

**NEW APPROACHES TO ACADEMIC HEALTH CENTER
AFFILIATIONS: PUBLIC HOSPITALS AND THE DEPARTMENT OF
VETERANS AFFAIRS**

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In the current period of rapid change in the structure, financing, and governmental oversight of the health care delivery system, two types of health care organizations may be the most vulnerable: public hospital systems and academic health centers (AHCs).

Both types of organizations must cope with unprecedented pressures to reduce costs. AHCs are especially likely to be high-cost providers of health services—25 to 40 percent higher, in fact, than non-academic centers. AHCs face decreases in traditional sources of revenue such as federal support for graduate medical education (GME); increased efforts to move GME outside the hospital setting; greater competition for new funds for biomedical research; and rising numbers of uninsured patients.

Public hospital systems must answer demands to clarify their roles as safety net providers, especially as other providers compete for Medicaid managed care clients. They must differentiate between the functions they alone can perform as governmental entities and those for which they can contract with other providers. For these contracted-out services, public systems are increasingly required to develop ways to measure the performance of the contractor in order to ensure appropriate accountability and the wise use of public funds.

The nation's two largest public sector health care delivery systems—the New York City Health and Hospitals Corporation (HHC) and the Department of Veterans Affairs (VA)—have, over the past four years, developed new systems and structures designed to meet the need for greater efficiency and accountability. At the heart of this effort is a review and rethinking of their relationships with affiliated AHCs, their major source of physician services. For HHC, whose core mission is patient care, the focus has been one of assessing whether contracts with academic affiliates provide for the market levels of productivity available from non-academic providers at comparable quality. For the VA, which has as one of its core missions health professions education, a heightened emphasis on patient-centered primary care has led to the need for new organizational structures—some of which do not mesh easily with those of their traditional academic partners.

The New York City Health and Hospitals Corporation

The New York City Health and Hospitals Corporation operates 11 acute care hospitals, six large diagnostic and treatment centers, four long-term care facilities, six certified home health agencies, and numerous community-based clinics in New York. HHC's annual budget of \$3.3 billion is mostly derived from third-party payers, a significant change compared with fiscal year (FY) 1994, when HHC received a tax levy subsidy of almost \$333 million from the city. As part of the redesign accompanying this change in revenue, HHC reduced its workforce from more than 36,000 employees in FY 1998 to 33,500 in FY 1999. Furthermore, HHC reduced its annual budgeted payments to the AHCs that provide physician and some other professional services from \$505 million in FY 1996 to \$428 million in FY 1999.

In the mid-1960s, HHC's predecessor organization, the New York City Department of Hospitals, entered into a series of affiliation agreements with New York's AHCs to provide physician and other professional services to the city's public hospitals. Through these agreements,

public hospitals were assured well-trained medical staffs while AHCs were guaranteed a broad patient base to support their teaching and research.

The affiliation agreements evolved over the 1970s, 1980s, and early 1990s. Most non-physician services were transferred to HHC's direct management, and the agreements themselves became regularized, written contracts. However, the focus on reducing HHC's tax levy funding that began in 1994 led to a closer examination of what exactly HHC was purchasing from its affiliates

A 1994 assessment of the affiliation agreements compared HHC's primary care physician (PCP) productivity unfavorably with the national average. The analysis calculated HHC's PCP cost per hour as, at its lowest (including resident physicians), \$86, compared with the national average of \$39–\$54. HHC's cost per PCP visit was \$57, compared with the national average of \$17–\$32.

The analysis suggested many reasons for this low PCP productivity, some of which were caused by HHC structural factors—limited numbers of exam rooms, block scheduling of patients, poor response times for ancillary services—and some of which were caused by components of the affiliation contracts. These included payment for non-patient care duties such as research and administration, and fragmented, oversized residency programs. In addition, the structure of the contracts was an issue: HHC was required to pay its affiliates according to the number of staff covered by the contract, regardless of the level or quality of their performance.

HHC had to decide how to use its market leverage as the largest purchaser of physician services in New York State to develop revised affiliation contracts that would provide for market compensation for market productivity.

Three principles guided HHC in developing its new affiliation contracts:

- active involvement of medical staffs in negotiation of new contract terms and requirements;
- sensitivity to the need to balance the affiliate's mission of teaching and research with HHC's emphasis on direct patient care; and
- change to a workload-based compensation model.

Each of the eight current affiliation contracts specifies its own payment methodology. Not all of HHC's affiliates chose to renew their relationship with HHC under the new contractual model; in cases where the affiliate broke off negotiations, HHC issued a request for proposals and eventually contracted with a new affiliate. Three hospitals that formerly had affiliation agreements with academic institutions now contract with either voluntary hospitals or professional corporations.

HHC also, for the first time, included performance indicators in the new contracts. There are 24 corporate-wide indicators covering quality of care, quality of service, and quality of providers, with individual facilities allowed to specify additional indicators related to their own

strategic goals. Performance on each indicator is reported and evaluated quarterly, and HHC may assess financial penalties if performance goals are not met.

In addition to a 15 percent reduction in cost for affiliation contracts, the change in contract structure has led to other improvements. HHC officials say that most recent reports show the majority of affiliates to be in full or significant compliance with the performance standards measured by the contract indicators. Officials also point to significant qualitative benefits arising from these efforts to quantify performance: improved morale resulting from greater accountability and clarity of expectations, and improved service owing to HHC's active measurement of both quality and productivity.

