AAMC
Tomorrow's Doctors, Tomorrow's Cures

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Welcome!

Thank you for joining us for today's webinar. The program will begin shortly.

You will not hear audio until we begin. If you have any technical questions, please email aamc@commpartners.com

Association of American Medical Colleges

AAMC
Tomorrow's Doctors, Tomorrow's Cures

Understanding the Impact of COVID-19 on Physician Faculty Compensation

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November 12, 2020

VCU Health
OHSU Health
SullivanCotter

Association of American Medical Colleges

Agenda

Part One
AAMC/SullivanCotter

The Impact of COVID-19: A National Perspective

- Survey Results: Short-Term Impact of COVID-19 on Compensation
- Long-Term Implications of COVID-19 on Compensation and Potential Responses

Part Two
VCU Health and OHSU Health

Compensation Decisions in Response to COVID-19 and the Changing Health Care Environment

- Organizational Overview
- Short-Term Impact and Lessons Learned
- Planning for 2021 and Beyond
- Potential Barriers for the Future and Concluding Thoughts

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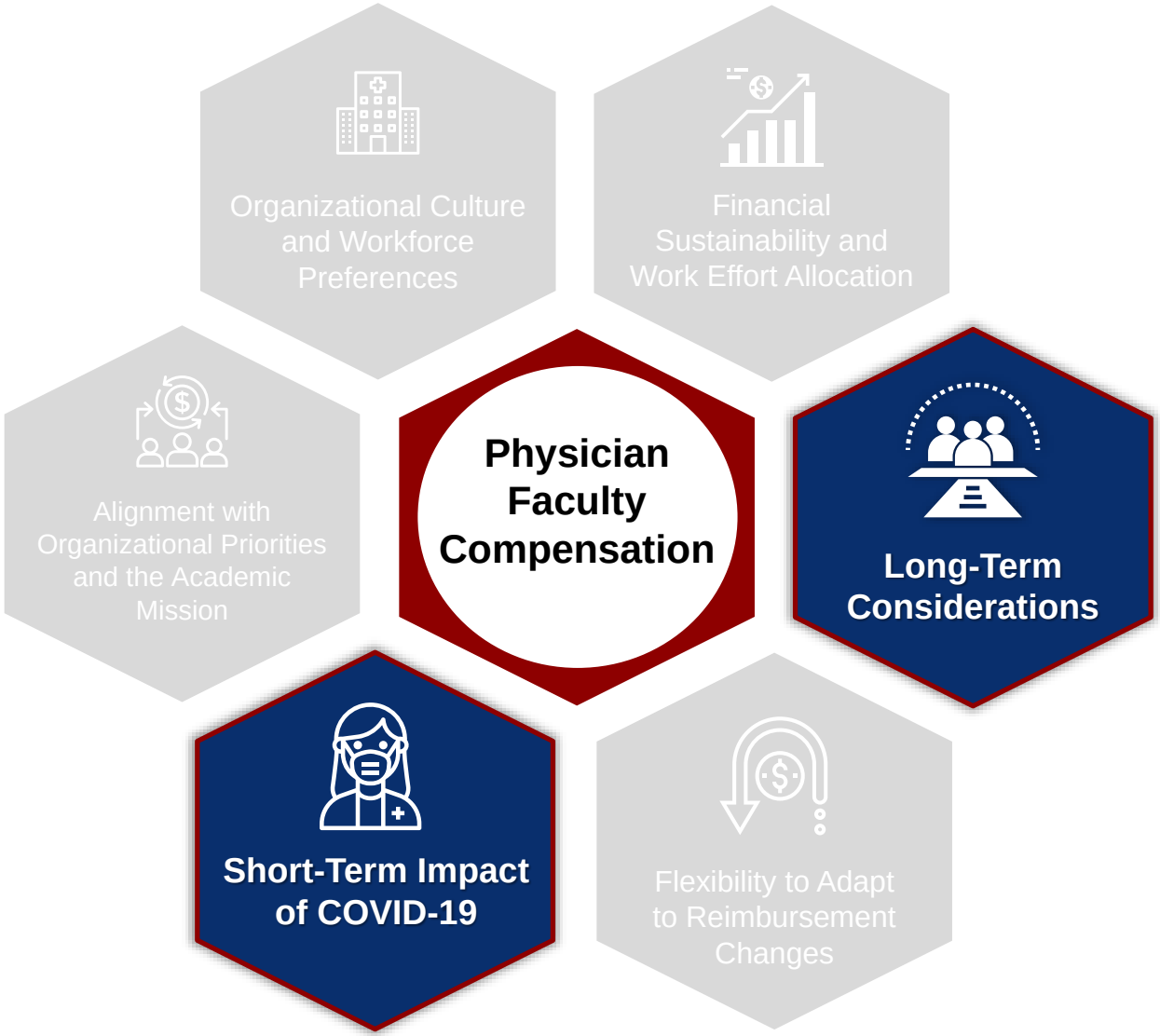
Part One

Physician Faculty Compensation
Considerations



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COVID-19: Survey Participants

Survey responses were collected from August through October 2020

44	21	23
Overall Responses	**Academic Medical Centers**	**Non-AMCs with Average Net Revenue > $2B**

Additional questions focused on academic medical centers were included in survey outreach conducted in October and yielded 10 responses (included in the 21 count above)

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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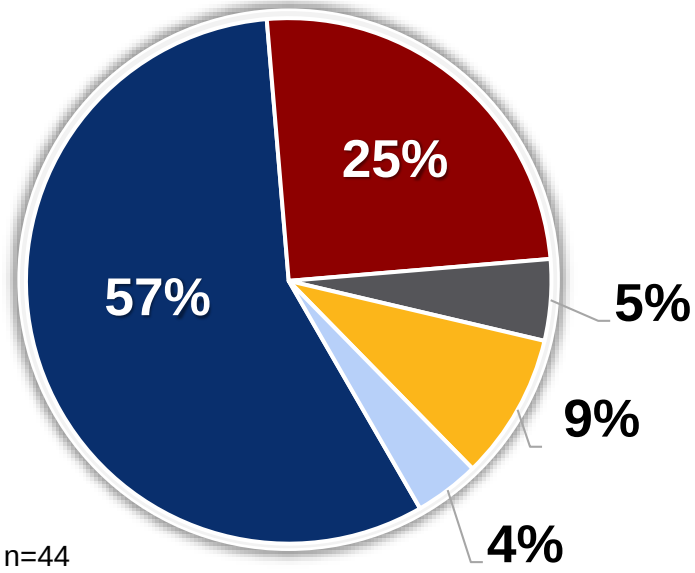
COVID-19: The Return to “Normal”

Many are adjusting to a “new normal” while also preparing for the next surge

All Organizations



n=44

- Returning to “normal”
- In the midst of a surge
- Returning to “normal” but preparing for another surge
- Preparing for another surge
- Other

- **82%** of respondents indicated they are returning to **pre-COVID volumes**
- Of these, **25%** indicated they are preparing for **another surge**
- The 21 AMCs included in the data set responded within 3-4% of the ‘All Organizations’ cut

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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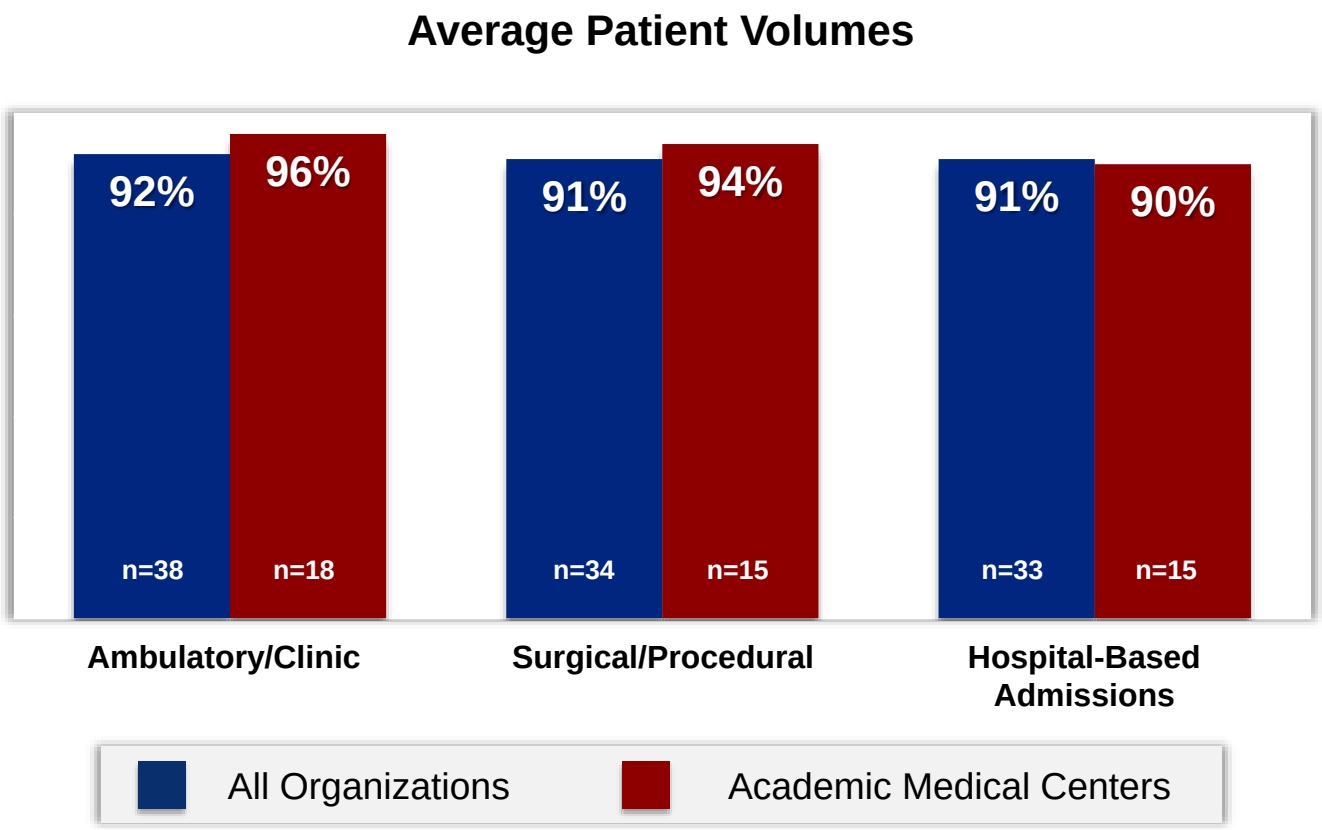
COVID-19: Average Patient Volumes

