Rural Wisconsin
Health Cooperative

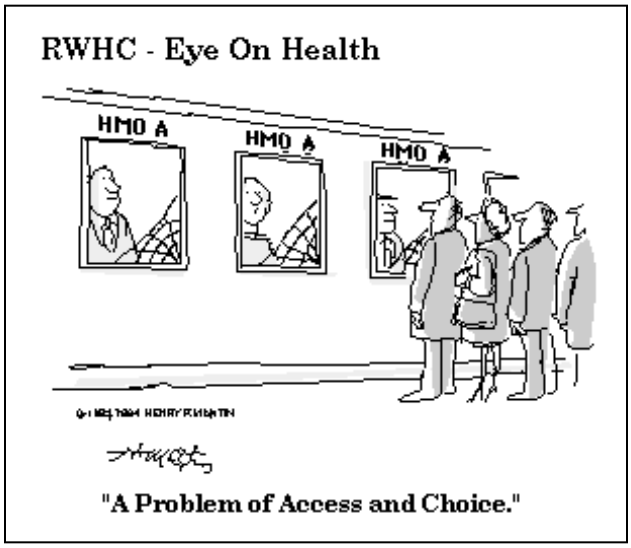
Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - July 1st, 1999

State Leadership Needed for Purchasing Pools

The Rural Wisconsin Health Cooperative is a cooperative supporting rural health care through out much of the state. It has long been active in organizing rural health interests in both public and market oriented issues. A high priority during this legislative session is that key parties find a way to support viable health insurance pools for small employers. Rural hospitals particularly understand and have long objected to how the "rules of the health insurance game" disadvantage small employers and rural communities.

The RWHC Board has expressed in the strongest terms its hope and expectation that the state's key political leaders, address the unsustainable reality faced by large numbers of small employers. Wisconsin needs a reasonable plan to come out of the legislative process which provides a workable health insurance pool for small employers. It is clear to the Cooperative that given the deteriorating condition of the health insurance market, particularly for small employers and their employees, that the political advantage will accrue to those who support reasonable changes in the status quo.



"A Problem of Access and Choice."

RWHC is unconvinced by those arguments which allege that these proposals create an inappropriate role for government--we find that a red herring leading to the continued disadvantage of small employers. Governments have sponsored mechanisms to facilitate trade since there have been governments, without taking over a market or inappropriately interfering. Small employers (including RWHC's own Sauk City office) need Wisconsin to more creatively address the market failures in healthcare. Current proposals could be better but "enough already"--it is time to stop talking, to put an insurance pool in place and learn to do it better.

Managed Care Is More than Managed Costs

From "The Ethics of Managed Care, The Challenges of Achieving True Managed Care" in *A Healthy Dialogue, Understanding Managed Care, Supplement of Corporate Report Wisconsin*, 5/99. Donna Shalala is the U.S. Secretary of Health and Human Services, and a former chancellor of the UW-Madison. This story contains portions of a speech presented by her at a business ethics symposium held at the Grainger School of Business:

"Whenever I think of difficult choices, I'm reminded of something that Woody Allen once wrote for a commencement speech. He noted, 'More than any other time in history, mankind faces a crossroads. One path leads to despair and utter hopelessness, the other to total extinction.' Unfortunately, whenever we discuss health care, too many people seem to believe that we're facing the same type of dismal, no-win, choice. When it comes to health care, it's care vs. costs, healing vs. savings, patients vs. profits. We are told we must choose one or the other. But I believe that we don't have to make a choice."

"I believe we have the ability to balance patient's health and corporate profits. After all, patients and profits aren't diametrically opposed forces--without patients there are no profits. And without profits, doctors cannot serve patients. What we need to do is institute real, or true managed care. Notice I said 'true.' Let me be clear from the start, I was in a managed care plan over 25 years ago -- long before most people even heard of the concept. When done right, managed care can provide a seamless system of care from prevention to primary care to patient management. The pioneers in managed care understood this. They had strong prevention services, fully integrated delivery systems, and comprehensive care."

