

Review & Commentary on Health Policy Issues for a Rural Perspective - October 1st, 2002

Rethinking Rural Health Advocacy

From a working paper "Arguing for Rural Health in Medicare: A Progressive Rhetoric for Rural America" by Thomas C. Ricketts, Ph.D., University of North Carolina at Chapel Hill, 9/5/02:

"Rural health policy is the laws, regulations, rules and interpretations that benefit or affect health and health care for rural populations. The ramifications of the label that is applied to the advocacy group and its constituency is of tremendous importance. At this time, it is not clear how the rural health advocacy coalition is viewed by the professional policy world or the public: as an issues network pressing for fair and equal treatment or as an interest group seeking special advantages."

"A central element of rural health policy, indeed a dominant part of the formal debate focuses on Medicare payment for health care services provided in rural communities. Since the inception of the Prospective Payment System (PPS) in the early 1980s, Medicare has been a central issue to rural health stakeholders, due to the very heavy dependence on Medicare revenues of most rural hospitals and health care delivery systems. In seeking redress for the administrative decision to differentiate payments to rural and urban hospitals, rural health stakeholders and advocates sought some statement of the intent of the Medicare program to justify their calls for fairness, equity, even equality. No such statement existed."

"The Medicare law starts with the unique statement: 'Nothing in this subchapter shall be construed to

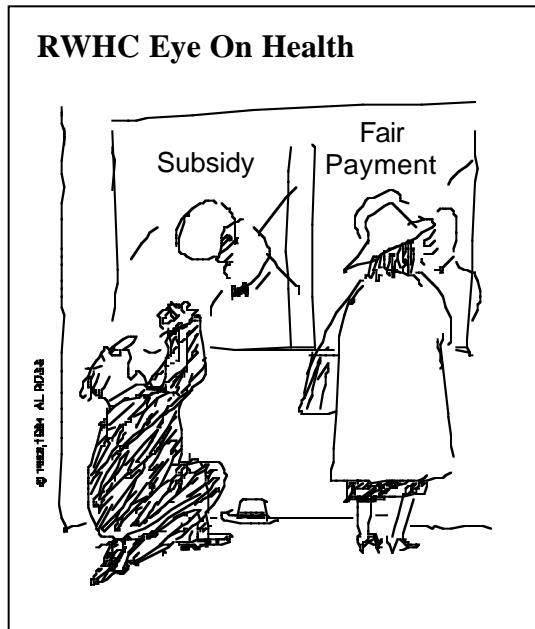
authorize any Federal officer or employee to exercise any supervision of control over the practice of medicine...' (42 USC § 1395). The conference reports that accompanied the legislation to the floors of the House and Senate were largely stripped of any mention of a greater social purpose for the program."

"Rural advocates cannot point to Congressional intent that clearly says that Medicare is meant to provide even a minimal level of access to rural residents. This became more apparent in the fall of 2000 and spring of 2001 as the Medicare Payment Advisory Commission (MedPAC) conducted hearings in preparation for release of a special report on rural beneficiaries and Medicare. That commission has strongly supported the position that the role of Medicare '...is to

reimburse the 'efficient case...' rather than to meet any standard of equity. This was driven home by the Minnesota District Court's decision to dismiss the suit brought by the State of Minnesota, the Minnesota Senior Federation and Mary Sarno against the federal government, seeking to eliminate the geographic payment differences in the managed care payment formula created under the Balanced Budget Act of 1997 in the Medicare+Choice program. The plaintiffs pointed to wide differences in payment levels between states and counties, differences that the court found to be 'wrong' and an 'injustice,' but nevertheless weren't unconstitutional or beyond the authority of

Congress or the U.S. Department of Health and Human Services."

"Arguments for payment policies that either are or can be viewed as favorable to rural health systems can be interpreted in two ways: as calls for subsidies or as equal policy treatment based on principles of fairness.