AMCs appear to have returned to slightly higher average patient volumes



Patient volumes ranged from **65% to 130%** of pre-COVID-19 levels

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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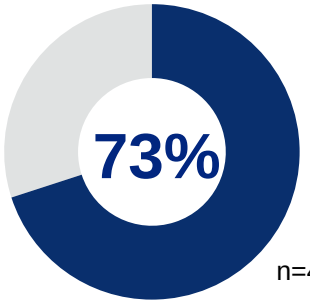
COVID-19: Short-Term Impact on Compensation

All Organizations

Adjusting Physician Compensation

Percentage of Respondents



n=44

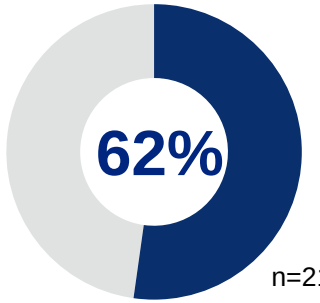
Response | n=32	**Prevalence**
Some form of compensation protection/floor	**56%**
Reduced compensation for all physicians, but provided some form of protection	25%
Reduced compensation for certain specialties	10%
Reduced compensation for all physicians	9%

- **73%** of respondents **made adjustments** to physician compensation programs
- Of those, **81%** provided some form of **compensation protection**

Academic Medical Centers

Adjusting Physician Compensation

Percentage of Respondents



n=21

Response | n=13	**Prevalence**
Some form of compensation protection/floor	**46%**
Reduced compensation for all physicians, but provided some form of protection	23%
Reduced compensation for certain specialties	23%
Reduced compensation for all physicians	8%

- **62%** of respondents **made adjustments** to physician compensation programs
- Of those, **69%** provided some form of **compensation protection**

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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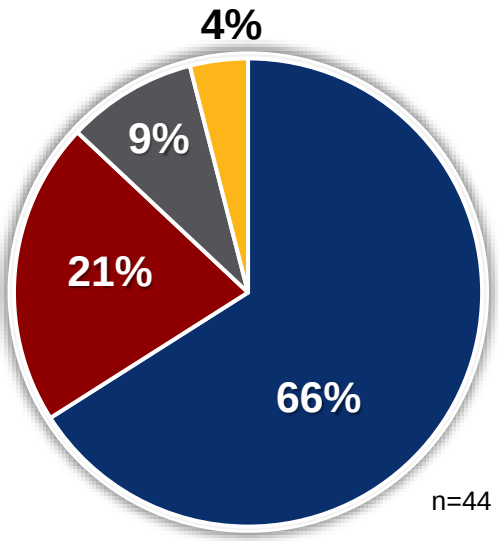
COVID-19: Short-Term Impact on Compensation

Remain on Current Compensation Plan v. Redesigning

All Organizations



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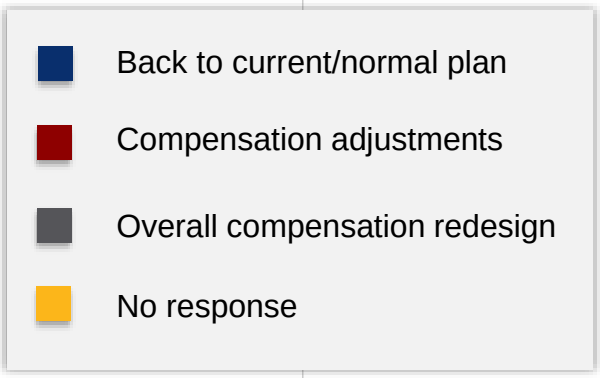
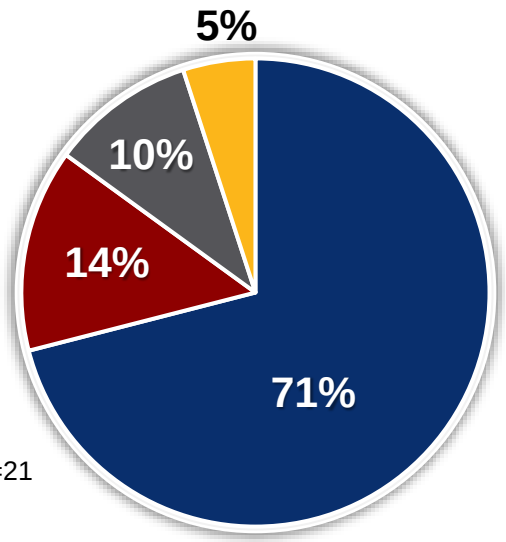


Academic Medical Centers



n=21

- **Nearly two-thirds** of respondents have returned to their pre-COVID-19 compensation plan
- However, respondents **remain flexible** to make additional adjustments if another surge should occur

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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COVID-19: AMC-Specific Questions

Additional outreach to AMCs focused on the following questions:

Question	n	Yes	No
Has COVID-19 impacted your academic promotion cycle?	9	22%	**78%**
Has COVID-19 impacted the level of academic funding available for compensation?	10	**60%**	40%
Have you had to adjust your work effort distribution to align with financial and operational challenges?	9	44%	**56%**
Have there been material changes in your approach to determining clinical work effort as a result of COVID-19?	10	20%	**80%**

- **Academic funding decreases** include reductions in state funding, grant activities and professional collections that are used to support the academic mission
- Clinical and administrative **work efforts** are being realigned by some respondents

Source: SullivanCotter *2020 COVID-19 Physician and Advanced Practice Provider Compensation Practices Survey* series

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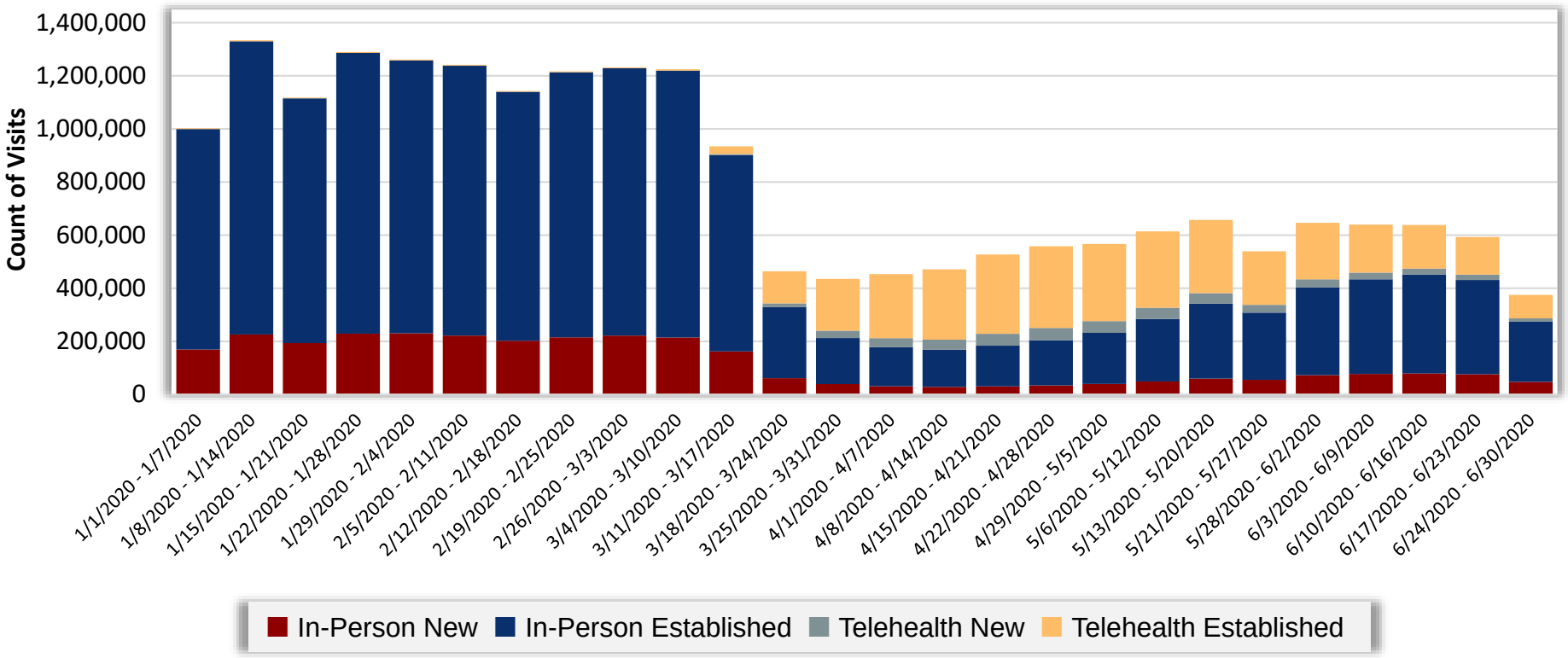
COVID-19 and Telehealth

Faculty Practice Plan Weekly In-Person and Telehealth E&M Utilization



Source: AAMC analysis of physician and non-physician claims billed by Faculty Practice Plan members of the Clinical Practice Solutions Center. The Clinical Practice Solutions Center (CPSC) is a jointly owned product of the Association of American Medical Colleges (AAMC) and Vizient that collects billing data from member practice plans to provide benchmarks and help them improve performance.