Hiker's Ode: "Better to meet a she-bear robbed of its cubs than to confront a fool immersed in folly." Proverbs 17:12

"The system we have today, for the most part, is not really 'managed care.' What we have instead, is 'managed costs.' To understand why, let me briefly discuss the managed care revolution. Many of you are well acquainted with the reasons why managed care emerged as the dominant force in health care over the last decade. Employers led the movement toward managed care as a way to constrain the costs of doing business. Large purchasers of care, private employers as well as the federal and state public employee health programs, were alarmed by the double digit increases in insurance costs each and every year. Between 1988 and 1989, for example, insurance costs for private employers rose 14 percent. The cost of public programs like Medicare and Medicaid were also rising at double digit rates during the same period."

"Employers and large purchasers believed that managed care could improve the quality of health care by providing comprehensive, coordinated care at a reasonable price. In 1988, about 71 percent of American workers were enrolled in traditional fee-for-service plans. By 1998, the figure dropped to 14 percent."

"And what have been the results of this fundamental shift in our health care landscape? Well, we've definitely seen managed costs. Managed care has acted responsibly to hold down costs, primarily by taking advantage of excesses in the system to negotiate substantial discounts from providers. And in 1995, average premiums actually dropped by one-tenth of one percent. But I want to caution that much of these savings may well be illusory--they resulted from deep discounts negotiated with doctors that can't be replicated in the foreseeable future. In fact, premiums are expected to actually rise an average of 7 to 8 percent in 1999, with even larger increases for small employers."

"Make no mistake, we've successfully advanced managed costs, but has the shift in our health care landscape also resulted in real managed care? Unfortunately, I believe the answer is no -- for three reasons."

"First, too many managed care plans are simply not providing the comprehensive, coordinated service that is the hallmark of real managed care. These plans are really just discounted fee-for-service plans."

"Second, real managed care would not put a strain on the most sacred bond in medicine: The doctor-patient relationship. Right now, too many doctors face a profound ethical dilemma. The Hippocratic Oath obligates them to always put their patients first. But as gatekeepers, they may face strong financial incentives to deny access to a specialist or other needed service."

"Third, the information systems needed to manage care effectively are not in place. In the early 1990s, a group of forward looking purchasers and plans developed a set of common standards, called HEDIS,--or Health Plan Employer Data Information Set--to measure quality of health plans. Last year we saw more plans than ever agree to provide HEDIS data to the responsible accrediting organization--but only on the condition that the data not be made public. We're helping to put an information system into place by collecting and disseminating HEDIS information for all Medicare and Medicaid beneficiaries. But more needs to be done."

But What's the Answer?

"The answer, as I said earlier, is to institute true managed care -- a seamless system from prevention to primary care to patient management. Above all, that means we first have to ensure quality. And that's exactly what our Patient's Bill of Rights is all about. Many -- but certainly not all -- managed care organizations have already stepped up to the plate to voluntarily provide the kind of protections contained in the patient's Bill of Rights. What they understand is that every type of health insurance must deliver high quality health care for all of us. To support this premise, the Patient's Bill of Rights lays out eight basic principles which I'd like to briefly outline."

"First, consumers should have the **information** they need to make knowledgeable choices. They need to know what's in a health plan and what's excluded, which health professionals are in a plan's network, how they can appeal a decision to deny coverage, and if a plan will restrict their access to certain drugs. Consumers also need information about the quality of the health plans, doctors, and hospitals that seek to serve them, so they can shop among plans armed with insights and knowledge."

"The second principle is that consumers should have greater **choice** in health care. Too many Americans actually have fewer and fewer choices -- choice of doctors has been reduced -- and many people with acute or chronic conditions have difficulty gaining access to spe-

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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cialists. When Henry Ford was first making his model T, he remarked, 'A customer can have a car painted any color he wants -- so long as it's black.' Lack of choice in cars is inconvenient -- but lack of choice in health care is inexcusable."

