

The Business Case for Optimized Academic Health Center-specific Metrics

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This issue brief frames the basic arguments supporting development of optimized metrics for academic health centers and considers the policy context in which such metrics would be implemented. It also addresses practical considerations and potential limitations with respect to development and implementation.

WHAT MAKES ACADEMIC HEALTH CENTERS UNIQUE?

A full appreciation of the scope, purpose, and value proposition of optimized academic health center-specific metrics begins with the definition of an academic health center. As defined by the Association of Academic Health Centers (AAHC), it is an educational institution that includes a medical school and at least one additional health professions school (e.g., nursing, dentistry, pharmacy, allied health, public health, veterinary medicine, graduate school), and either owns or is affiliated with a hospital or health system.

In the course of carrying out their mission of advancing and applying knowledge to improve health and well-being, academic health centers engage in three essential activities:

- Educating the nation’s health workforce through their health professions schools;
- Conducting cutting-edge biomedical and clinical research; and
- Providing comprehensive patient care.

Although they are part of the system of higher education and located within universities, academic health centers engage in clinical activities that extend beyond those of traditional academia. Similarly, while they compete in the health care marketplace with for-profit and not-for-profit physician groups, hospitals, and health systems, academic health centers engage in far more extensive educational and research activities than their competitors. In other words, they are neither purely academic institutions nor purely health care providers.

Academic health centers have additional distinguishing characteristics. For example, they frequently serve a disproportionate share of the uninsured and underinsured in their communities, and often have a mission (if not mandate) to serve as provider of last resort. Academic health centers are also more likely to provide tertiary and quaternary health care services, specializing in the most complex and difficult diagnoses and treatments.

THE BUSINESS CASE FOR OPTIMIZED METRICS

Is there a compelling need for optimized academic health center-specific metrics, and if there is, what might such metrics might look like?

The academic health center clinical revenue stream is at risk for the foreseeable future. In response to the current economic and budgetary environment, federal and state governments are likely to reduce Medicare and Medicaid reimbursements over time, and private payers are likely to reduce coverage and shift costs to patients if costs cannot otherwise be contained. Moreover, with several states implementing alternative payment models, and Medicare (and eventually other payers) expected to move to value-based bundled payments in the near future, academic health centers face a potentially difficult transition to new reimbursement methodologies. Because most academic health centers use clinical revenue to cross-subsidize education and research activities, erosion of the fiscal health of clinical activities undermines the viability of the entire academic health center enterprise.

Successfully navigating these financial challenges demands that academic health center leaders have effective tools to measure

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and benchmark their institution’s performance, identify best practices, and significantly improve efficiency and efficacy. Currently, academic health center leaders manage their institutions with suboptimal metrics. While several organizations offer academic health centers an array of well-established clinical metrics as well as metrics for aspects of medical school or university operations, none of these metrics are optimized specifically for academic health centers (as defined above) to take into account the interrelationships of their education, research, and clinical activities.

For example, many academic health centers rely on what Dr. Steven A. Wartman, President/CEO of the AAHC, frequently refers to as “the virtuous cycle”: the education and research functions of the academic health center enhance the innovation, prestige, and market competitiveness of its clinical function, while the clinical function returns a portion of clinical revenue to subsidize and enhance the education and research functions. As a result, there are fund flows between the education, research, and clinical functions within an academic health center that simply don’t exist in other academic institutions and clinical enterprises, impeding an optimal comparison of cost structures and relative efficiency.

In the absence of optimized metrics, the fallback for academic health center leaders has often been to use traditional hospital metrics, despite their inadequate accounting for academic health centers’ shared infrastructure and unique fund flows. During more favorable economic conditions, these deficiencies were easier to overlook because access to this information was not critical. In the current economic environment, where federal and state budget deficits threaten both clinical revenue streams and funding for education and research activities, the need for reliable metrics to measure and improve performance is far more acute.

What types of optimized academic health center-specific metrics are needed? Ideally, several distinct types of metrics would be useful, including (but not limited to):

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- Near-term human resource and infrastructure management tools;
- Long-term performance measurement and strategic planning tools;
- Comparative benchmarks;
- Measures designed for a value-based reimbursement system;
- Measures related to the health workforce pipeline; and
- Measures of health outcomes and community well-being.

