

Closing the Gaps Through Academic Medicine

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About the AAMC – Member Institutions



Medical Schools

158

LCME-accredited
US medical schools

13

LCME accredited
Canadian medical
schools



Teaching Hospitals

~400

teaching hospitals and health systems,
including Veterans Affairs medical centers



Academic and Professional Societies

More
than

70

academic and professional
societies

About the AAMC - Communities



193,000+ full-time faculty members

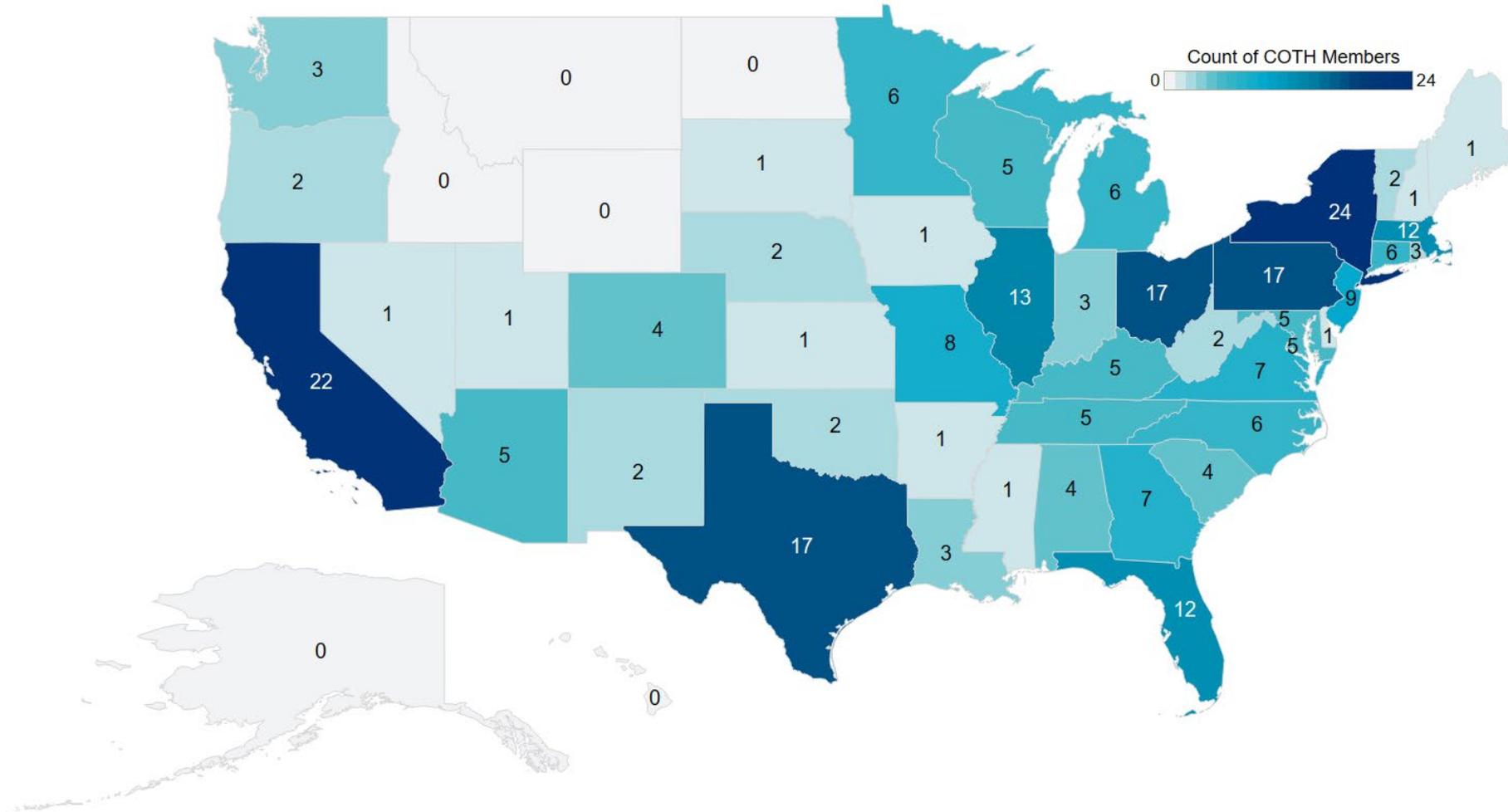


153,000+ resident physicians



96,000+ medical students

AAMC Membership Geography, December 2022



AAMC & AiAMC – A Natural Partnership

~400 teaching hospitals and health systems

150 institutions with 500+ beds

153,882+ residents

158 total US medical schools



~69 teaching hospitals and health systems

32 AiAMC institutions with 500+ beds

11,936+ residents

128 US medical school affiliations



AAMC Relationships With Other Associations



A Healthier Future for All

The AAMC Strategic Plan

OCTOBER 2020



MISSION

The AAMC leads and serves academic medicine to improve the health of people everywhere.