"The third principle of the Patient's Bill of Rights says consumers have a **right to emergency care** whenever and wherever the need arises. You and I know that if you're experiencing severe chest pains, you should go to the nearest hospital emergency room."

"The fourth principle is that patients and doctors must be able to **communicate freely**. Patients need all the available information about treatment options, alternatives, risk, benefits, and consequences. The Patient's Bill of Rights says there should be no gag rules. There should be no contractual agreements to hamper the flow of information between doctors and nurses and their patients."

"Fifth, the Patient's Bill of Rights states that there must be an environment of **mutual respect** and nondiscrimination in the health care industry and in insurance enrollment -- regardless of race, sex, age, sexual orientation, genetic make-up or other factors."

"The sixth principle in our Patient's Bill of Rights states that a patient's health records must be kept **confidential**. Today, information is being shared by whole networks of providers and insurers. Today we have federal laws that protect the privacy of our motor vehicle records, our credit card records and even our video store records--but not our health care records."

Wisconsin Helped the Success of the Bald Eagle; It Can Do the Same for Rural Health.

"The seventh principle says that consumers must have **recourse to challenge** decisions made about their care. Consumers should be able to appeal those decisions to an external group of experts who are independent of their health care plan, and who had nothing to do with the original decision to deny coverage."

"Rather than fighting managed care's existence, all of us must work towards improving it -- and instituting true managed care that provides a seamless system of care at a reasonable cost. The choice is ours. We stand at the crossroads. The great sage, Yogi Berra, advised all of us that when we come to a fork in the road -- take it. We don't have that luxury -- this time we must choose. Our choice is to return to the days of spiraling health cost and fragmented health care. Or to invest in the promise and potential of true managed care. To paraphrase Woody Allen, if we have the wisdom to choose wisely, then I know we'll be able to balance patient health and corporate profits. To always put the patient first, and to ensure that managed care will truly be able to manage both costs and care."

Same Quality Standards but in Rural Context

From "Quality Of Care Challenges For Rural Health" by Ira Moscovice and Roger Rosenblatt in a monograph with support provided by the Office of Rural Health Policy, Health Resources and Services Administration, and the Agency for Health Care Policy and Research, Public Health Service, 1/99:

"The United States is renowned for the quality of its health care, particularly in sophisticated urban medical centers. But what about the smaller towns and cities spread across America? The purpose of this paper is to examine the issue of quality of care in rural America and to help others to improve quality in a way that is consistent with the very real challenges faced by rural communities in assuring adequate health care."

"Providing health care in many rural areas is a struggle. Community energies can be so absorbed in ensuring that there is a local doctor or hospital that the quality of health care the rural clinicians and institutions provide is ignored. Yet in a world where transportation and communication links make it possible for people to interact with distant doctors and institutions instantaneously, rural health care systems often directly compete with their distant urban cousins for patients. More important, rural citizens have a right to expect that their health care meets certain basic standards that are applicable to virtually all health care institutions and clinicians in our large and diverse country."

"Quality has become much more of a frontline issue because of the rapid expansion of managed care plans. As a large proportion of patients receive their health care within these organizations, increasing attention has been paid to ensuring that cost constraints do not affect the quality of care. Even though rural areas have been much slower than urban areas to become involved, managed care is around the corner in most parts of the country. Managed care in and of itself is neither good nor evil, but it does usher in major changes in the way health care is structured, purchased, consumed, and delivered. And the quality of care is affected by the organization of medical care, potentially both for good and ill."