While each of these types of metrics directly relates to core academic health center issues, there appears to be a consensus among academic health center leaders that optimized metrics concerning research infrastructure costs, and faculty effort and support, are most urgently needed and most feasible in the short term.

In addition to their usefulness with respect to internal management, strategic planning, and benchmarking, optimized academic health center-specific metrics are relevant to the public policy concerns of academic health centers. For example, public policymakers are often unaware that:

- Care provided at academic health centers may cost more, compared to other settings, in large part because clinical revenue is subsidizing the academic health center’s education and research activities; and
- These cross-subsidies are necessary because health professions education, as well as biomedical and clinical research, are chronically underfunded.

Optimized metrics would quantify these underappreciated and misunderstood costs and cross-subsidies, and offer an opportunity for better informed public policymaking with respect to funding health professions education and research.

IMPORTANT CONSIDERATIONS AND LIMITATIONS

A number of challenges are inherent in the development and implementation of academic health center-specific metrics, including:

- *The size and complexity of academic health centers vary across a wide spectrum; optimized metrics are likely to be most robust when making comparisons within affinity groups.* Despite their similarities, the academic health center community is diverse and inclusive of public and private universities, large research-intensive institutions and smaller institutions that do not emphasize research to the same degree, as well as historically community-based institutions with explicit social missions. One of the challenges in developing optimized academic health center-specific metrics is ensuring they are as broadly applicable as possible given this heterogeneity. Even when fruitful comparisons are not applicable across the entire academic health center community, there is still value in applying them within affinity groups, e.g., comparing public institutions to one another, comparing large research institutions to one another, etc.
- *An academic health center may have inadequate access to certain financial information held externally by its affiliated partners.* Some academic health centers own and control their hospitals and practice plans, while others have affiliation agreements with hospitals and practice plans that are independent of the academic institution. In the latter circumstance, depending on the degree of alignment and financial transparency between the academic institution and its affiliated hospitals and practice plans, academic health center leaders might not have immediate direct access to all the data elements that could be included in the metrics as they are developed. As a result, some academic health centers may only be able to collect and report partial data until they are able to make arrangements with their hospital and practice plan partners to obtain the remaining data.

- *Internal administrative structures and financial controls differ between academic health centers, such that data may be more readily accessible for some institutions than others.* Because each academic health center has evolved in a unique manner, differing combinations of administrative structures and financial controls may affect data categorization and retrieval among the institutions. As a result, the metrics developed need to be sufficiently flexible that they can accommodate this variation without significantly distorting the results.
- *Data collection and reporting can be staff and resource intensive; development and implementation of optimized academic health center-specific metrics should avoid creating burdensome barriers to participation.* Several steps can be taken to help reduce the costs of collecting and submitting data. For example, establishing a lexicon of definitions, relying as much as possible on those already defined and used elsewhere, would reduce confusion and ensure consistent data collection and reporting. NIH cost allocation methodology can be used as one of the foundations of the metrics (assuming adjustments are made to account for NIH exclusions in order to arrive at an “all-in” true annual cost report). In some cases, it may be necessary to rely on estimates (which should be identified as such) where deriving more precise measures would not be cost effective.
- *Protecting the privacy interests of participating institutions must be a paramount concern.* The nature of the data under consideration makes it highly sensitive. In addition to ensuring that the data is collected and housed in a manner that protects the privacy of participating institutions, it is essential that any shared data should be aggregated and disclosed anonymously. This approach leaves an opportunity for best performers to share their best practices without exposing an institution that may not be performing at the same level.

CONCLUSION

The goal of any initiative to develop and implement optimized metrics for academic health centers is not data collection for its own sake, but the creation of an analytic platform to assist academic health center leaders to identify and disseminate peer best practices. Such metrics are needed not just for improving performance, however, but also for assisting public policymakers to understand the value proposition of academic health centers in an environment of budget deficits and cost constraints. Future AAHC issue briefs will address the design and application of such metrics in more detail.



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