The Department of Veterans Affairs

The health care system run by the VA is massive in terms of the population it serves and the scope of its involvement with medical education. Organized as 22 integrated networks of care with an annual budget of \$17.4 billion, the VA treats about 800,000 patients annually in its hospitals, 82,400 in nursing homes, and 25,000 in domiciliaries. VA outpatient clinics provide about 36 million visits per year. The VA is currently affiliated with 107 medical schools and 55 dental schools; about half of all medical students and one-third of all medical residents in the United States rotate through VA facilities each year. Health professions education and training is an explicit mission of the VA in its congressional mandate.

In FY 1995, the VA began a strategic transformation effort driven by a recognition among the system's leadership that it could no longer continue as a hospital-focused, specialist-based organization geared toward the episodic treatment of illness. Key principles of the transformation included:

- defining the primary business of the organization as health care, not hospitals;
- recognizing patients as the center of the health care universe;
- defining health care as primarily an outpatient activity; and
- accepting as essential the mandate to provide good value.

The transformation effort led to several structural changes. In a shift from viewing the hospital as the VA system's basic operating and budgetary unit, a new management entity—the Veterans' Integrated Service Networks—was established. All VA facilities are now organized into 22 such networks. Other structural changes include a new capitation-based resource allocation system, decentralization of decision-making, and a new performance management system featuring performance contracts for network managers and for facility and other managers. Finally, strategic health care groups (e.g., primary care, acute care, and diagnostic care groups) that crossed boundaries of traditional AHC departments, such as medicine or surgery, were established.

From 1995 to 1998, the types of services delivered by the VA changed dramatically. The VA closed 52 percent of acute care hospital beds, reduced bed days of care per 1,000 patients by 62 percent, increased ambulatory surgery from 35 to 75 percent of all surgeries, and established

263 new community-based outpatient clinics. The focus on primary care was so strong that by FY 1998 more than 80 percent of VA patients could identify their own primary care physician

Guided by the belief that the medical education system it supports is critical but that its size and shape should be driven by the clinical care delivery system, the VA has realigned the types of medical residencies it offers. It is a change, VA leaders note, that is in conflict with what some of the VA's academic partners would like to see. Overall residency positions in the VA system have decreased from more than 8,900 to 8,660 (the 1987 level), and primary care as a percentage of these positions has increased from 37 to 49 percent. The VA has augmented the resources it provides for preventive and occupational medicine and geriatrics and has instituted its Primary Specialist programs to train specialists and psychiatrists to provide primary care. Fellowships have also been established in quality management and in end-of-life care.

As with clinical care, the VA is currently working to identify appropriate measures—especially outcome measures—of performance expectations for education and research activities so that it can be better managed and VA providers held more accountable. VA officials, however, are experiencing difficulty finding the appropriate metrics. Also problematic is determining what amount of time should be set aside for research, and for whom; reconciling the VA's new service line organization that integrates resources across departments for areas such as cancer care with the traditional, discipline-specific model used by most academic medical institutions; and managing the tension that has resulted from the VA's decision to move the sites of care away from traditional hospitals and into the community.

Issues for the Future

The experiences of HHC and the VA reflect growing trends in the relationship between academic medicine and public-sector health care delivery. As HHC has demonstrated, the establishment of performance-based payment mechanisms is critical for both public institutions and their academic partners. Experts are beginning to report interest in moving beyond payment for services based on measures of number of services provided. Instead, they are considering methods that mimic those of managed care, including capitation, which bases payments on the characteristics of the specific population to be served.

The VA's effort to redirect its focus toward primary care, and the inherent conflict with the traditional structure of GME this represents, has relevance for other public sector providers as well. In many cases, AHCs are concentrating on providing tertiary or quaternary care and seeking to become national and international referral centers—centers of technological expertise. If these AHCs move out of the business of primary care altogether, public systems offering mainly primary care services will have a more difficult time forming alliances with those AHCs oriented exclusively toward specialty care. In essence, the needs of one entity will be out of alignment with the needs of the other.

The future will require public sector health systems and AHCs to evaluate fully the potential benefits of strengthening a sense of partnership. The public sector's experience with the types of service rationalizations and accountability initiatives undertaken by HHC and the VA can

help accelerate change in AHCs, which rely on their public-sector affiliations as they face demands to increase productivity and the value they provide. Alternatively, while links with academic medicine can ensure that public health system patients benefit from the most recent developments in medical care, some public systems will find that "shopping around" for the best cost-quality package is increasingly possible, and even preferable.

The future effectiveness of partnerships between public hospitals and AHCs will depend increasingly on achieving a common alignment of goals and purpose. This consistency would allow both types of organizations to respond effectively to changing patient expectations and economic realities. If that alignment is not realized, these once-expected partnerships may no longer be a given in the present competitive environment.

This issue brief is based on the first of four symposia sponsored by The Commonwealth Fund and the Robert F. Wagner Graduate School of Public Service, New York University. These sessions provide a forum for policymakers, researchers, and practitioners to explore current issues in health policy. Topics for future symposia will include government accountability as a purchaser of health services and Medicare in New York City.