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"Measurement is the first step in assessing the quality of any product. Managed care organizations spend more time than the traditional private practitioner measuring and comparing performance. Thus the evolution of managed care in rural areas increases the demands on rural systems not only to measure what they do, but to demonstrate that the quality of their product is comparable to that of the urban providers with whom they develop relationships. This is one key to the survival of locally provided rural health care. Unless rural providers can document that the quality of local care meets objective external standards, third-party payers may refuse to contract with rural providers, and increasingly sophisticated consumers may leave their communities for basic medical care services."

"One example of an effort by rural-based provider networks to collaborate on quality of care issues is the Wisconsin Rural Zones of Collaboration Initiative. Two rural-based provider networks in south central Wisconsin are working with multiple competing HMOs and insurers in the region to increase the effectiveness of a regional credentialing service. As part of this effort, they intend to collaborate on data collection, site visits, and other administrative audits required of rural network members by external regulatory or accrediting bodies; to centralize health plan customer satisfaction surveys; to create a common clinical practice guideline review and adoption process; and to implement locally driven clinical quality management projects to improve the health status of the populations served by multiple health plans. This effort is significant because it attempts to address the fragmentation of rural providers as well as the multiple rural-urban linkages that are necessary to ensure."

"The purpose of quality assurance systems is to improve the health care status of populations. Rural quality of care lies as much in having the ability to deliver low-risk babies in a local facility as in ensuring that all women over 50 have periodic mammograms. The test of the system lies in the overall health of the population, not in compliance with a set of indicators that measure only isolated parts of the interaction between patients and providers."

"Rural areas offer the opportunity to design the next generation of quality assessment measures, based on population outcomes rather than process measures. As a part of the process implementing new efforts such as the Medicare Rural Hospital Flexibility Program, the ORYX system, and the National Advisory Commission on Consumer Protection and Quality, we urge the development of measures to examine the impact of health care systems on the health of the community. In this way we can move toward a system that isolates the true components of excellent health care and focus future investments on those interventions that improve the quality of life for the residents of rural communities."

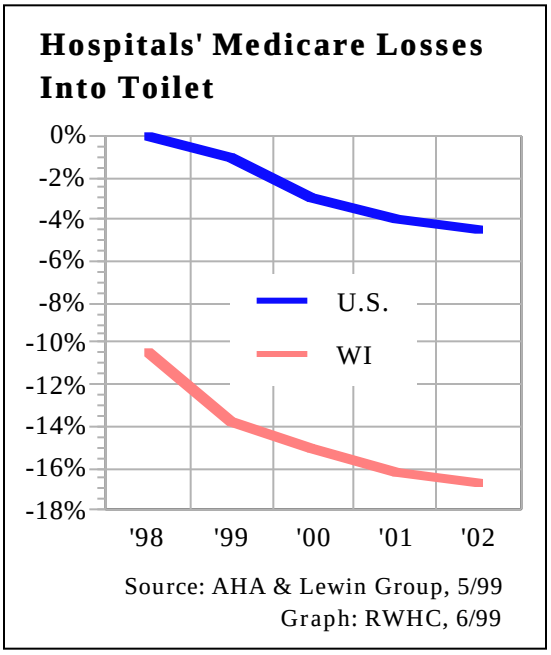
For a copy, call Jane Raasch at 612-624-6151 or from web at <www.hst.umn.edu/centers/rhrc/rhrc.html>.

Wilensky Calls for Select Medicare Increases

From "Head of Medicare Panel Says Some Payments Should Be Increased" by Robert Pear in *The New York Times*, 6/3/99:

"The head of a federal advisory commission, an influential Republican, said Wednesday that Congress should increase Medicare payments for certain nursing home and hospital services because budget cuts appeared to be harming the quality of care for some patients."

"The statement by Gail Wilensky, chairwoman of the Medicare Payment Advisory Commission, was a breakthrough for health care providers, who have been pleading with Congress to restore some of the money cut by the 1997 budget law. Dr. Wilensky said she agreed with some health care providers that certain patients were vulnerable, particularly those with complex medical problems who are in nursing homes and those needing outpatient hospital services or physical therapy."