Note: 83 CPSC members had shared their claims data at the time of this analysis (August 2020). June data may be incomplete. "E&M Utilization" includes all in-person and telehealth claims with CPT codes 99201-5 (new) and 99211-5 (established) across all applicable places of service, specialties, and payers. Telehealth visits identified based on modifiers 95, GT, GQ, G0 on the claim.

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COVID-19: Organizational Impact

The global pandemic is driving fundamental change and uncertainty with respect to health care organization budgets, reimbursement, internal processes and operations

Financial Sustainability

- Decreases in volume/revenue
- Increases in expense

Population Health

- Flexibility to adapt to traditional and non-traditional access to care
- Increased focus on care coordination

Patient Access

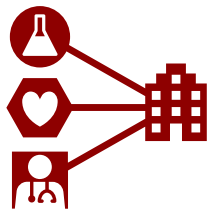
- Constraints on in-person patient consults due to COVID-19 protocol
- Requires expanded in-office hours

Optimizing Clinical Workforce

- Physician/APP redeployment
- Expanding APP scope

Virtual Medicine

- Development/expansion of non-traditional patient access
- Long-term uncertainty in virtual care reimbursement



Pandemic-driven change and organizational response may have long-term impact and requires aligned leadership

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Other Considerations

2021 CMS Proposed Physician Fee Schedule Changes

- Impact on physician productivity (wRVUs) and reimbursement

Stark Waivers and Proposed Stark Law Changes

- Uncertainty and potential policy changes
- Provides increased flexibility

Expansion of Virtual Health

- Temporary vs. permanent reimbursement
- Demand and commercialization
- Competition

Emerging Providers

- Walmart, Walgreens

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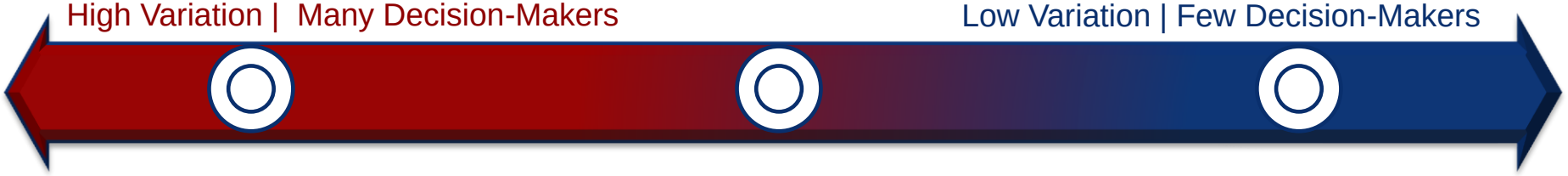
Long-Term Considerations

Degree of Institutional vs. Departmental Decision-Making

Dependent upon the organization's current physician and APP compensation strategy, degree of centralization and number of compensation plan types

Departmental
High Variation | Many Decision-Makers

Institutional
Low Variation | Few Decision-Makers



- Higher levels of **autonomy** promote **Departmental decision-making**
- **Barriers to care coordination** and collaboration for traditional and non-traditional patient care
- **Internal equity issues** due to differences in pay structure between specialty groups (e.g., percentage of base/variable compensation)
- **Retention and/or recruitment risk** (e.g., low pay, high productivity)
- High levels of **administrative burden**; mixed level of **financial sustainability**

- Risk **lower levels of physician engagement** due to less local control and input on key decisions
- A more **consistent reward structure**; supports a more uniform response and **flexibility as reimbursement changes**
- Ability to make **strategic decisions** related to **mission support**
- Fewer compensation approaches may not **recognize the differences between practice settings** and the various **physician phenotypes**

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Part Two

AAMC

VCU Health – a snapshot

- Commonwealth of Virginia's largest and fully-integrated academic medical center
- Integrated leadership/governance of SoM, FPP and health system
- Four schools and one college of health sciences
- Commonwealth's largest Level 1 trauma center verified for adult, pediatric and burn
- One of only two NCI-designated cancer centers in Virginia
- The region's only full-service children's hospital

By the Numbers (FY19)

1,081 Licensed Beds

200+ Clinical Specialties

19 Clinical Departments

12,500+ Team Members

850+ Physicians

400+ Advanced Practice Professionals

668 Patients enrolled in clinical trials

1,020 Patients in research studies

306 Studies open to enrollment

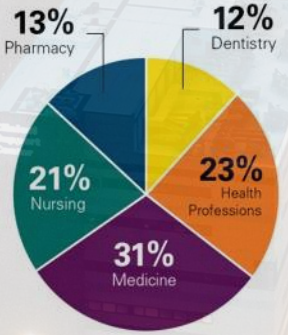
252 Clinical trials open to enrollment

$310.2M Total Amount of Research Awards

4,078 Total Students

779 Total Residents*

2019 Enrollment by College or School



*as of Fall 2019

VCU Health™

MCV Physicians

Faculty practice plan

Employs near 2,000 clinicians and team members

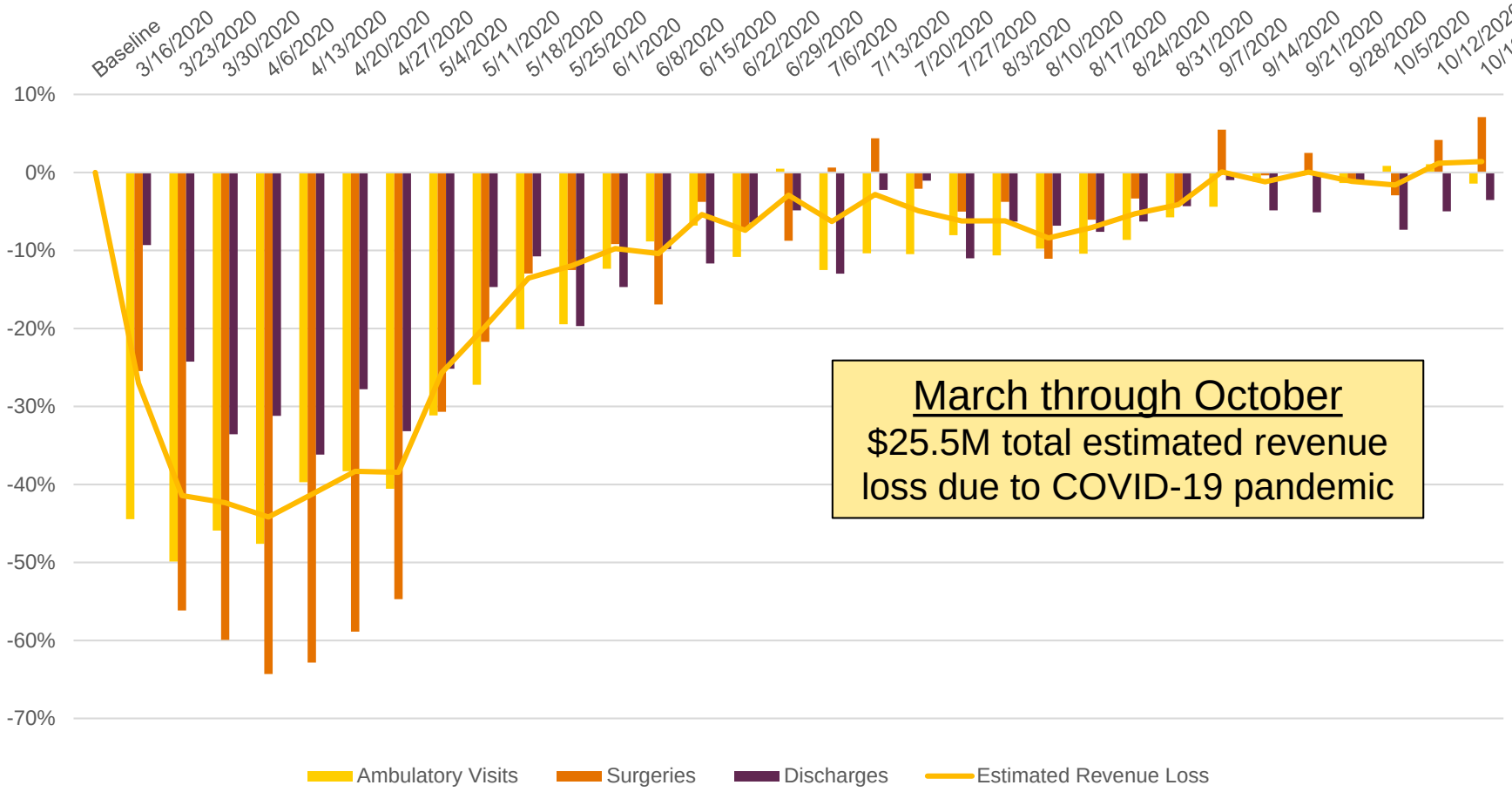
- 804 physician FTEs (615 cFTEs)
  - 21% growth in last three years
- 360 APP FTEs
  - 48% growth in last three years
- 706 staff FTEs
- $462M in total operating revenue (FY20)
- MCVP Comp plan – high degree of Centralization

At MCV Physicians, our mission is to set the standard for quality in patient care and to support the physician members and the mission of the VCU School of Medicine.