Those who see arguing for rural health as a claim for subsidy are viewing payment policies for federal programs as ‘redistributive’ or ‘zero-sum’ games. They see that the provisions in Medicare that allow for geographic distinctions in payment rates rest on principles of economic efficiency. Those who see it as a plea for fairness are asking for a form of distributive justice based on the notion that all citizens and Medicare beneficiaries should be treated equally.”

“The assumption that equity is the standard for Medicare is not easily accepted by the staff of CMS or the Congressional staff who write amendments to Title XVIII; this is due, in part to their focus on and comfort with the technical aspects of the program. But the more important issue is whether equity should be the central value in overall rural health advocacy? If the goal is a sense of social justice, then this may be appropriate, but arguments for justice, especially justice in health care, may produce a resulting policy prescription for ‘a decent minimum’ rather than any level of comparability or equality.”

“How rural health advocates currently express their claims for equal treatment can be seen in two ways: Either in terms of seeking justice for their treatment as equals in a full sense, or for justice in the distribution of resources that are provided through the ‘beneficence’ of the national government. Asking for justice within a framework of beneficence means that the resources which are claimed are a portion of what Congress chooses to give to its less advantaged citizenry out of a sense of ‘kindness and compassion’ rather than as what is due to equals. The fundamental nature

of the claims for better treatment under a policy that is focused on underservice, for example the current debate over the reconstruction of the HPSA/MUA designation process, may need to be explicitly contrasted to claims for fairness under the Medicare program. At the national level, the former rests on a beneficence justification (‘The Safety Net’) while the latter relates more to a claim of justice (‘getting what is due to us’). The arguments for special treatment of frontier areas in the former may depend on different principles than the geographic equalization of PPS rates. A complication to this parsing of arguments is the desire on the part of the advocacy network to function as a unified community which makes it more effective in its role in affecting specific policy development.”

“Rural communities may be better served by a progressive logic and accompanying rhetoric that makes their claims. Rural communities may be treated unfairly due to the special treatment of urban places and accommodations made for the urban social ecology rather than overtly discriminated against. The rural claim may better be expressed as one of parity in treatment in policies that have been redistributing benefits based on the claims of the more powerful, urban components of the health care system: large, teaching hospitals, researchers, managed care systems that depend on high turnover and low margins, and a technology-driven health care delivery structure with very high fixed costs that requires high rates of utilization to justify investments. **The favorable treatment that urban health systems receive can be pointed out in the context of a progressive rhetoric that focuses on bringing the nation together as one community.”**

“It may be that our national political discourse that shapes Medicare and other policies that affect rural America is so laden with symbols that there is no room to express succinctly and effectively that we are leaving behind a large portion of our society. The larger metaphor of Medicare: health care for older Americans, may somehow convey the idea that we could not possibly treat our seniors unfairly. Alternatively, Medicare may be so powerful a positive element of American policy making that complaints that it is fundamentally unfair to a particular minority of Americans may be rejected as the broader program energizes support for its own extension, even survival. The largely partisan clamor for privatization of Social Security and the opening of Medicare to market discipline has not played well in the economic stagnation of the new century.”

“Medicare policy in the Congress has repeatedly responded to calls for expansion of the program to pay for things that are effective and necessary part of a rea-

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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sonable standard of care for beneficiaries. Including new procedures and strategies can be as broad as bringing in all end stage renal disease patients or as focused as determining whether or not a specific procedure should be covered. For the former, Congressional action is required, and Congress has been aggressive in including detailed prescriptions for coverage, breast cancer treatment being one example. However, many more decisions that determine allocations are made within the bureaucracy that administers the program Medicare policy making within CMS and HCFA has been dominated by pressures to maintain fiscal solvency across the program. It is not clear that one system dominates the other in their consequences. **The rural argument, then, ought to accommodate both of these mechanisms and provide support for each of their dominant impulses.**

“Rural health systems have been less costly than urban systems due to lower patterns of demand and use, not necessarily lower per provider costs. In the Congress, fairness in payment systems can be expressed as a reasonable enlargement of the benefits of Medicare as necessary to give rural beneficiaries reasonable access to a reasonable standard of care. That access can be shown to be an effective way to ensure that all Medicare beneficiaries have equal access to the program while creating administrative efficiencies through this extension by providing the mechanism to support providers that have proven to draw less on the system than urban providers. The costs of care in rural places and for rural beneficiaries overall is the same or nearly the same but rural health systems and rural Medicare beneficiaries manage to use fewer overall resources than urban systems. Why, then cannot this efficiency be rewarded?”

