transfer and access of data (including internet, intranet and voice) with either business or clinical applications, and telehealth is understood to focus on specific diagnostic, treatment or educational applications. Responses are due by March 27th. The complete Request For Proposal is available at <www.rwhc.com>.

“What the Internet promises health care managers and clinicians is a flexible, external information architecture that can reach down into the dozens, even hundreds, of health care information ‘silos’ and extract, analyze, aggregate, and redirect data, which clinicians or managers need to make decisions.”

“Beyond clinical uses, promising business-to-business Internet applications in health care include paperless transmission, verifications, adjudication, and payment of medical claims; online marketing of health insurance to individuals and small businesses; paperless pre-

scribing of, monitoring of, and payment for prescription drugs; medical product ordering and inventory management; and outsourcing of data processing and other management functions.”

“The Internet has a greater potential to fundamentally transform both the structure and the core processes of medicine than any new technology we have seen in the past fifty years. Professional resistance to adoption of the technology and political problems associated with protecting the confidentiality of patient records pose the two biggest hurdles to fully realizing this potential.”

“I see the Internet generating some demand for new products and services. However, that demand is



likely to be counterbalanced by a more careful weighing of potential benefits, reduction in medical errors, and the elevations of less expensive substitute therapies to parity with traditional invasive medicine, as well as savings from improved disease management.”

“As a consequence, the Internet’s impact on health care costs may be surprisingly benign. The most important effect of the Internet will be to strengthen the consumer’s role in relations to practitioners and health care institutions, and to create a powerful new tool to help people manage their own health risks more effectively.”

Not A Virtual HMO, But Mean

A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. The clinic operates with grass roots support from family and friends and many others. AMP is a non-profit, tax-exempt organization. Donations are welcomed c/o: Amazon Medical Project, Inc., 5372 Mahocker Rd., Mazomanie, WI 53560.

Yanamono, January, 2000: “Most of the time, I live perfectly tranquilly here, and the tourists who exclaim about my bravery and so forth seem a little overexcited to me. Then again, there are moments The other night, I went to take a shower before dinner; as usual, it was getting dark, and of course there are no lights in my house, except for one kerosene lantern which was not yet lit. There is a set of steps leading from the back door of the house down to the walkway which goes to the shower, and the steps have a thatched roof.”

“I opened the door and started down, noting as I did so that one of the vines holding the thatch in place had come loose and was dangling down from the peak, right in the middle of the doorway. I ducked under it and started down the stairs, just as a flash of realization struck me--I realized that the vine had a startlingly smooth S shape, and that it had a small triangular head and eyes besides.”

“I leaped back faster than I have moved in the last ten years, emitting what I think would have been called a hoarse cry, to find myself standing eyeball to eyeball with what was definitely a snake and might, based on its brown and beige and rattlesnake-y styled markings, have been a fer-de-lance, the most popular of the vipers around here. Great, I thought. I’m going to be

the first person in the history of the world to have fang marks in the middle of the forehead.”

“I didn’t hold that thought for long, though. No, I continued to move on back, then went to the front door, trembling only a little, and called for Roldan and Celso, two of the guides who had been sitting in the sala of the guides’ house about fifty yards away. They obligingly and quickly came, and as I clutched my towel around me, I pointed out the intruder to them. Celso had grabbed a long pole on the run, and they studied the snake from a safe distance. Then Roldan assured me that it was not a fer-de-lance, only a boa. ‘But it’s malo, doctora,’ he said. He explained that it does indeed bite, and in fact is known for sort of lying in ambush and leaping out at you. He said that although it is not venomous, it is aggressive, and mean. I said that I didn’t care about that, as long as it wasn’t venomous. Then Celso poked lightly at the snake, and it slithered unhurriedly back up into the thatch. Roldan warned me that it would probably come down again, that it liked being at ground level.”

“The next morning, I opened the door cautiously, just in case, and ... yup, there he was again, neatly folded into a striking position, artistically arranged so he was dangling from the very center of the roof peak, and looking like something right off the set of ‘Cleopatra.’ This time, though, I was neither taken by surprise nor frightened by what he might be, so I took the broom and gently prodded him up into the rafters again. Edemita (*who works with Linnea*) came by, and when I showed her what was still visible of the snake, she said, ‘ooh, doctora, it is too a fer-de-lance.’ And proceeded to worry about me. While the guides have had a snake identification course from a herpetologist, Edemita is something of an expert on the creatures (her daughter was bitten once, she has personally killed at least four or five snakes in my presence, and has of course lived in the forest all her life). I am going to believe the guides’ identification, but will also open the door cautiously for a while.”

National Rural Health Association

Annual Conference--May 24-26, 2000

Hyatt Regency Hotel, New Orleans, La.

New Orleans, La., will host as members and other participants gather for the learning and networking experiences of "NRHA 2K: À bonne santé! (To good health)." Following the successful three-day format of last year's event, the conference will run Wednesday, May 24, through Friday, May 26, 2000, allowing attendees to take in the sights of New Orleans during the Memorial Day weekend. Visit www.nrharural.org for more information.