Response to COVID-19

- Targeted 80% reduction in ambulatory visits compared to pre-COVID levels, beginning in mid-March
  - All elective and non-urgent procedures postponed
- Converted physicians in wRVU-based productivity models to fixed salaries
  - Guaranteed 100% of previous total compensation (including incentives) earned over the previous 12 months
    - Fixed compensation levels in effect March through September
  - Productivity-based models resumed effective October 1
- No staff salary decreases or furloughs
  - Health system financial performance allowed for recognition bonuses to be paid to every team member in October
- Implemented more stringent review and approval processes around physician and APP recruitment, including a university-based hiring freeze
- Quickly stood up robust telehealth services

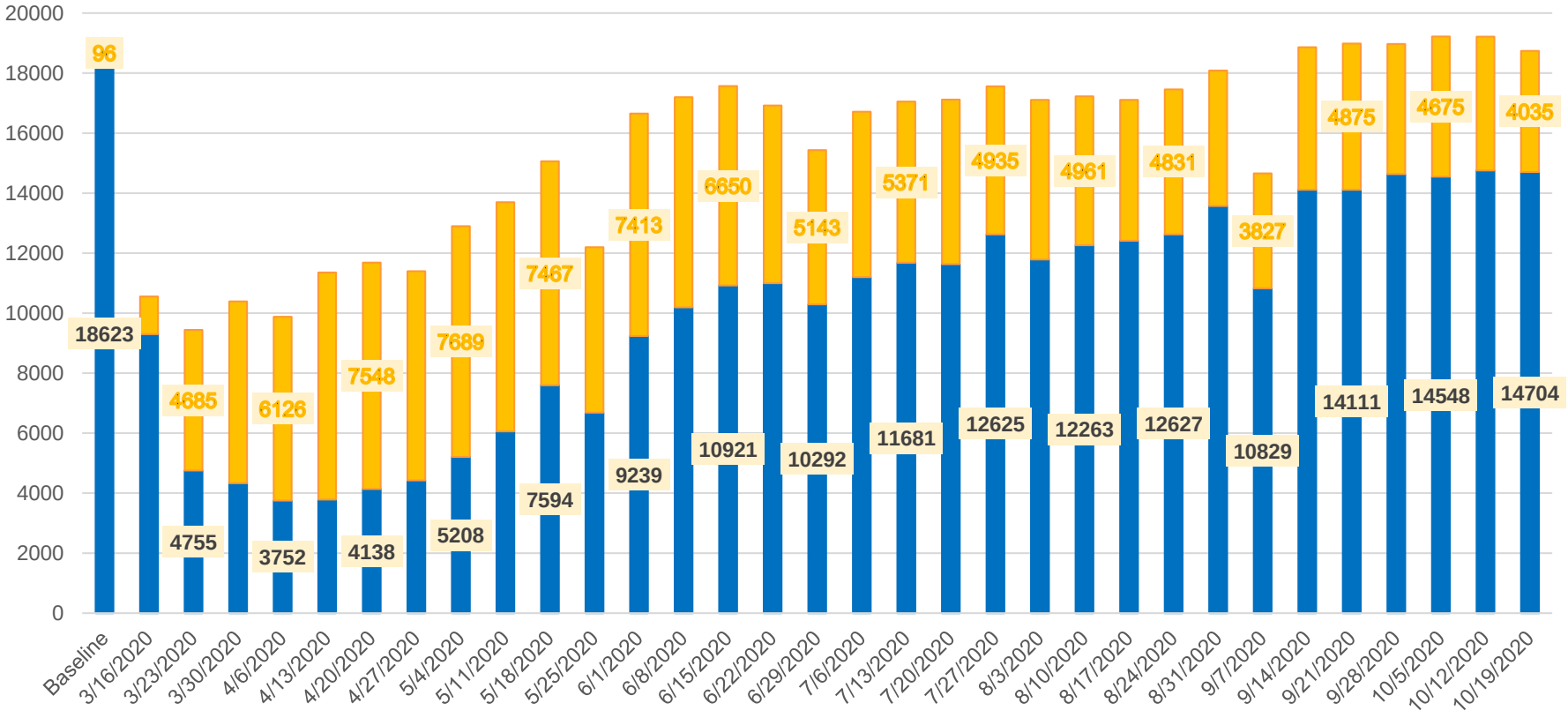
COVID Impact - Weekly Estimated Revenue Loss Trend (MCVP)



- Significant recovery in three statistical drivers through July, decline in August showing recovery in September and October

Lessons Learned

- "Necessity is the Mother of Invention"
  - Years of work towards building a telehealth program were accelerated by COVID-19
    - 470 telehealth visits in Fiscal Year 2019 (July 2018 – June 2019)
    - 5,833 telehealth visits in March 2020
    - 17,785 telehealth visits in April 2020



COVID-19 Lessons Learned

- Telehealth CAN BE a successful care delivery model
- Communication is the quintessential success driver
  - Incident Command Center established to help manage pandemic COVID-19
  - Twice-daily updates via email to all team members received
  - Dedicated intranet page was created
  - Sr leadership met virtually twice per day
  - VCUHS Town Halls every week
- Guaranteed fixed salary for all comp plan faculty beginning with COVID surge March thru Oct 1 including historical incentives
  - Protecting salaries has helped recruitment efforts – great investment
- Telework - proven to be a successful strategy for certain administrative roles
- The organization has become more nimble and is much better prepared in the event we experience another surge

Planning for 2021 Post COVID19 & Beyond

- Increased pressures on funding for academic mission and decreases in clinical revenue will require continued focus on Financial Sustainability in physician compensation models
  - Changes in CMS Proposed Rule for 2021 (ie., shift in wRVUs and decrease in conversion factor) also raise concern and are being closely monitored and analyzed
- Telehealth will remain a significant part of our new care delivery model
  - Increases patient satisfaction and should lead to more effective use of our physical facilities in the future
  - Focus right now on reducing number of audio-only visits in response to likelihood of reimbursement ending for these services at the end of the pandemic
  - System-wide telehealth adoption? – Include in minimum work standards expectations
- Enhanced strategic relationships with regional colleges and universities

Overview of MCV Physicians Faculty Compensation Plan

Factors Contributing to Current Compensation Plan

- Physician productivity was declining
  - wRVUs were down
  - Surgeries were down
  - Outpatient visits weren't meeting budget targets
  - Inpatient visits were down
  - Payer mix was declining
- Physician morale was lagging
- Salaries were below AAMC benchmarks in many specialties
  - Limited incentive opportunities for most

Key Goals for Current Compensation Plan

- Properly align funding with effort allocation
- Bring compensation up to market levels
- Incentivize and appropriately reward clinical productivity
- Fund ARTS (administrative, research, teaching, and strategic) roles consistently across all departments
- Fund all faculty for – and expect them to contribute to – institutional citizenship
- Payer blind compensation

Basic Compensation Plan Components

Clinical Salary Floor
(Base salary determined by prior year productivity)

Clinical Incentive

Administrative Compensation
(Clinical and Academic Administration)

Research (Equal to Funding)

Teaching

Strategic

Total Cash Compensation

Establishing a Clinical Salary Floor

Productivity-Based Departments/Specialties[1]

- Anesthesiology (pain management only)
- Dermatology
- Family Medicine
- Internal Medicine (excluding hospitalists)
- Neurology
- Neurosurgery
- Ophthalmology
- Orthopedic Surgery
- Otolaryngology
- Pediatrics (excluding hospitalists and intensivists)
- Physical Medicine & Rehabilitation
- Psychiatry
- Radiation Oncology
- Surgery (excluding pediatric surgery)

Shift-Based Departments/Specialties[2]

- Anesthesiology (excluding pain management)
- Emergency Medicine
- Pathology
- Radiology

Hybrid Departments/Specialties[3]

- Obstetrics and Gynecology (excluding reproductive endocrinology)

[1]Based on wRVUs and collections from elective cash procedures (where applicable)
[2]Based on clinical hours (Anesthesiology/EM) or clinical days (Pathology/Radiology)
[3]Based on wRVUs, L&D sessions, and health department sessions