“The arguments for greater equity in the Medicare system for rural populations can show that rural systems are different. To quote Joseph Newhouse: ‘...the market for most medical services is local; inherent differences in scale and modes of treatment complicate comparisons the efficiency of a small rural hospital with that of a large teaching hospital, not to mention a solo general practitioner with a subspecialist in a large group.’ The fundamental differences between urban and rural health care delivery have not been explored as well as they ought because, as much as anything, we have structured a Medicare system that is as uniform as it can be across the very complex system of care we have.”

“We have recognized differences of other types: mental versus somatic health; health care in long-term settings versus acute settings and the home; and by different practitioners. Not so for the differences in scale, scope and culture of care between small (and

large) rural providers and their urban counterparts. Those accommodations do not need extraordinary research efforts to identify the basic differences but a recognition that the burdens of rural-located care giving are at least equal to urban places. The infrastructures and cultures surrounding those rural places provide different incentives and barriers to urban health care delivery that are no less real and no less costly.”

Subsidize MDs as Needed, Not Med. Schools

From “Dreaming The American Dream: Once More Around On Physician Workforce Policy, *A proposal to entice physicians into low-valued corners of the market, without trying to control the overall composition of the health care workforce*” by Uwe E. Reinhardt in Health Affairs, Sep-Oct/02:

“A realistic U.S. physician workforce policy must accept as permanent a payment system that envisages harsh rationing of health care for upward of thirty million uninsured Americans at the bottom of the economic ladder and lavish, often wasteful care for customers on the upper rungs who are able to pay for what is now called ‘boutique medicine.’ In between will be an entire spectrum of arrangements, ranging from tightly managed health maintenance organizations (HMOs) for low-income workers and Medicaid beneficiaries to relatively more open-ended preferred provider organizations (PPOs) for higher-income families, albeit with high cost sharing at the point of service. Nothing on the horizon suggests an alternative payment system for the next several decades.”

“A distinguishing characteristic of such a system is that it values the work of physicians so differently in different corners of the market. Federal and state legislators may be willing to pay pediatricians \$10 to see a poor child covered by Medicaid—or nothing at all for an uninsured child—but to pay the same pediatrician \$50 or more to see these legislators’ own children in the commercial corner of the market.”

“What, then, should a ‘firm regulatory grasp’ on physician workforce policy be in the face of the American approach to valuing the physician’s work?”

“One approach might be to abandon altogether the dream of controlling the size and composition of the physician workforce and to search instead for financial levers, other than fees, by which an adequate number of physicians can be enticed into the low-valued corners of the health care market. A good start in that direction would be a reexamination of the

premises on which the current public subsidies of medical education and training are based. The commonplace rationale for them is that the education of a physician is a public good, which according to well-established economic principles should be publicly financed. But on what rationale can the education and training of a physician in the American context be declared a public good?"

"As I and others have argued elsewhere, correctly viewed, the process of educating and training physicians produces 'human capital' that subsequently is owned by the graduates themselves and, in the United States at least, can be deployed by them in any manner they choose. Some physicians may use that capital to establish boutique medical practices. Others might use it to produce goods characterized by what economists call 'positive externalities'—that is, benefits in addition to those reaped by the physician's patients themselves. One thinks here of health care rendered the indigent on a charitable basis or rendered Medicaid beneficiaries at fees far below the physician's opportunity costs of delivering those services or rendered in less desirable, rural locations. To encourage the delivery of services with positive externalities, however, it would be far more efficient and powerful to subsidize the production of these services directly. How might this be done in a country that will never embrace the idea of universal health insurance at uniform fee schedules?"