VISION

A healthier future through learning, discovery, health care, and community collaborations.

AAMC Mission: Your Mission



AAMC's Legislative Agenda

- ✓ **FY 2024 Appropriations** for NIH, HRSA, CDC, VA, AHRQ, ARPA-H, and all other federal agencies
- ✓ Extending key programs; for example:
 - Pandemic and All-Hazards Preparedness Act
 - Funding for Community Health Centers, National Health Service Corps, Teaching Health Centers GME
 - Conrad State 30 and Physician Access Reauthorization Act
- ✓ Averting Medicare Physician Fee Schedule cuts
- ✓ Eliminating pending Medicaid DSH cuts
- ✓ Preventing Site Neutral Payments; Medicare payment cuts to hospital outpatient departments (HOPD)



AAMC Data & Programs Support the Advancement of Academic Medicine

Advocacy

- More GME positions
- Dobbs SCOTUS
- Race conscious admissions SCOTUS
- Student Financial Aid
- Pathway Programs
- DACA

Medical Education Initiatives

- Foundational Competencies for UME
- QIPS, Telehealth & DEI Competencies
- Transition to Residency & MSPE
- Pedagogy
- Interprofessional Education
- Faculty Development

Data & Reports

- SCOPE
- AAMC Resident Readiness Survey Program
- Year Two Questionnaire (Y2Q)
- Matriculating Student Questionnaire
- Physician Specialty Data Report
- Report on Residents
- Specialty Workforce
- GMETrack
- Faculty Roster
- Faculty Salary Report
- Graduation Questionnaire

Service Programs

- Medical College Admissions Test (MCAT)
- American Medical College Application Service (AMCAS)
- Visiting Student Learning Opportunities (VSLO)
- Electronic Residency Application Service (ERAS)
- Careers in Medicine

Publications

- *Academic Medicine* Journal
- *MedEdPORTAL* Journal
- Curriculum Reports
- Data Snapshots
- Various Topical Reports

Student Resources & Programs

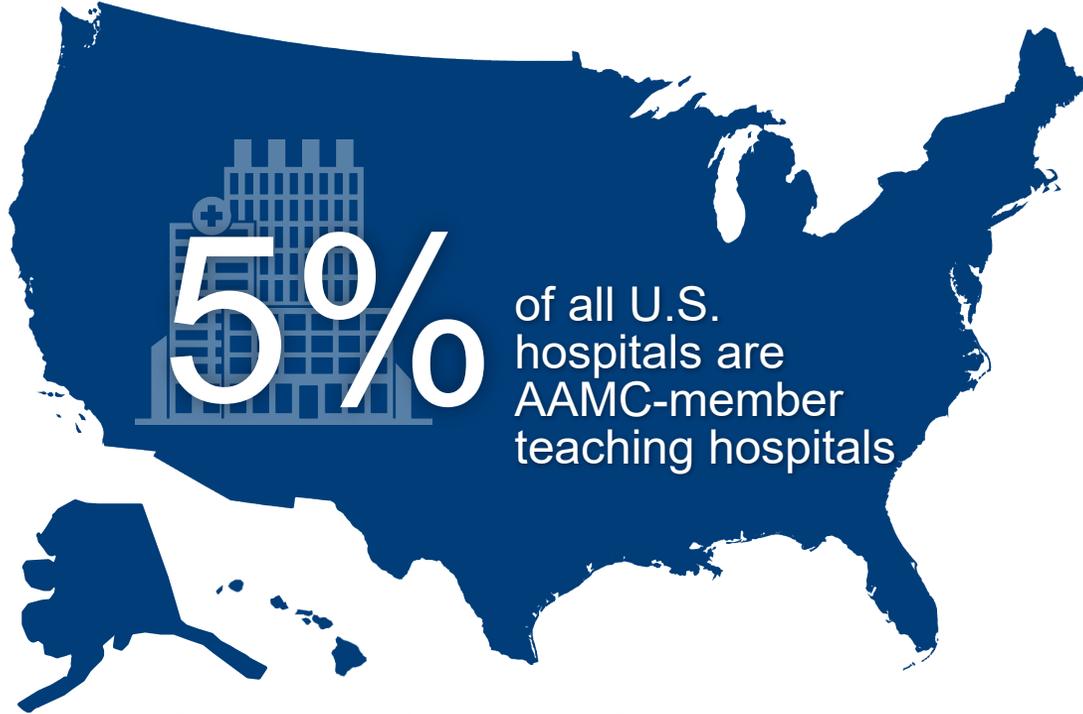
- Careers in Medicine (CiM)
- Residency Explorer (with 8 other organizations)
- FIRST (financial guidance)
- Virtual medical school & specialty fairs

Diversity in Medicine

- Summer Health Professions Education Program
- K-12 Educational Initiatives and Summit
- Pathway Programs and Outreach
- Disability in Medical Education
- Specialty-specific demographic reporting across the continuum

The Critical Role of Academic Medicine

Overview of AAMC-Member Hospital Services



 AAMC-member teaching hospitals operate:

However, they provide:

26%  of Medicaid hospitalizations

32%  of hospital charity care

100% of comprehensive cancer centers

72% of burn unit beds

61% of level-one trauma centers

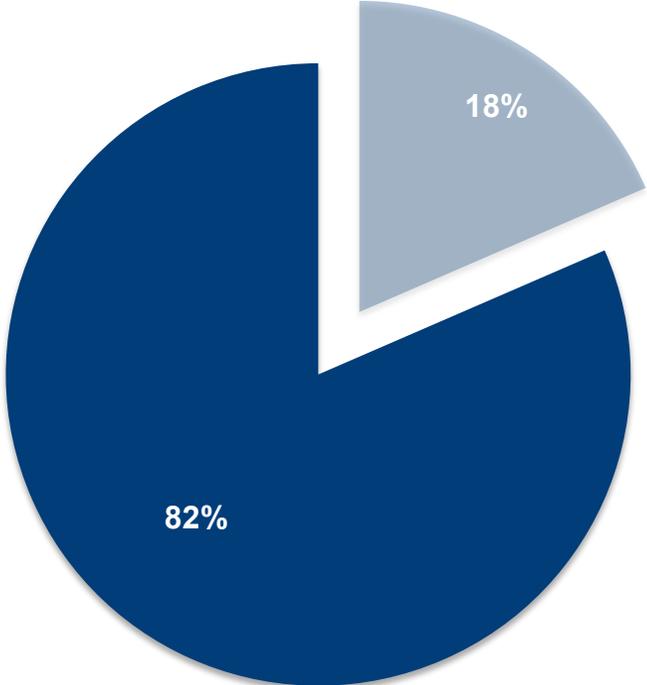
63% of pediatric ICU beds

Note: Data reflect short-term, general, nonfederal hospitals.

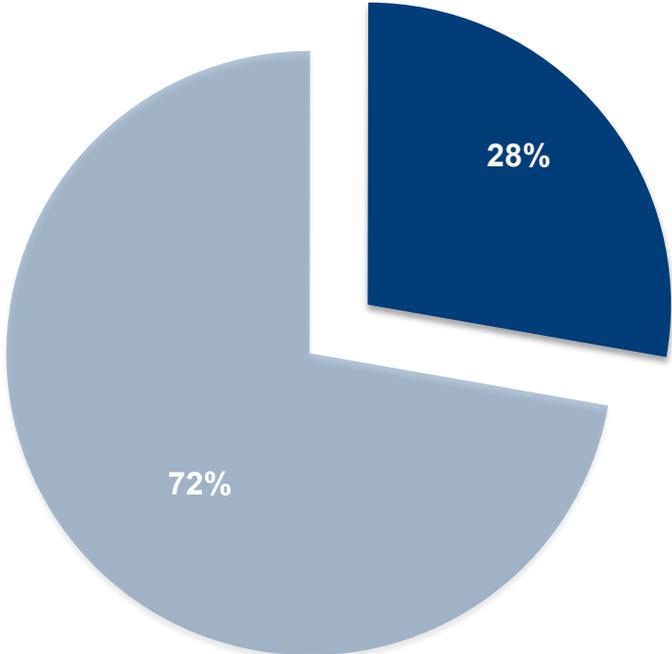
Source: AAMC analysis of FY2022 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2023, and the National Cancer Institute's Office of Cancer Centers, 2022. AAMC membership data, December 2023.

The Role of AAMC-Member Teaching Hospitals in Graduate Medical Education, 2022

AAMC-Member Teaching Hospitals as a Percent of All Teaching Hospitals



Residents Educated at AAMC-Member and Other Teaching Hospitals



■ AAMC Teaching
■ Other Teaching

Notes: Data reflect short-term, general, non-federal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members.
Source: AAMC analysis of FY2022 American Hospital Association data. AAMC membership data, December 2023

Academic Medicine: Disproportionate Provider of Patient Care, Research, and Training



5% of all inpatient U.S. Hospitals are AAMC-member teaching hospitals...but they account for

24% all inpatient days

22% Medicare days

26% Medicaid days

30% charity care costs

98% of comprehensive cancer centers

67% burn unit beds

63% pediatric ICU beds

65% level-1 trauma centers

Medical Schools and Teaching Hospitals

50+% of all NIH external grants

72% of all residents

Note: Data reflect short-term, general, nonfederal hospitals.

Source: AAMC analysis of FY2020 American Hospital Association data, American College of Surgeons Level 1 Trauma Center designations, 2020, and the National Cancer Institute's Office of Cancer Centers, 2022. AAMC membership data, December 2021.