Recent Compensation Plan Changes

- Introduced organizational definition of CFTE
  - All providers are 100% clinical unless they have obtained approved and funded administrative and/or teaching roles, or funded research
  - Standard Citizenship/Teaching funding designed to recognize and reward individual provider effort but does not reduce CFTE
- Piloted ability for department chairs to define metrics to determine eligibility for Citizenship/Teaching funding
  - All providers previously received same funding amounts regardless of contributions
- Introduced Minimum wRVU Threshold for Incentive Eligibility
  - All providers must be meet 100% of CFTE-adjusted median wRVU benchmarks to be eligible for clinical incentives
- Payout rates held steady
  - First step towards moving to “calculated” rate (clinical salary benchmark divided by wRVU benchmark) to eliminate phenomenon of providers earning clinical incentives for doing less than the prior year

Guiding Principles for Compensation Plan Redesign

VCU Health

New Compensation Models – January 2021

- Primary Care Compensation Model
  - Reduces salary variability from year to year, moving from model where every incremental wRVU impacts salary to a model with a larger guaranteed salary tied to minimum work standards
  - Maintains ability to rewards high performers through clinical performance salary based on mix of wRVUs and panel size
  - Introduces incentive pay based on quality/patient experience metrics
  - More departmental control than current model
- Transplant Compensation Model(s)
  - Separate models for transplant surgery and transplant medicine (ie., transplant hepatology and transplant nephrology)
  - Reduces emphasis on wRVUs to encourage faculty to focus on other activities vital to the success of the transplant program (e.g., clinic visits rather than endoscopies)
  - Introduces incentive pay based on group and individual quality/program enhancement metrics
  - Introduces procurement incentives to reward surgeons outside of wRVUs
  - More departmental control than current model

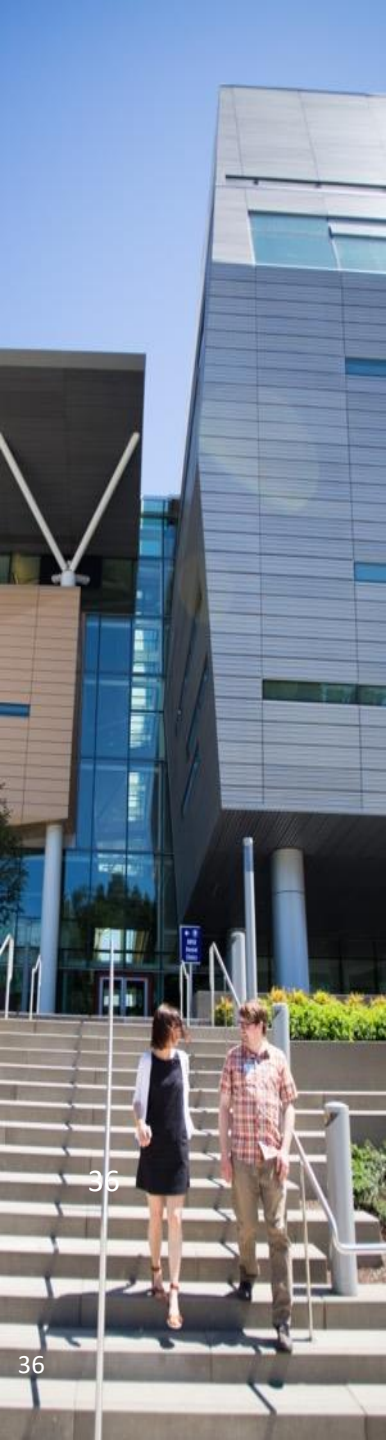
Compensation Plan Changes Under Consideration

- Tiered Payout Structure
  - Payout rates would decrease after providers exceed median and 65th percentile productivity
  - Intended to decrease incentives to “churn” patients as well as to underreport CFTEs
- Capping Clinical Salary Floor at Reported-CFTE
  - Clinical salaries would be no more than CFTE-adjusted benchmark
  - Intended to better align reported CFTEs with actual clinical effort
- Enhanced Medical Director Funding
  - Intended to more appropriately fund medical directors for effort as a percentage of clinical salary floor benchmark as opposed to a historical, generic benchmark
- Introduction of Monthly Draw vs. Quarterly Incentives
  - Intended to smooth out cash flow for providers who earn large clinical incentives and reduce pressure to inflate base salaries


OHSUHealth
Where healing, teaching and discovery come together to improve the health of all Oregonians.

OHSU Health - By the numbers

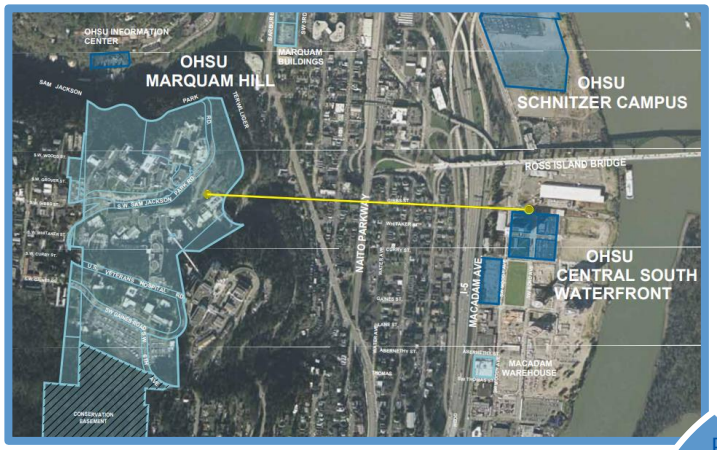
- Employees: 17,532
- Students: 4,739
- Clinically integrated w/ four hospitals; 52 clinical sites throughout Oregon
- Licensed beds: 1,071
- Annual operating budget: $3.1 billion
- Value of OHSU's community contributions: $437 million
- 2,700 faculty (2,100 OHSU Practice Plan members)
- > 1 million patient visits per year
- More than $550 million in annual grant funding
- More than 150 annual invention disclosures
- 45% of MD graduates continue to practice in Oregon



OHSU Practice Plan

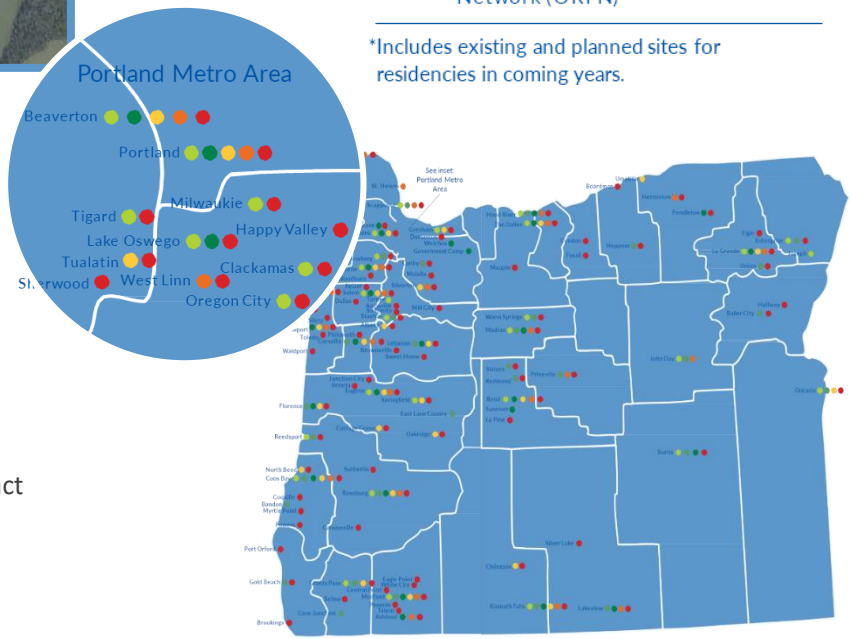
- Transitioned to the medical school in 2009
  - *Formerly 20 separate 501c3 organizations*
- Our providers (1,975 FTE – 1,350 cFTE)
  - 1,500 physicians including,
    - *150 Clinical Associates*
  - 475 APPs
- $559M Clinical Revenue (FY 20)
- OHSU comp. plan, very decentralized
  - *Pending complete revision for FY 22*
- 270 Clinically integrated providers
- Largest organized clinical practice in Oregon

Statewide Collaborations – our 96,000 sq. mi. campus



- Residency training sites*
- Student rotations or clerkships
- Continuing medical education
- Clinical practices
- Research
- Oregon Rural Practice-based Network (ORPN)

*Includes existing and planned sites for residencies in coming years.