"Instead of across-the-board subsidies toward the human capital of all physicians, regardless of the subsequent deployment of that capital, a workforce policy more in tune with the twenty-first-century U.S. health system might eliminate these subsidies altogether and establish instead a government-run human capital market in which medical students could borrow the funds needed to pay fully for their own medical education. A

graduate's indebtedness of, say, \$200,000 upon entry into medical practice could then be fully amortized over twenty-five years, at an interest rate of 8 percent, with annual payments of about \$18,700. If the payments were made tax-deductible, as they should be, the net burden on the physician might be no higher than half that amount. As Main Street enterprise goes, this is not an enormous debt-service burden."

"A good case can be made also for eliminating public subsidies toward the graduate medical education (GME) of physicians. The economist's argument here is that the low remuneration now paid highly skilled residents per hour actually worked is so low that the residents in effect pay fully for the added costs incurred by their employers for their training. The only reason why at least this economist would be loath to see that sound economic principle on GME (the elimination of public subsidies) actually applied in practice is that the teaching hospitals now divert the public subsidies ostensibly granted them for GME to cross-subsidize the otherwise uncompensated care they render uninsured Americans."

"If all physicians were forced to debt-finance the full cost of their medical education, then a public physician workforce policy might take the form simply of judiciously targeting tax-financed loan forgiveness to achieve certain desired social ends, be it a desired ethnic or gender mix in the physician supply, a desired specialty or spatial distribution of physicians, or a desired delivery of health services with positive externalities, such as care provided below the physician's opportunity costs (including uncompensated care). In principle, one could even use the mechanism to modulate the overall size of the physician workforce. In effect, the policy would be a slight variant of the current ROTC program for the military or the National Health Service Corps for physicians. These two programs prepay the cost of the student's human capital and then hope to collect on it through mandated subsequent service. The program proposed here would force the student to accumulate financial indebtedness first and forgive that debt only in step with actual service delivery."

RWHC Eye On Health



"What's next? Now those rurals want to invest in people where they are needed, not in schools where they are not wanted."

"Limitation of space does not permit more than a sketch of the concept proposed here. Admittedly, it would be a radical departure from conventional physician workforce policy in the United States and in other countries. Unlike the United States, however, most other countries do not treat health care as basically a private consumer good and medical practice as just another form of free enterprise. Instead, they tend to treat physicians as quasi civil servants with explicit social obligations. To that end, they think nothing of controlling their physicians' fees, incomes, and even locations, which then

furnishes the economic rationale for granting them fully tax-financed medical education and training in return. Because these countries pay explicitly for all services rendered by physicians, through truly universal health insurance systems whose uniform fee schedules assign the same social value to the physician's work, regardless of the patient's socioeconomic class, the distribution of physicians across regions and socioeconomic groups is not driven by differential social valuations of the physician's work. It is an entirely different context for a public physician workforce policy."

Small Employer Crisis: "While Rome Burns"

Last December, the Wisconsin Private Employer Health Care Coverage Board (PEHCCB), in its annual report to the Governor and Legislature, stated that significant progress had been made in addressing barriers to implement the statutorily mandated health insurance purchasing pool for small employers. But it also had to write: **"Unfortunately, two key issues remain: adequate start-up funding and significant market reform or some other alternative means of protecting the program from adverse selection."** The recent Budget "Repair" Bill addressed the former but not the latter—providing startup funding but not addressing the critical issue of a mechanism to protect the pool from significant adverse selection. (For better or worse, EOH Editor Tim Size is Chair of this board, is not a neutral observer and is not speaking for the PEHCCB in this article.)