"Congressional aides said Wednesday that Congress seemed likely to take Dr. Wilensky's advice. Medicare issues have traditionally been Democratic issues, but Republicans are aware that increasing numbers of the elderly now vote Republican, and in the last three years, Republican lawmakers have given hundreds of speeches insisting that they want to protect Medicare. Dr. Wilensky said she was recommending 'targeted and limited changes' in the Balanced Budget Act of 1997, not a wholesale revision or repeal of its Medicare provisions."

"Specifically, Dr. Wilensky said, Congress should provide more money for physical therapy, eliminating what she described as an arbitrary limit of $1,500 a year in Medicare payments for physical therapy for any beneficiary. In addition, she said, Congress and Medicare officials should devise some way of increasing payments to nursing homes for patients who need the most costly and extensive care."

"Finally, Dr. Wilensky said she tended to agree with hospitals that say Medicare is paying too little for outpatient services, which include a wide range of diagnostic tests, treatments and procedures. As significant as what Dr. Wilensky said is what she did not say. She did not, at this time, endorse pleas by teaching hospitals for more money. And she did not endorse the pleas of home health agencies that say beneficiaries' access to home care has been impaired by the Medicare cuts."

Clinton's Medicare Reform--More of the Same?

From "Next, a Medicare Proposal" an Editorial in *The Washington Post*, 5/30/99:

"The President is preparing a proposal for the restructuring of Medicare. The plan will be an interesting test of whether anything -- even a little straight talk -- can be salvaged from a year that has degenerated mainly into political posturing, on the part of both parties, over small accomplishments hugely amplified in hopes the voters will mistake them for large."

"The disagreeable fact is that no one has thought of a plausible way to secure Medicare's finances -- provide increasing numbers of elderly and disabled people with adequate health care in the future -- without a tax increase, and probably not a small one, either. To try to do it just by curbing costs will be to vitiate the care."

"The need for revenue becomes the greater if the program is expanded somehow to cover prescription drugs, as it ought to be, and as a commission majority came round to recommending at least in principle. Plainly, the price of the revenue needs to be a continuing effort to contain costs. The commission *(last year's bipartisan advisory effort*) majority recommended shifting to a kind of defined-contribution system in which the government, instead of acting as insurer and paying bills itself, would limit its exposure by giving people chits with which to buy their own insurance. That might not be bad if the chits were adequate and the market could be regulated to keep insurers from seeking out the healthy at the expense of precisely the sick who need insurance most. But at best, the hoped-for cost savings from a competitive system such as this would ease the Medicare problem, not solve it."

"If there were no ability to choose among products or firms, the basis of most of the American economic system--competition--would vanish."

"That's what the President needs to tell folks in whatever plan he now comes up with. Medicare is a larger and less tractable problem even than Social Security, to which there are no easy answers. Instead, what he has mainly done to date is tout the sweet and blur the sour -- call for a drug benefit together with diversion of a part of the surplus to defer the day of reckoning, without a hint as to what that reckoning might then be. So also with Social Security, to which he would devote a much larger share of the surplus, without a word as to the benefit cuts that he himself acknowledges would still be required; those will be for others to propose."

"Both parties are marking time until the elections while seeking to protect themselves against the charge that marking time is all they are doing. The President, having begun the year by saying he wanted nothing more than to solve these long-term problems, has made his own large contribution to postponing them. The question is whether the forthcoming Medicare proposal will be more of the same."

What is Choice Worth?

From "Choices in Health Care: What Are They and What Are They Worth?" by Amy B. Bernstein and Anne K. Gauthier, the Alpha Center, in: *Medical Care Research and Review*, Vol. 56, 1999:

"Americans place such high value on the ability to make choices that our economic and social systems are dependent on that ability. It pervades most aspects of our being--where to live, where to go to school, what to do with our lives, and what health care we receive. Competitive markets work, in theory, because consumers choose among competitors, favoring firms/products with lower costs and high quality. If there were no ability to choose among products or firms, the basis of most of the American economic system--competition--would vanish."