OHSU is a unique and crucial asset to the State of Oregon

- **4th largest** employer in the State
- **Largest** employer in Portland
- Generates **$4.3 billion** of economic impact

OHSU Onward – Financial Situation

Impact

- **$200M decline in revenue**
- **Stopped all elective surgeries/procedures**
- **40% decline in patient activity**

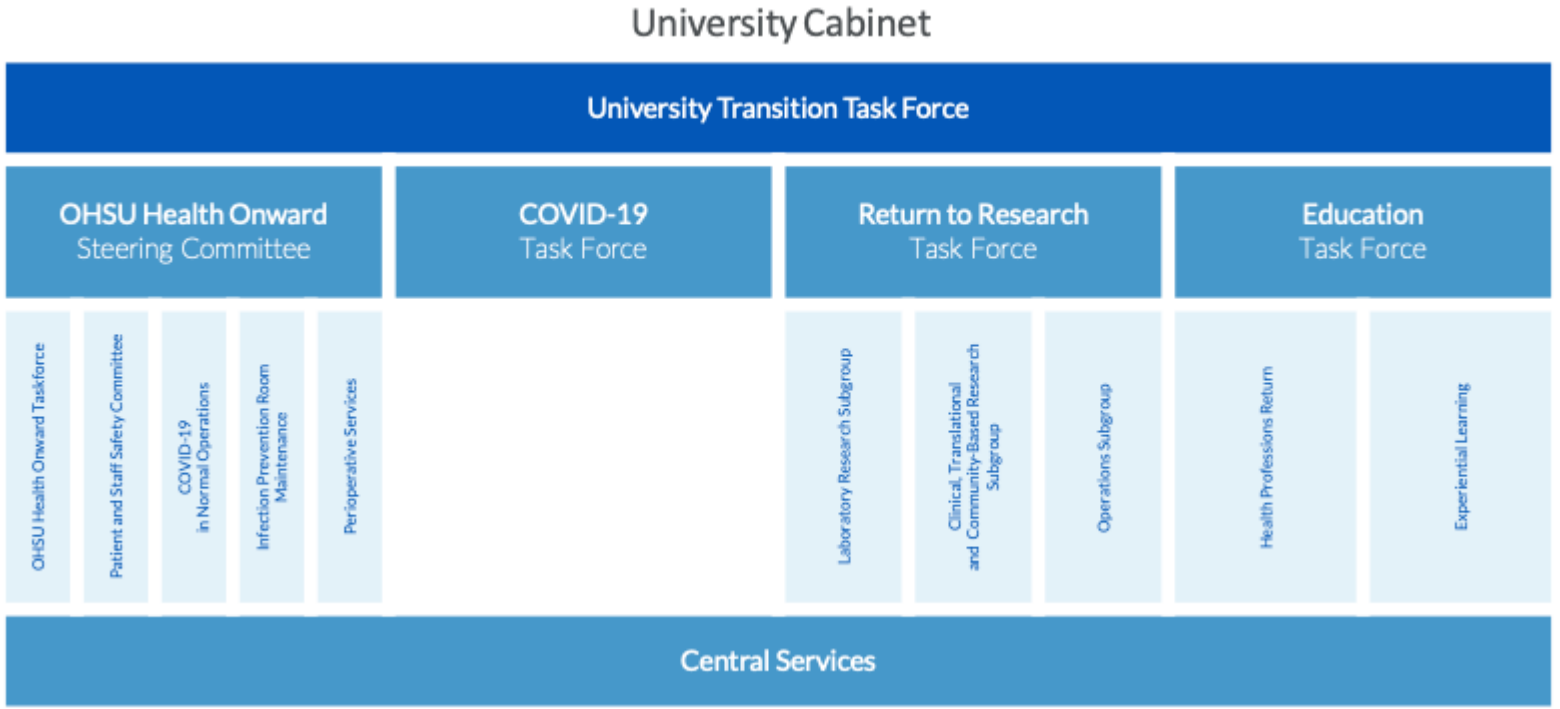
OHSU's approach to pandemic and recession:

- **Tightened first to loosen later, to avoid repeated rounds of cuts if the situation worsened.**
- **Avoided wide-spread layoffs by reducing salaries instead,**
- **Acted as one University, even though different units and different missions would be impacted to differing extents and at different times**
- **Maintained full pay from mid-March through June**
- **Provided a $1m emergency fund**

Transforming During a Pandemic

OHSU Onward: University Transition Task Force

- The University Transition Taskforce (UTT) is tackling a holistic, institutional framework for all OHSU members, patients and visitors to help enter a new normal, safely.
- UTT works closely with several mission-oriented taskforces and councils shown below.
- Recommendations are reviewed by the University Cabinet and executive leadership.
- OHSU leaders also plays key roles in groups advising the State and region as Oregon carefully reopens.



UTT Vision and Framework

The vision of the University Transition Taskforce is to move OHSU towards a reopening — a "new normal" balances meeting our missions with the need to protect our people.

The vision statement provides the direction for the guiding principles:

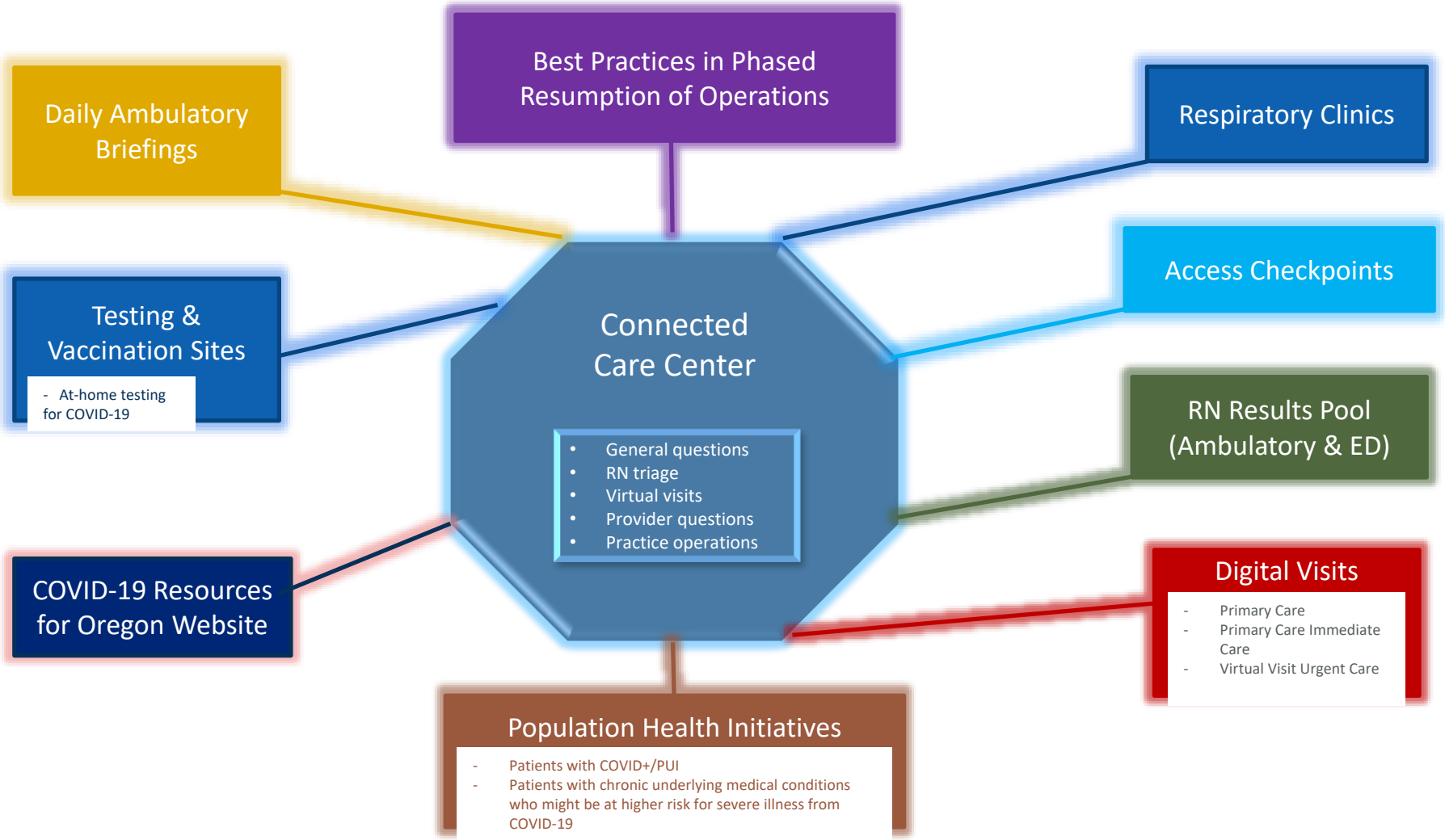
- **Protect our staff and faculty**
- **Protect our students**
- **Protect our patients**
- **Protect our community**

The guiding principles provide the outer most layer of the framework to reopen OHSU. They should be used as a guide to direct planning questions and the underlying readiness checks that will aid leadership in preparing for and monitoring the transition to a return to campus.

- **Ready** and **able to protect OHSU community members** through monitoring, contact tracing, isolating, and supporting those who are positive or exposed.
- Ready and able to quickly **re-implement appropriate control measures** based on predetermined criteria.
- Ready and able to **limit infection** in people who are at risk for more severe COVID-19
- Ready and able to **handle a surge** in COVID-19 cases.
- Ready and able to provide clinics, healthcare facilities, classrooms, public spaces, administrative offices, laboratories, and all forms of core support areas with **appropriate physical distancing** and other mitigation measures.
- Ready and able to **support a telework environment** which aides and supports both our returning faculty, staff, students, and patients as well those working and studying remotely.