Academic Medicine's Pursuit of Its Missions Has a Major Economic Impact Nationwide



Contributes
more than

\$728

Billion

to the U.S.
economy



7.1
Million Jobs

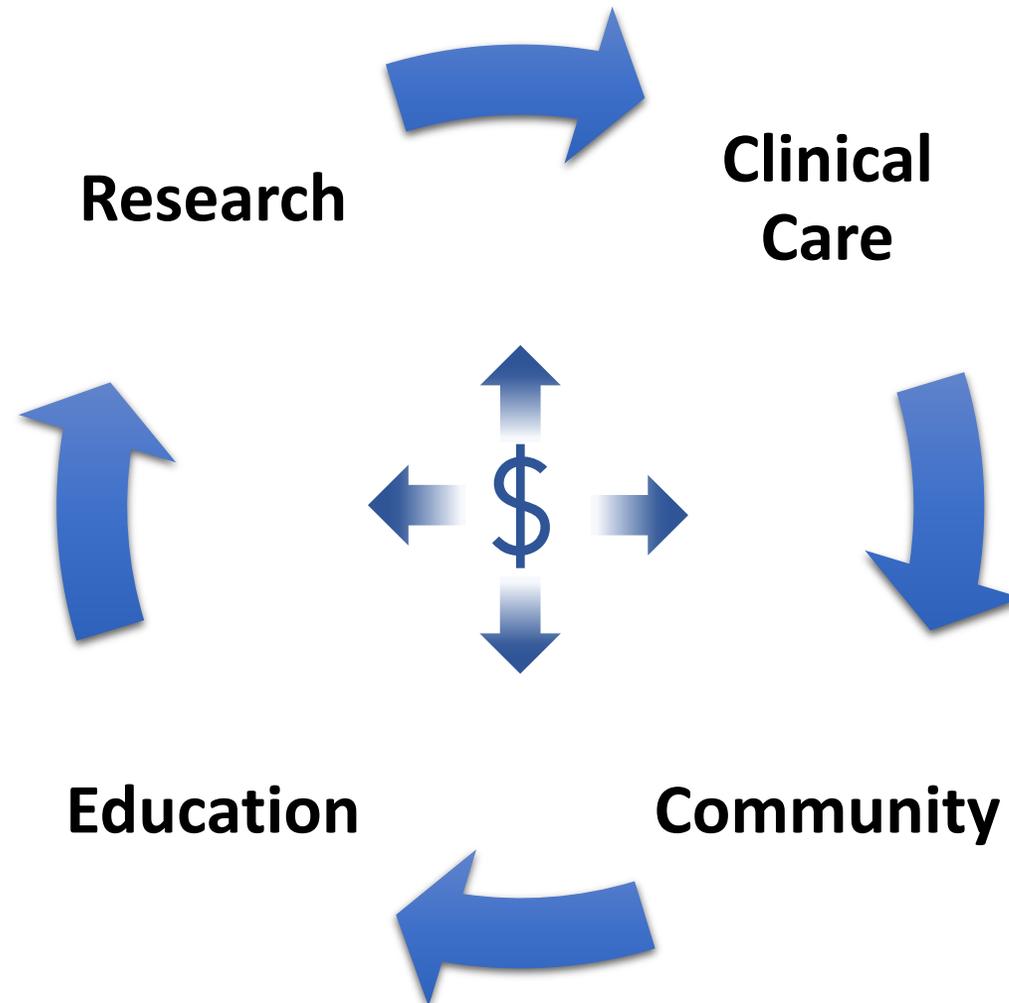
Direct
3 Million

Secondary
4.1 Million

Represents about 3.23% GDP, 4.4% of jobs nationwide

Source: Economic Impact of AAMC Medical Schools and Teaching Hospitals June 2022 report: <https://www.aamc.org/data-reports/teaching-hospitals/interactive-data/economic-impact-aamc-medical-schools-and-teaching-hospitals>

Cross Subsidization in Academic Medicine



Gov't. Payments Critical to Academic Medicine Missions



Health System Payments in Context

How does a Medicare policy impact my hospital?

Need to translate to their own finances or operations—and impact of cuts on community.

Why does the policy impact me in that way?

Understanding the policy rationale behind special payment streams.

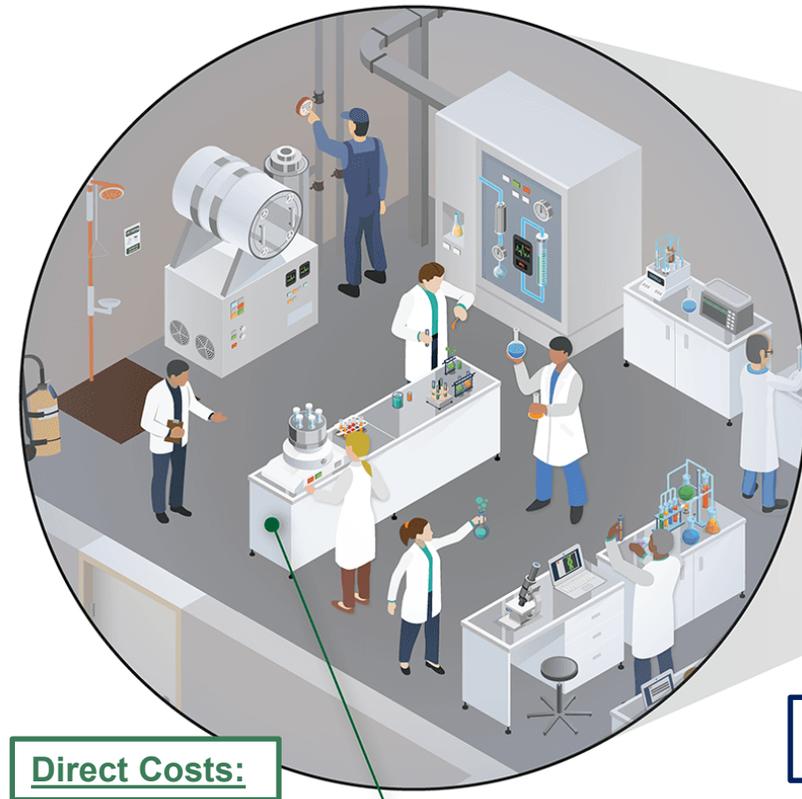
Where should I focus my strategic efforts?