Factors that Affect Choices in Health Care

"There are many different choices that affect the health care that patients receive, made by many different parties, and they are rarely independent or fully under any one individual's control. They are both iterative and interrelated. Most of the time, there is a hierarchy governing choices where the choices an individual makes at one point determine the choices he or she faces down the road. Individuals choose a career path, which determines a choice of employers, who in turn choose a set of plans (or any one plan); plans can choose the providers they will include in their networks, enrollees can choose particular providers, and providers ultimately determine treatments. When circumstances change, the hierarchy may be overturned. For example, one does not choose to become a patient with a dreaded or chronic disease, but once a disease is diagnosed, the patient's choices change--or at least the most important choices change. A loss of job triggers an entirely new set of choices."

The Superior CEO: A Profile

Ram Charan and Geoffrey Colvin Fortune, 6/21/99:

- **Integrity, maturity, and energy.** "The foundation on which everything else is built."
- **Business acumen.** "A deep understanding of the business and a strong profit orientation--an almost instinctive feel for how to make money."
- **People acumen.** "Judging, leading teams, growing and coaching people; cutting losses where necessary."
- **Organizational acumen.** "Engendering trust, sharing information, and listening expertly; diagnosing whether the organization is performing at full potential; delivering on commitments; changing, not just running, the business; being decisive and incisive."
- **Curiosity, intellectual capacity, and a global mindset.** "Being externally oriented and hungry for knowledge of the world; adept at connecting developments and spotting patterns."
- **Superior judgment.**
- **An insatiable appetite for accomplishment and results.** "Powerful motivation to grow and convert learning into practice."

A Self-Test For CEOs

Ram Charan and Geoffrey Colvin Fortune, 6/21/99:

- **How's' your performance--and your performance credibility? "**Of course you have to deliver results, but you're unlikely to do so if you haven't developed performance forecasts for the next eight quarters, not just the usual four. You should have ideas now for changes you may have to make six to eight quarters out."
- **Are you focused on the basics of execution?** "You should feel connected to the flow of information about your company and markets; that includes regular interaction with customers and front-line employees. Are you following through on all major commitments from your direct reports? Are you listening to the inner voice telling you whether things are going well or badly?"
- **Is bad news coming to you regularly?** "Every company, even the most successful, has bad news, usually lots of it. If you're not hearing it, are you letting the trouble build? The information you get should force you to take issues seriously."
- **Is your board doing what it should?** "That means evaluating you and your direct reports, asking for information about your markets, and demanding a succession plan--but not formulating strategy or trying to manage operations."
- **Is your own team discontented?** "Subordinates often start bailing before CEO goes down."

"The Consumer Choice Model"

"Many of the strategies being proposed by purchasers to reduce health care costs without sacrificing quality rely on the so-called consumer choice model. As described by Hibbard and colleagues, 'strategies to reform health care rely on encouraging consumers to make informed choices in order to help discipline the market.' When consumers are informed about the relative cost and quality of health plans, it is assumed that, faced with the collective effect of their educated choices, plans and providers will compete on both cost and quality."

"Do all the caveats or known violations of the assumptions underlying the consumer choice model described above mean that it does not, or cannot, work to produce lower-cost, higher-quality plans? Not necessarily. Rather, by pointing out the violations in the assumptions necessary for the most successful workings of the consumer choice model, policy makers and participants in the health care system can identify areas in which public policy, regulation, or other mechanisms can be used to help make the system more effective."

"It is important to remember that the issue of choice in health care is not simply about how consumers choose their health care plan. There are a large number of decision makers in the health care arena, including consumers, providers, health insurers, employers, regulators, and governments. Their decisions are interdependent and often have conflicting goals. When the issue of choice in health care arises, then it is necessary to ask what is being chosen and for whom. Most important, what is the provision of choice supposed to accomplish?"