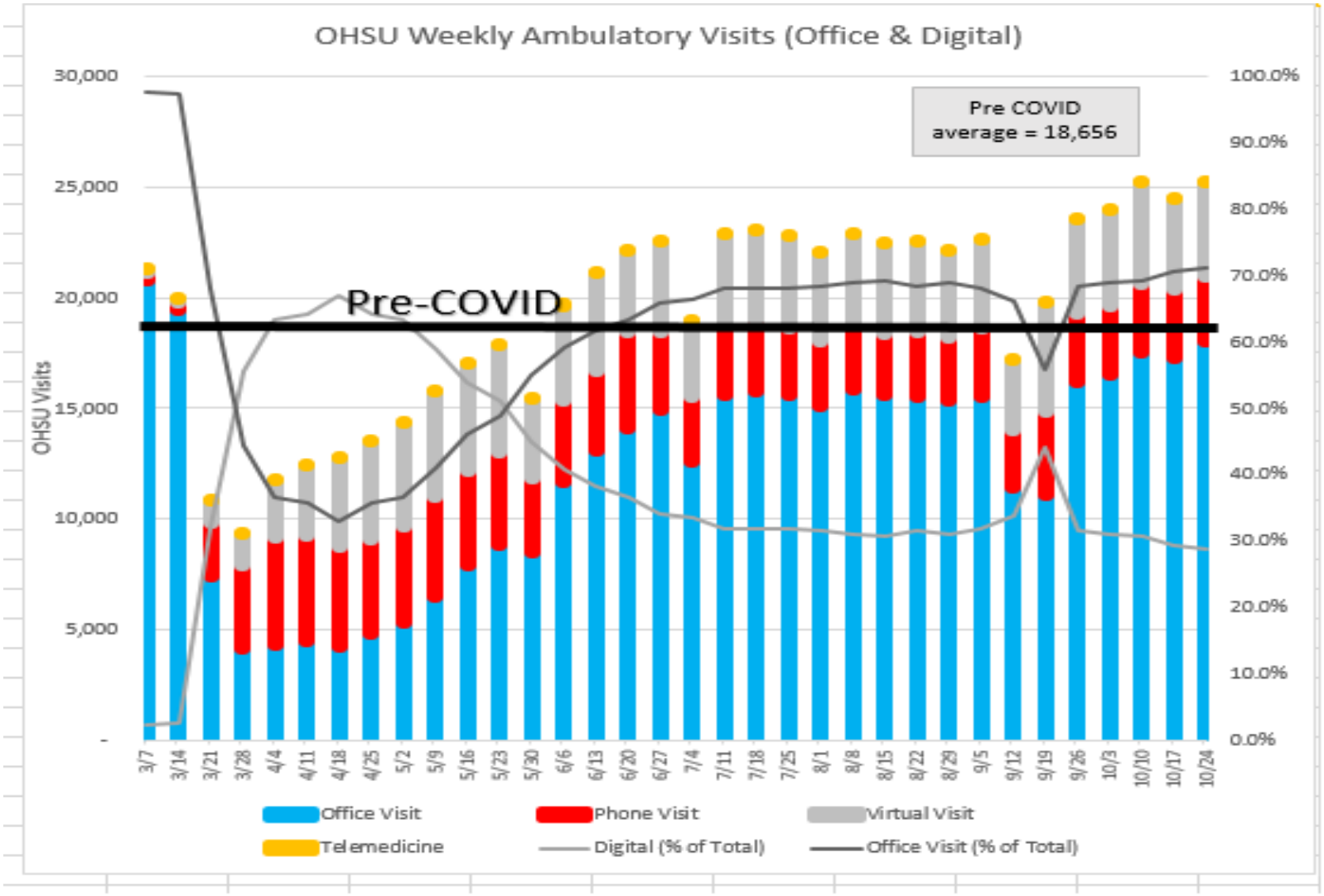
OHSU

OHSU Ambulatory Initiatives Implemented to Address COVID-19 Pandemic



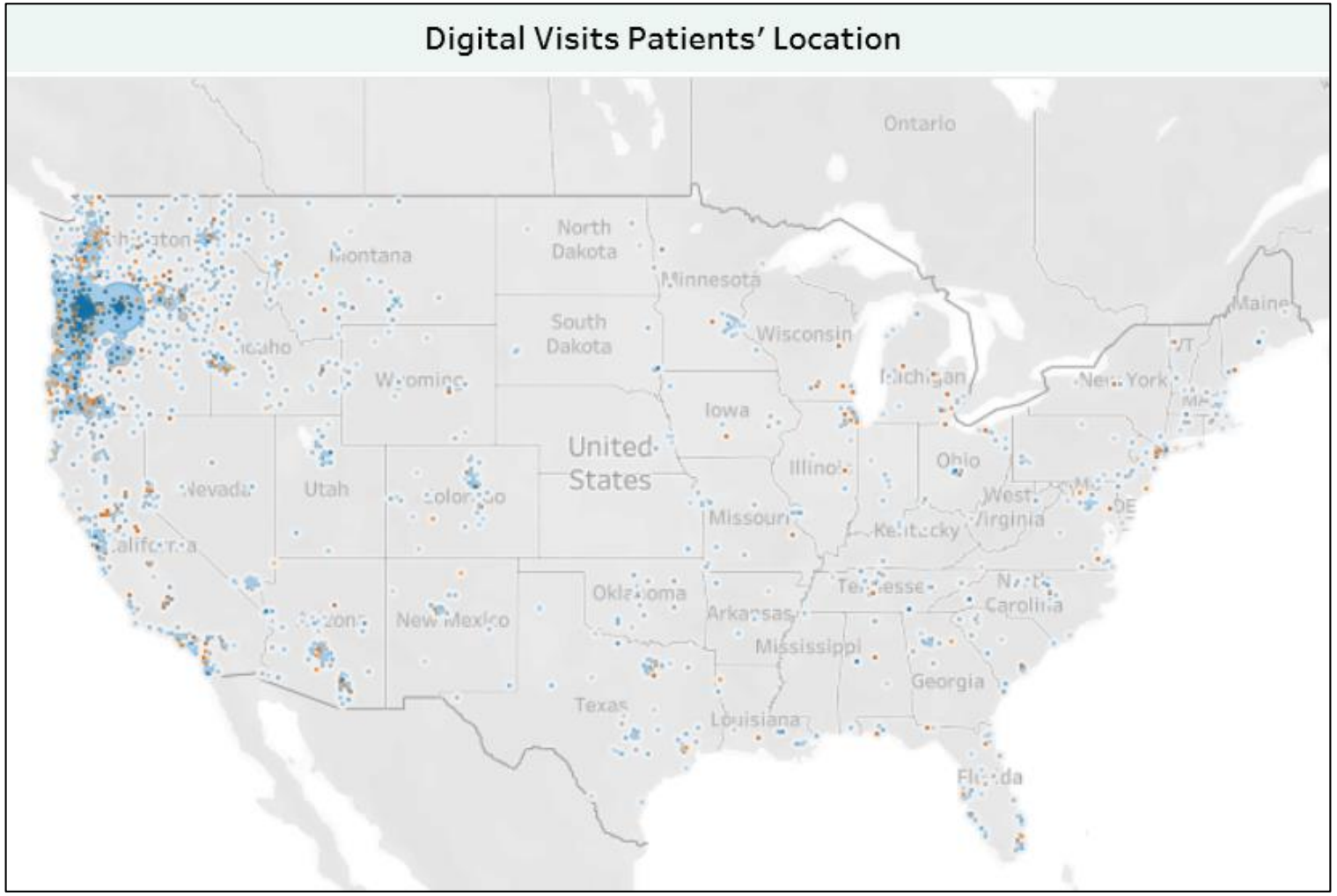
OHSU Ambulatory Volumes March-October 2020

+ Ambulatory visits have rebounded and now surpassed Pre-COVID volumes.



OHSU Digital Health Encounters by State

Based on Patient's reported address with OHSU EMR



Key Lessons Learned

- Early communication of “the why” is critical
- Integrated leadership will drive change faster
- Engaging staff at all levels focused on access to leadership and quick answers to high priority issues
- Modifying compensation and funds flow barriers drove light speed change
- Digitally enhanced care is here to stay
- Centralized decision making critical

Proposed FY22 Faculty Compensation Plan

Aligning Faculty compensation, productivity, and incentives

Rationale for a New Plan

- Review of our faculty compensation and effort identified **many variant compensation models** (44 variants to the plan and 100+ metrics across 20 clinical departments).

- While these models contributed to market leading growth over the past 5 years, the models were **not transparent**, varied by department and division, and mission and included a variety of metrics.

- As a result, this contributed to **faculty confusion and distrust**.

- As informed by the 2025 strategic plan working groups, we need:
  - A compensation plan that is **market-driven and coherent**
  - A compensation structure that can be **applied consistently, equitably and transparently** across the entire institution
  - A compensation plan that **recognizes the heterogeneity** of faculty roles and activities

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New Compensation Principles – FY 22

- Committee to draft strawman – led by Chief Clinical Officer/Vice Provost
- In addition to all of the previously mentioned needs addressed, the compensation plan will:
  - **Clearly identify expectations** of mission-related salary components
  - **Incentivize** positive overall faculty **behavior/citizenship** with "at-risk" portion
  - Provide clear **mechanisms for incentive pay across missions**

- **At-risk** represents **15%** of a Faculty members' pre-determined Total Annual Compensation
- Component of **total compensation** that is not guaranteed but **should be attainable**
- Compensation will be **paid at full cash compensation** (base and risk)
- **Align** compensation with **APPs** and **Clinical Associates** (non faculty employed providers)

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At-Risk Components – FY 22

- Variables underlying clinical activity (10%):
  - **Number of clinic sessions**: A session is 4 contact hours (template of patients expected to be seen based on patient type);
  - **Number of shifts** covered (for clinical coverage providers—intensivists, hospitalists, consultants, anesthesiologists, and emergency medicine physicians);
  - **Patient panel size** and sessions scheduled (eg. primary care providers);
  - **wRVUs** (surgical and other procedure-based providers); or
  - **Number of virtual visits** per week (a session equivalent to face-to-face visit)
  - Productivity/Effort **expectations determined by national benchmark**
  - Expectation that **appropriate and timely coding and billing** is performed