In early September, the PEHCCB met to discuss how to best advise the Wisconsin Employee Trust Fund administration (who also temporarily "staffs" the PEHCCB) to proceed. It was emphasized that the purpose of this initiative was not global but targeted—not to address the many substantial drivers of statewide health insurance costs but bring a degree of price stability and insurer choice to small employers. The decision was made to not immediately proceed to refill the PEHCCB staff positions which were vacated when the initial funding commitment expired until we knew we

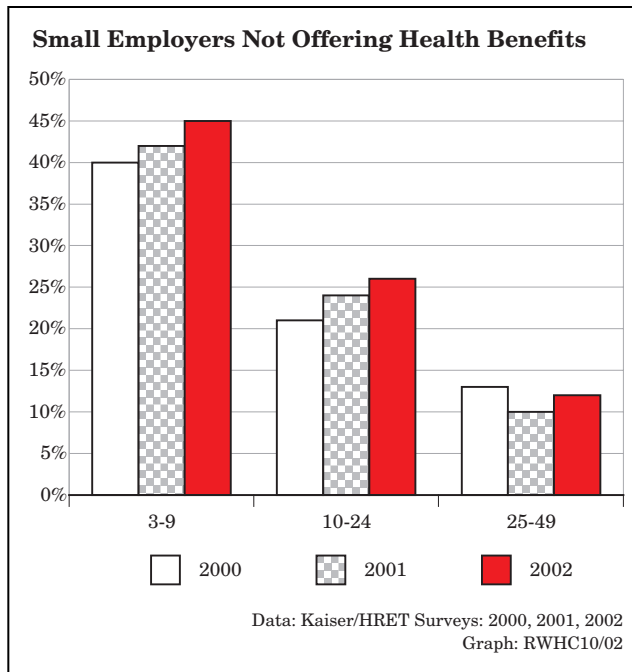
would be able to actually implement the program. It was decided not to immediately re-release a Request For Proposal to the insurance sector as our best available information is that potential insurers and administrators remain unwilling to participate, as they do not believe the current program design is workable.

To move forward as responsively as possible, the Board recommended two actions: (1) That a national consultant (to be determined) be engaged to review current program design and suggest what policy options could be legislated to address the adverse selection issue. (2) That meetings be requested on behalf of the PEHCCB with the Wisconsin Association of Health Plans and the Wisconsin Association of Life & Health Insurers. The purpose of these meetings will be to determine what, if any, legislative or regulatory action they are willing to support.

In the meantime, the health insurance crisis for small employers and the people who work with them worsens. The following article is from "Small Employers Severely Reduce Health Benefits" by Milt Freudenheim in the *New York Times*, 9/6/02:

"Kathy Steever, office manager of her family's automobile repair shop in Sioux Falls, S.D., is expecting a baby in December. Her father, who also works at the shop, learned last year that he has cancer."

"Even so, their company, called Pro Tune Up, canceled health coverage for all five employees last spring. Ms. Steever said premiums jumped by two-thirds, to \$2,000 a month, from \$1,200 in 2001, just when demand for the shop's services was slowing in a faltering economy."



"The cancellation of benefits at Pro Tune Up added seven adults, including two spouses, and four children to the estimated 40 million Americans without health insurance. Cutbacks at other small businesses squeezed between rising premiums and the sluggish economy are likely to add to that number."

"Although most large employers still offer health benefits, fewer small companies are providing coverage. Forty-five percent of employers with three to nine workers now offer no health benefits, up three percentage points

from 2001, the Kaiser Family Foundation said in its annual report on employer-based insurance.” (Released 9/5/02, available at www.kff.org).

“Michael Wiston, president of the Valley Marble Slate Corporation, which makes kitchen countertops in New Milford, Conn., said premiums for his seven employees had doubled since 2000, to a total of \$39,600, while the services covered had been reduced.”

“‘I have a liver problem,’ he said. ‘In another year, I’ll be on a list for a transplant. What worries us is: What do they cover, and what don’t they cover?’”

“Workers are paying more of the costs, as higher premiums, deductibles and co-payments for prescription drugs, doctor visits and hospital charges outpace wage increases.”

“The average share of the premium for single workers rose 27 percent, to \$454 a year, and 16 percent, or \$2,084, for families. But wages rose only 3 to 4 percent.”