Stability in funding for missions, services critical to long term planning

Research Funding

Costs of Federally Sponsored Research

The total cost of federally sponsored research includes a combination of both direct and facilities and administrative (F&A) costs. Both types of expenditures are key to an institution's ability to conduct cutting-edge research. F&A consists of the construction and maintenance costs of laboratories and high-tech facilities; energy and utility expenses; and safety, security, and other government-mandated expenses. These costs are real and research cannot be conducted without them.



Direct Costs:

Direct costs - These expenses solely cover research and include lab supplies and equipment; salaries and stipends for researchers and graduate students; and travel costs for conducting and sharing research

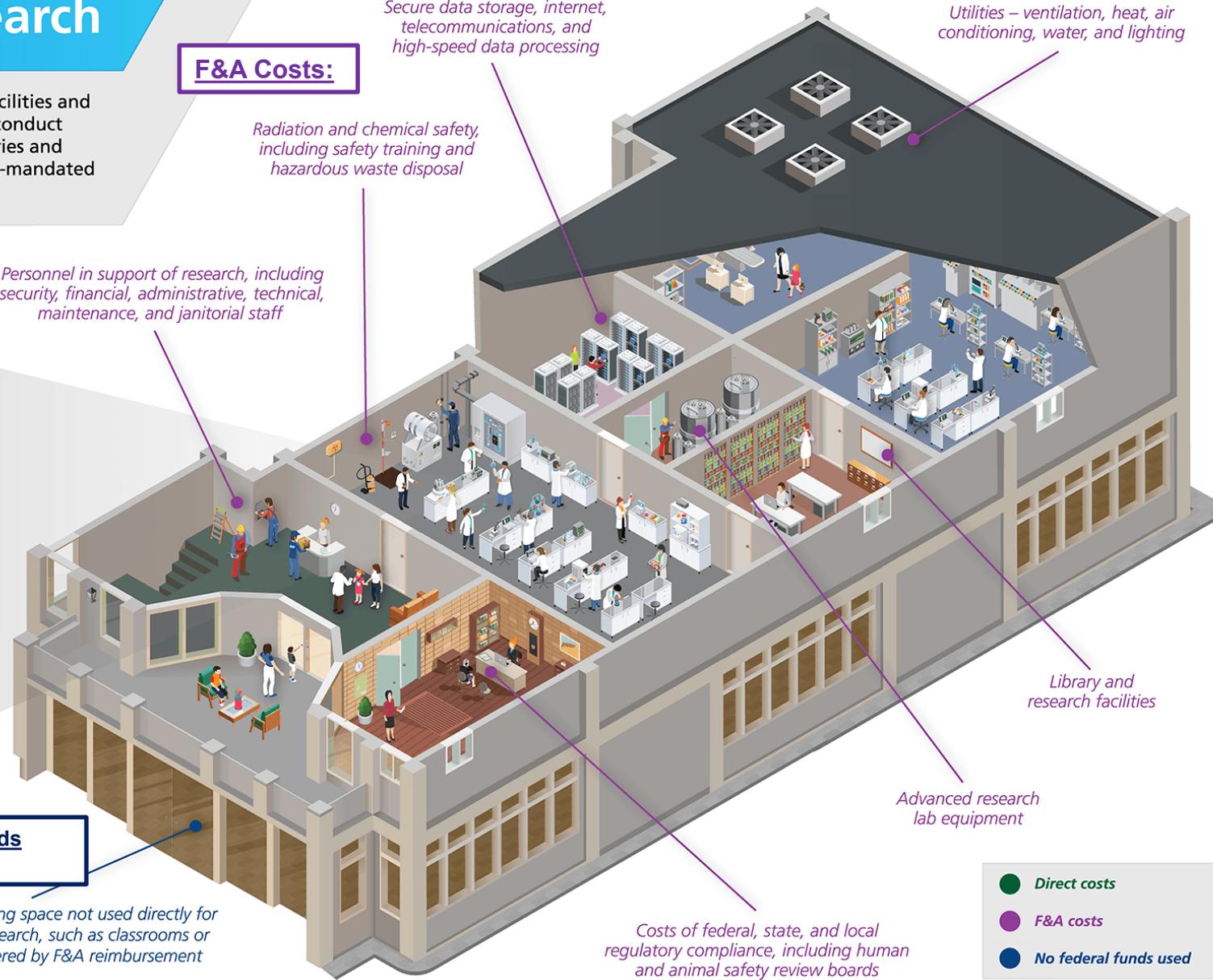
F&A Costs:

Personnel in support of research, including security, financial, administrative, technical, maintenance, and janitorial staff

Radiation and chemical safety, including safety training and hazardous waste disposal

Secure data storage, internet, telecommunications, and high-speed data processing

Utilities – ventilation, heat, air conditioning, water, and lighting



No Federal Funds Used:

Upkeep of any building space not used directly for federally funded research, such as classrooms or lobbies, is **not** covered by F&A reimbursement

Library and research facilities

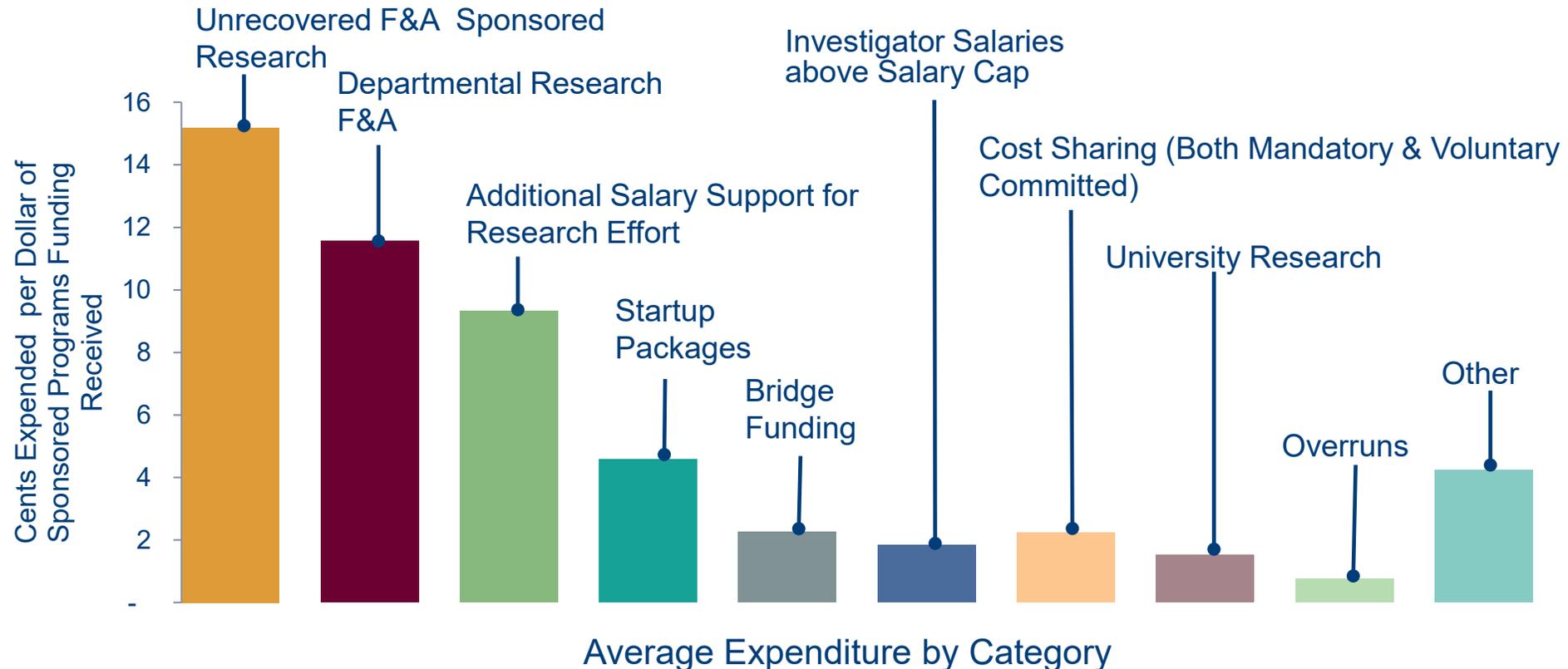
Advanced research lab equipment

Costs of federal, state, and local regulatory compliance, including human and animal safety review boards

- Direct costs
- F&A costs
- No federal funds used

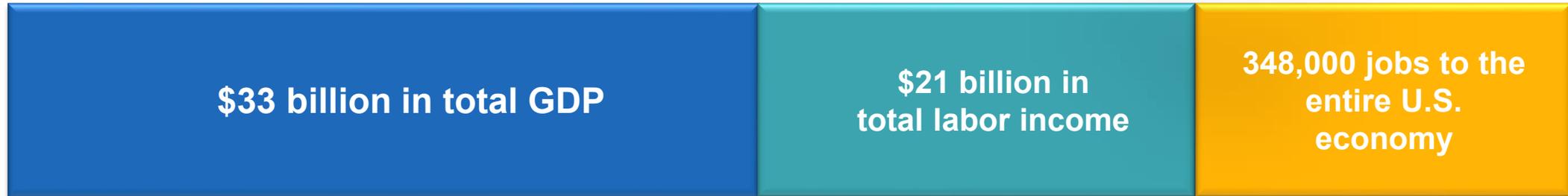
Academic Medicine's Investment in Research

For every \$1 of federal support, on average, med schools contribute \$0.53 more of own funds to research mission.