- Other metrics (5%)
  - **Access**—based on current Practice Plan standards (could be individual and/or team-based)
  - **Patient satisfaction**—based on current Practice Plan standards
  - **Clinical outcomes** (quality/safety)—based on OHSU Health standards
  - **Citizenship/Service**

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Incentive Opportunity – FY 22

All faculty will be able to earn additional compensation:

- Must fully achieve expectations for their total annual compensation including fulfillment of all metrics related to their variable component
- Complete additional clinic sessions, extra shifts, and/or generate wRVUs above their expected target
- Eligibility for additional compensation begins when productivity above expected target
- Compensation earned for each additional clinic session, shift, and/or dollar per wRVU will be published at the beginning of each fiscal year

OHSU

Upcoming Webinar

National Study on Physician Compensation

February 8, 2021

GBA & GFP Joint Webinar: An Update on Physician Compensation Methodologies in Academic Medical Centers

In this 75-minute webinar, we will discuss the results from the 2020 AAMC/SullivanCotter Survey on Physician Faculty Compensation Methodologies. This is the third survey conducted by the AAMC and SullivanCotter to help members understand how compensation methodologies for faculty physicians, community physicians employed by an AMC and Advanced Practice Providers are evolving. Organizational characteristics of participants will be provided and topics covered include an overview of work effort methodologies, market benchmarking and compensation strategies. Perspectives from AAMC member institutions will also be shared during this webinar.

For more information, contact **Shawn Rosen-Holtzman**, Director of Constituent Engagement | srosenholtzman@aamc.org

AAMC

National Study on Physician Compensation

AAMC/SullivanCotter Survey on Physician Faculty Compensation Methodologies

24 survey responses were collected from December 2019 to July 2020

Survey Purpose: Identify contemporary pay practices and approaches used by academic medical centers (AMCs) to compensate faculty and clinical physicians

Topics Covered Include:

Organizational Characteristics

- AMC structure and growth goals
- Oversight and decision-making processes related to physician compensation

Work Effort and Performance Criteria

- FTE and cFTE definitions and approaches
- Promotion criteria and funding sources
- Faculty and community-based physician expectations

Benchmarking Approaches

- Faculty and community-based physician total cash compensation and productivity market benchmarking

Compensation Strategies

- Evolution of faculty compensation by specialty grouping
- Base and variable plan components
- Value-based compensation and panel size

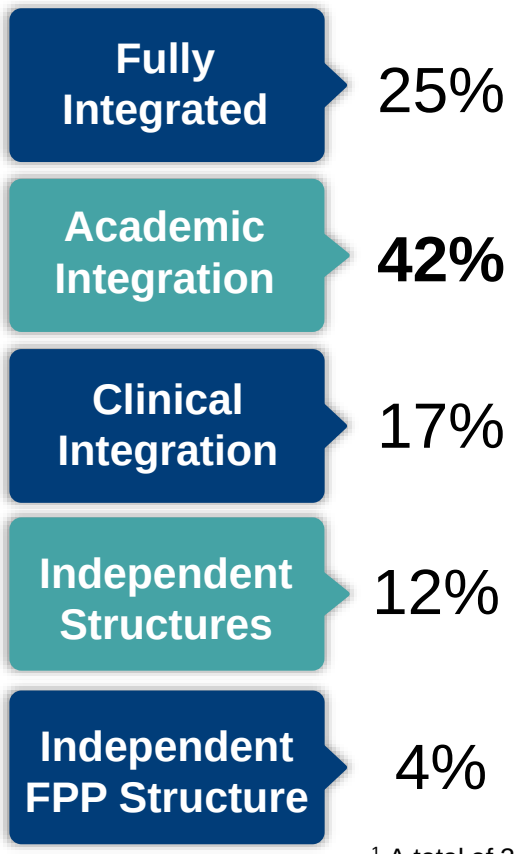
Source: 2020 AAMC-Sullivan Cotter Survey on Physician Compensation Methodologies

SullivanCotter AAMC

National Study on Physician Compensation

2020 Participant Overview

Organizational Structure[1]

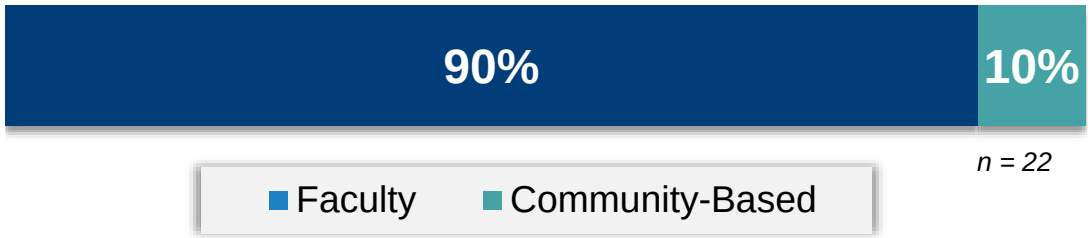


Physician and Advanced Practice Provider (APP) FTEs

FTEs	Physicians *Faculty and Community* *n = 22*	APPs *n = 18*
Median	1,003	353

Median ratio of physicians to APPs is 3:1 Based on 11 responses

Physician FTEs: Faculty vs. Community-Based[2]



[1] A total of 24 AMCs participated in the study. The participant list can be provided upon request.

[2] 32% of participants do not employ community-based physicians.

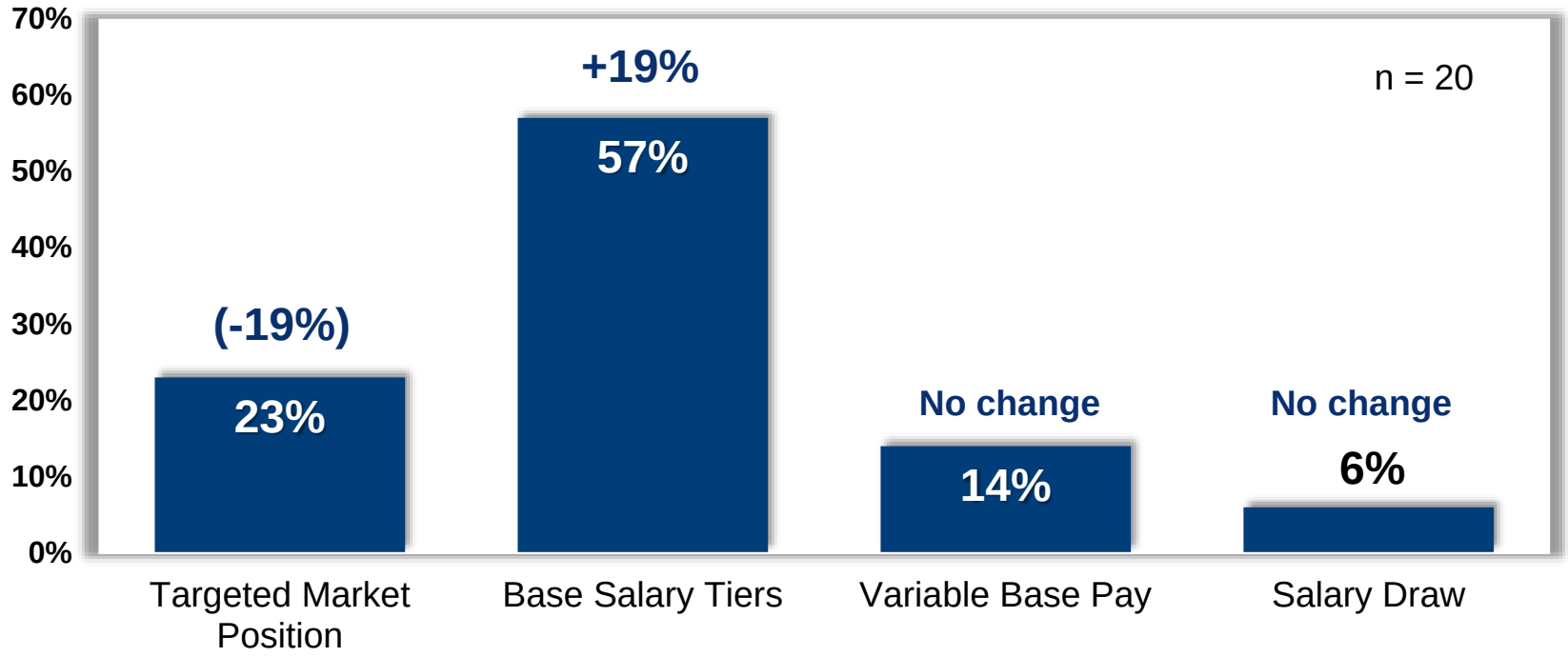
Source: 2020 AAMC-Sullivan Cotter Survey on Physician Compensation Methodologies

SullivanCotter AAMC

National Study on Physician Compensation

Key Trends

Few respondents use a salary draw methodology, while base salary tiers are being used more frequently than before — replacing the target market position approach as the most common approach



Guaranteed Base Salary
Lowest Variation

At-Risk Base Salary
Greatest Variation

Source: 2020 AAMC-Sullivan Cotter Survey on Physician Compensation Methodologies

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Discussion

AAMC

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Association of
American Medical Colleges