"Some believe that only when enough good information on the various choices becomes available will the health care system improve. Some say that consumers must also be given a chance to participate in more decisions, which are now made by agents on their behalf (for example, employers). Others believe that relying on choice alone will not necessarily move the health care system toward higher-quality and lower-cost care. Still others believe that while more information is needed, we need to be more parsimonious in choosing what information is disseminated, to whom it is disseminated, and how it is presented."

"As managed care proliferates, there may be more choice of health plan (although not necessarily, as employers do not provide a choice of health plan more than half the time), but within a health plan, choice of provider, or choices that providers may make about treatment, may be more limited than in years past. Assuming that focusing on providing information about the quality of health plans will force poorer-quality health plans to improve, what about the other choices that lead to health care? Will focusing attention on health plans force individual providers to improve? Will the restrictions put on individual treatments help or hurt consumers (and which ones)? What about employers--should public policy or regulations force them to provide choices to employees in order to make the consumer choice model work?"

"Choices in health care: what are they and what are they worth? The answer clearly depends on the perspective of the beholder. But the importance of continuing to explore the question is equally clear."

Medicare Fee-For-Service or Managed Care?

The following is from "Medicare and Managed Care in Wisconsin, Making an Intelligent Choice" by the Coalition of Wisconsin Aging Groups, 4/99; Copies of the 23 page, clear, consumer oriented booklet are available through the Coalition at 608-224-0606.

"Most older Americans at age 65, regardless of income, are eligible for health care through the Medicare program. Medicare is also available to persons with disabilities who are under age 65. As managed care becomes available in all regions of the country, individuals will have to decide how they want to receive their Medicare benefits. Most will receive benefits through the fee for service system or through a managed care plan. Either choice entitles the beneficiary to Medicare's hospital and medical benefits. the differences in the two systems are essentially the same as the differences outside of Medicare. They include how benefits are delivered., how and when payment is made, and how much is paid out-of-pocket."

"There are two requirements for enrollment in a Medicare Managed Care plan: (1) consumer must live in the area covered by the plan and (2) consumer must currently be enrolled in Medicare Parts A and B and continue to pay the Part B premium. [An individual is not eligible for Medicare managed care if *prior* to application s/he has been diagnosed with end stage renal disease.]" Some of the advantages and disadvantages of Medicare managed care noted by the Coalition are:

Advantages of Medicare Managed Care

- "It can be easier to get services through one source."
- "Quality of care may be enhanced because of the coordination of services."
- It is easier to budget medical costs because the amount of any premiums are known in advance and the total of other out-of-pocket expenses is likely to be less than under the fee-for-service system.
- "Generally there are nominal or no co-payments."
- "There are often times benefits included beyond those covered by Medicare at a low, or no, additional charge."

Disadvantages of Medicare Managed Care

- "Generally, the hospital(s) and physician(s) available are limited to a designated group."
- "Members may need to have prior approval from their primary physician to see any specialist, to receive elective surgery or to obtain equipment or other medical services."
- "It can take up to 30 days to disenroll so that if an individual chooses to leave the plan, s/he cannot seek coverage elsewhere until the first day of the following month. (beginning in the year 2002 there are additional 'lockin' requirements regarding managed care plans that will significantly reduce the umber of times an individual can change plans."
- "The location of service may be so distant that it precludes access to what is otherwise considered an allowable service. The federal government does look at this when approving plans and services must be available in the geographic area."

Change in Federal Definition of Rural Areas?

From "Change in Federal Definition of Rural Areas?" by Pat Taylor, in *Rural Health News*, Spring 1999:

"Billions of federal dollars each year are distributed to counties and communities according to their location in federally designated metropolitan or nonmetropolitan areas. Since 1950, the President's Office of Management and Budget (OMB) has delineated the nation's metropolitan areas, each made up of one or more metropolitan counties. All other counties are termed nonmetropolitan counties. This year OMB is weighing major changes in its metropolitan area standards."