“Annual premiums for preferred provider networks, or P.P.O.’s, which cover more than half of insured workers, rose to \$8,037 for families, including \$2,148 on average contributed by each employee. And P.P.O. deductibles rose 37 percent, to an average of \$276 a year.”

“For a family with income of \$30,000, added health care costs, including higher payments for drugs, doctor visits and hospital fees, could swallow more than half the average raise, said Mr. Gabel, a researcher at the Health Research and Educational Trust in Washington. He has tracked employer-based health costs since 1987.”

“Almost all employer health plans use a type of managed care. Only 5 percent still have traditional fee-for-service coverage; 26 percent are in health maintenance organizations; 52 percent are in P.P.O.’s, which have fewer restrictive rules than H.M.O.’s; and 17 percent are in point-of-service plans, hybrids that typically combine features of H.M.O.’s and preferred provider networks.”

Admissions Of Two Serial Pollsters

From “Opinions On Public Opinion Polling, by Drew Altman and Mollyann Brodie, *Health Affairs* (A Web Exclusive), 8/14/02:

“We believe that the real value of polling is to show leaders and groups where the public is and where they still have some educating and convincing to do. Another value is in helping elected officials to avoid big mistakes by misreading the public. And most importantly, polling adds value by documenting problems and experiences and by giving people a voice they may not otherwise have had. But polls need to be read with a critical eye. And it should always be remembered that public opinion can be fluid and is just one of many elements in the national agenda-setting and decision-making processes.”

“**What polls cannot tell us.** First, polling can tell us where the public stands on an issue, but it cannot tell us what is right. Poll after poll shows that the public cares about the problem of the uninsured but is unwilling to pay enough to solve it. Does that mean that we should abandon the cause of solving health care’s biggest problem?”



“**Polls do not tell the whole story.** Second, in interpreting polls, it is important to keep in mind that public opinion is just one factor in the political/policy process. Let’s stick with the example of the uninsured. Our most recent NPR/Kaiser/Kennedy School of Government poll found that most people care a lot about a variety of health care topics, including helping the uninsured and helping seniors to afford prescription drugs. However, when they were later forced to choose in a head-to-head question, more people picked the uninsured as a priority than picked helping seniors pay for prescription drugs. The finding is totally accurate as far as it goes, but it doesn’t change what we also know (in part from polling, in part from experience): While there is great concern about the uninsured, the public doesn’t want to pay enough to provide for universal coverage, and there is no consensus about how to solve the problem, especially among policymakers.”

“Think like average people, not experts. Third, in interpreting polls we should try to think like average people, not like we ‘experts’ think. For example, we frequently ask people to rank the priority they give to different health issues before Congress because we want poll findings that are relevant to current debate. So in our questions we ask the public to rank the issues of the uninsured, prescription drugs for seniors, patients’ rights, assuring the long-term fiscal health of Medicare, and so forth. But it turns out that real people aren’t organized like congressional committees and don’t put the issues neatly into policy buckets like we do. What they are concerned about is the cost and affordability of health insurance, a concern that cuts across all of these issues. So when Americans say they are concerned about health insurance coverage, they don’t just mean the thirty-nine million uninsured people. They also mean that they are worried about their own insurance and what might happen to them.”

“Getting the labels right. Fourth, let’s be more precise about what we call ‘public opinion polling,’ a catch-all label that includes the public’s opinions on issues or candidates but often also includes hard data on people’s experiences with the health care system. Polls measure more than just opinion. Sometimes the more relevant information is not what people think but what they actually do and experience. For example, in the ongoing debate about consumer protection legislation, polling shows consistently that people favor patient protections, although (not surprisingly) when respondents confront the potential downsides of the proposals, like increased costs or employers’ dropping coverage, support wanes. However, perhaps even more enlightening are poll findings that show that about half of people with private health insurance report experiencing some sort of problem with their health plan and that many times these problems lead to serious negative outcomes. This shows, to an often cynical reporter or political commentator, that the debate occurring in Washington is about a real issue affecting real people in real ways.”