Source: Academic Medicine Investment in Medical Research: Summary and Technical Reports, Association of American Medical Colleges, 2015

The Research Enterprises at AAMC-Member Institutions Contribute Nationally



Every dollar granted to AAMC members for research contributes **\$1.60** to the U.S. economy

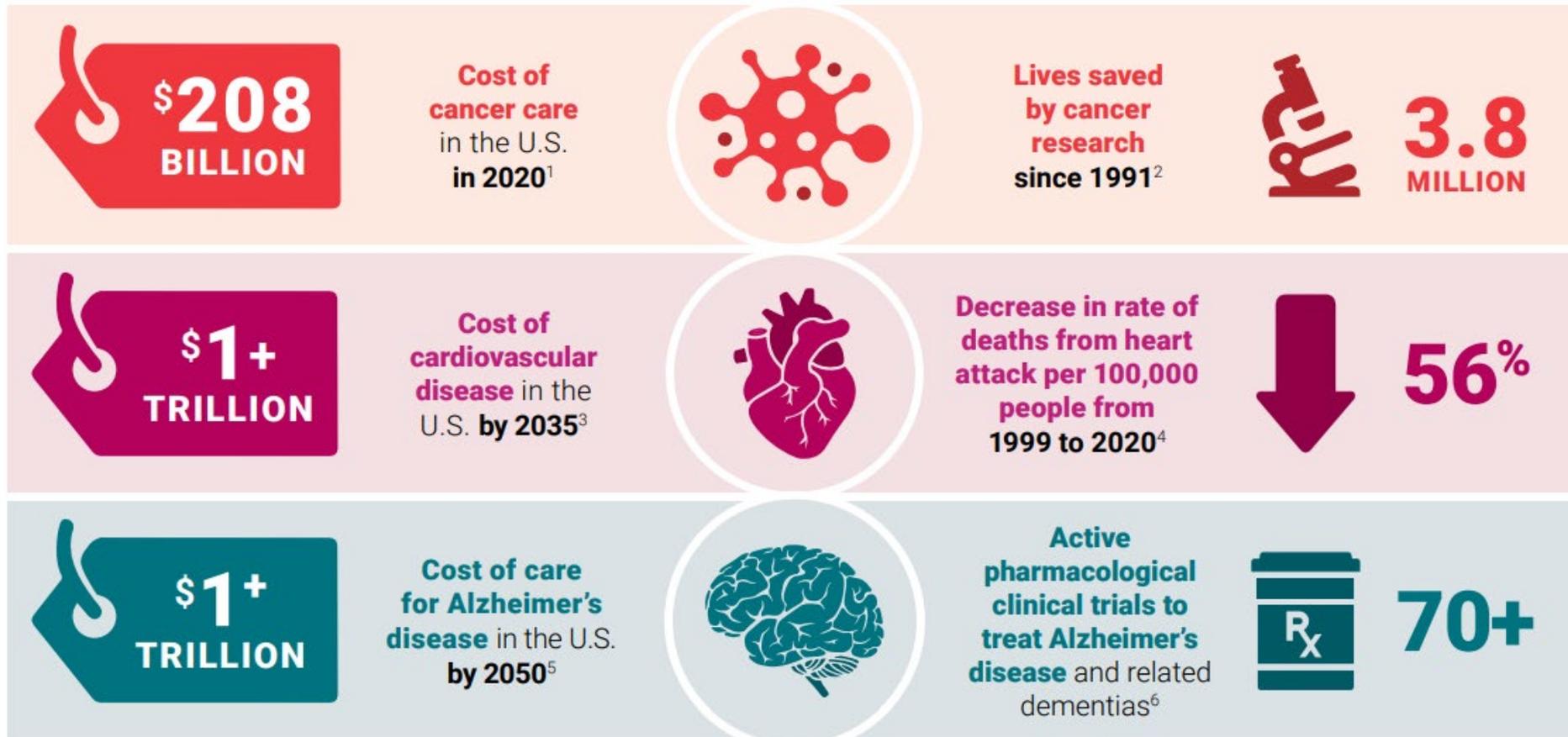


Source: Nienow S, Brown E, Hogan M, Smith D, Woollacott J, Depro B. Economic Impact of AAMC Medical Schools and Teaching Hospitals. Washington, D.C.: AAMC; 2022.