"Rural health providers and communities have sometimes been critical of OMB's current metropolitan and non-metropolitan area delineation. They point out that extensive, highly rural areas are misclassified as metropolitan. This problem occurs all across the nation, but particularly in very large counties which are mostly in the West. Isolated rural communities in such counties are often not eligible for federal programs for rural people because these programs use the federal standard, equating 'rural' with nonmetropolitan counties."

"OMB has asked the public to help it decide on changes by answering several key questions. What geographic unit should be used as the 'building block' for defining areas: county, census tract, or some other? What criteria should be used to aggregate the geographic building blocks into statistical areas: daily commuting patterns, population density, or some other? What criteria should be used to classify all the territory of the nation?"

"In July 1999, OMB will report its progress in narrowing the changes being considered, and announce its new criteria for defining metropolitan and nonmetropolitan areas in March 2000. The new criteria will first be used with Year 2000 Census data."

"For further information, contact James Fitzsimmons, Metropolitan Area Standards Review Committee, 301-457-2419, or pop.frquestion@ccmail.census.gov. Pat Taylor is a consultant of the Office of Rural Health Policy, HRSA. She can be reached at ptaylor@cpcug.org. Descriptions of alternative approaches can be found at:

www.whitehouse.gov/WH/EOP/OMB/html/fedreg.html

Staring into Coffee

From "Psychologist-Farmer Helps His Fellow Cope" by Dirk Johnson, *The New York Times*, 5/30/99:

"After hauling oats to his cattle before sunrise on the Iowa prairie, Michael Rosmann drives to an office and sits down with farmer after farmer to listen to their troubles. A fourth-generation farmer as well as a clinical psychologist, he speaks the language of men and women on the verge of losing their place on the land."

" 'These are good people who feel like terrible failures,' said Rosmann, who knows what it is to endure sleepless nights spent worrying about crop prices and peril to family tradition. 'Somebody needs to tell them it's not their fault.' A quiet desperation shrouds the countryside in places like Harlan, where plunging corn, bean and livestock prices are bringing ruin to farms nurtured by families for generations. But if troubles are in plentiful supply in much of rural America, psychological help like Rosmann's most often is not."

"So, with the farm economy lurching toward the dreadful conditions of the early 1980s, when suicidal gunshots rang out from red barns, rural social and church groups are trying to extend solace to men and women on the verge of breakdown, both financial and emotional. 'When you're a farmer, your work is your home, and there is no escape from the suffering,' said Fred Moskol, at the University of Wisconsin Medical School."

"A steep drop in income has meant disaster to farmers already working on slim margins. Besides the low commodities prices, American agriculture is seeing 'substantial structural change,' with more farmers working under contract with big processing companies, especially in the hog business."

"For the most part, Rosmann said, farmers understand the benefits of psychotherapy and drugs in treating depression and anxiety. 'These are smart people, he said. They're stubborn, but they're also innovative. They've got to be. A good manager will try anything that helps the operation. If that means going to a psychologist, then fine.' The big problem, he said, is making the time out of a busy schedule, especially if you are forced to drive 50 miles or more to find a counselor."

"Without psychological help, says Larry Barber, a rawboned 57-year-old patient of Rosmann who recently lost a farm that had been in the family for more than a century, he would have lost his mind as well. 'People tell me, 'It's not your fault,' Barber said, 'but it is a little like driving a car, then skidding on a bad patch of ice and hitting a child. It wouldn't be your fault, but you'd live every day with the doubts and thoughts of how could I have avoided this terrible thing.' The old Barber farm is a pretty place, with bur oaks, ponds and rolling prairies. The Barbers were able to hold on to their house there, and these days they often sit at the kitchen table, looking out at the countryside when they are not just staring into their coffee.