“Understanding the technical side. Fifth, technical features of polls are often misunderstood. A good example is response rates, a measure that often gets too much attention. They are important, but not all-important. Journals typically look for 50–60 percent response rates, but a poll can have a 90 percent response rate and not be representative if it misses a key group or if the initial sample was chosen badly. More important determinants of survey quality are often question wording and question order, but in our experience these often get less attention from reviewers and the users of polling data.”

“Dangers of polling about complex issues. Sixth, beware of polling about specific, complex policy options. Policy-option polling pushes the limits of what polling can do, particularly if the policy options are complex. We think that it is important to understand the limitations of polls, but also to look for whether the pollsters have taken steps to try to mitigate these limitations. For example, did the question explicitly offer a ‘don’t know’ response, allowing uncertainty as a perfectly legitimate and acceptable answer for the respondent? Did the question give the respondent more information about the topic to help fill information gaps that may be present? Did the poll show the results of similar questions using slightly different wording to illuminate how the choice of words and people’s reactions to those words may have influenced their answers?”

“Research versus political uses of polling information. Seventh, it’s useful to keep in mind that health services researchers and political people approach polling very differently. Politicians and political consultants focus on voters and swing groups such as the elderly or suburban women. It may sound strange, but the views of the public as a whole may not matter a lot to those in the political arena. Also, political people keenly understand the power of an influential minority and their opinions. For example, we know that for many years most Americans have said they would be willing to pay more in taxes to cover the uninsured, but almost half are not willing to pay much at all. From a research perspective, the finding is that a majority support paying more; from a political perspective, the finding is that the tax would be unpopular with a whole lot of people, many of whom are higher-income voters.”

“It is important to keep in mind also that what pollsters refer to as ‘salience’ can be as important as or more important than the rank people give to an issue. It is often the intensity of people’s opinions and how strongly they feel about an issue that determines whether they will really care about how policymakers choose to deal with a given issue or whether they will reward or punish a politician. For example, the public ranks HIV/AIDS as one of the top health problems facing the nation and the world, but very few people feel so strongly about the issue to base their vote on a candidate’s position on HIV/AIDS. Also, policy issues such as health care, education, or the environment are just one of many factors that influence peoples’ votes. The personal characteristics of the candidates, their perceived values and leadership ability, or whether they have delivered for their districts are often more influential than their position on the issues.”

“Polling is not in a vacuum. Finally, and most importantly, it is critical to keep in mind that public opinion doesn’t exist in a vacuum, waiting to be measured by pollsters and social scientists. Rather, it is affected mightily by leadership and by real-world events. How else to explain the sharp rise in concern about terrorism, the economy, and corporate scandals and the decline in priority placed on some other domestic issues since September 11? When leaders discuss patients’ rights or there is a controversy in Washington about it that is widely reported by the news media, patients’ rights climbs up on the public’s list of concerns. Same for Medicare, as polls conducted during the last election showed. There are core values and beliefs that don’t change a great deal.”

“Patients are not getting what they need, but it is not a matter of skill or will. Doctors and nurses can’t give the care they want to give. It’s time for new systems. It’s not about blame. It’s about change.”

Donald Berwick, M.D., M.P.P.
Institute for Healthcare Improvement

RWHC Quality Program Gets National Plug

Quality Improvement in Rural Hospitals: How Networking Can Help is an excellent technical monograph by the Academy for Health Services Research and Health Policy and was supported by a grant from the Robert Wood Johnson Foundation. Written by Kerry Kemp, it discusses “the challenges and obstacles that small rural hospitals face, as well as the assets and advantages that are often overlooked.”

The RWHC Quality Indicators Program, highlighted in the monograph, was started with help from the Robert Wood Johnson Foundation in 1988, and now “specializes in data collection for small to mid-size health care organizations. The fees for the RWHC program are considerably lower than those for other programs. JCAHO has accepted the RWHC Quality Indicators Program as a performance measurement system authorized for use in JCAHO’s ORYX initiative, which focuses on outcome measurement as part of the accreditation process.” The monograph is available at www.ahsrhp.org/.

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