AAMC Advocacy: The Value of NIH-Funded Research at Medical Schools and Teaching Hospitals

DISEASE IS COSTLY

RESEARCH PROVIDES HOPE



Source: Association of American Medical Colleges, 2024.

NIH Funding FYs 2003-2023

Adjusted for Inflation

+ \$17.5 billion (58%) since
FY 2015



Sources: NIH Office of Budget; White House Office of Management and Budget; P.L. 117-328. Updated 3/30/23

Note: Funding levels do not include emergency supplemental funding or funding for the Advanced Research Projects Agency for Health (ARPA-H).

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Medical Education: Resource Intense

Federal Sources of Funding for GME

Medicare

- The largest single explicit funder of GME programs*

Medicaid

- The Medicaid program contributed about ~\$7.93b

The Department of Veteran's Affairs

- 90% of VA facilities host residents for training

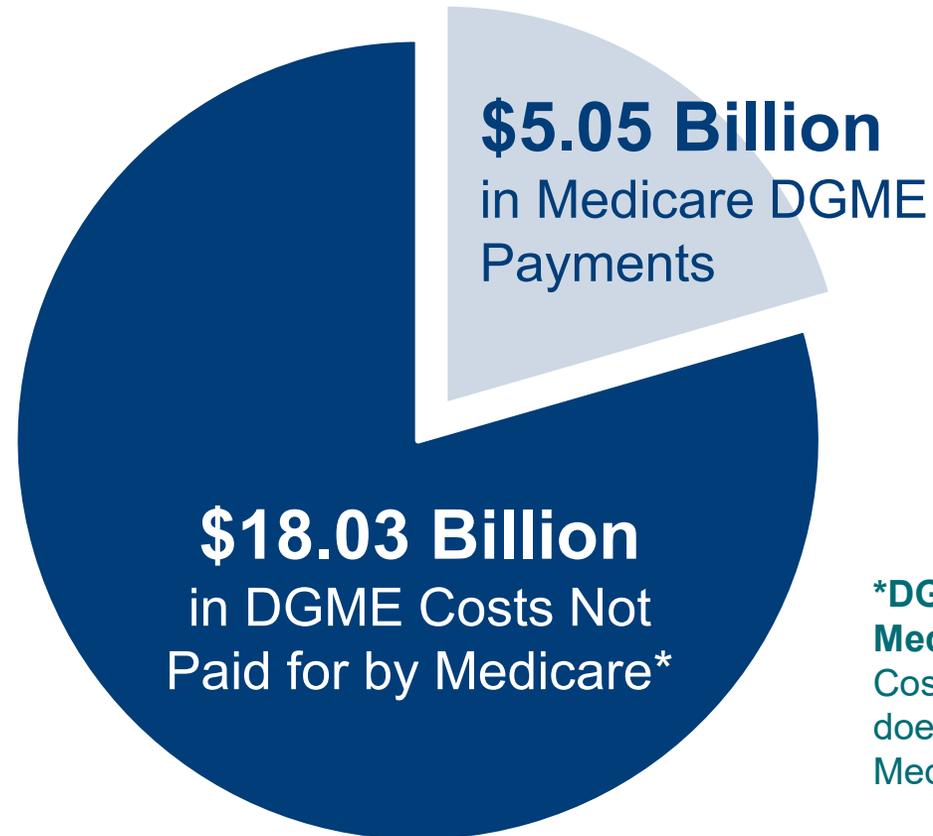
The Health Resources and Services Administration

- Teaching Health Center Graduate Medical Education (THCGME)
- Children's Hospital Graduate Medical Education (CHGME)

Department of Defense

Medicare Covered Only 22% of All DGME Costs for US Teaching Hospitals in FY2021

Total Teaching Hospital DGME Costs FY2021
\$23.1 Billion



***DGME Costs Not Paid for by Medicare = \$3.41B in Medicare Costs above the Cap that Medicare does not pay and \$14.63 B in non-Medicare DGME costs.**

Note: This analysis was restricted to hospitals that were included in the FY2024 IPPS impact file released by CMS. The total training costs include intern and resident salary, fringe, and other costs.
Source: AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

DGME Costs for US Teaching Hospitals in FY2021

There are approximately 125,238 trainees, including 119,539 residents in ACGME accredited programs. Of trainees in those programs, Medicare reimburses only 93,885 at or below the cap established in 1997.

Per Resident Amount, FY2021

DGME Cost per Trainee	Average Cost
Average Cost per trainee	\$184,313
Average Per Resident Amount (PRA)*	\$125,826
Average Medicare DGME payment per Resident (based on Medicare's share of the PRA)	\$53,823
Total Cost of Training in US Teaching Hospitals	\$23.1 billion
Total Medicare DGME Payment	\$5.05 billion
Medicare underpayment (based on Medicare share of DGME costs)	\$3.41 billion

*The amount Medicare uses which represents the maximum payment from Medicare per resident assuming 100% of care is borne by Medicare

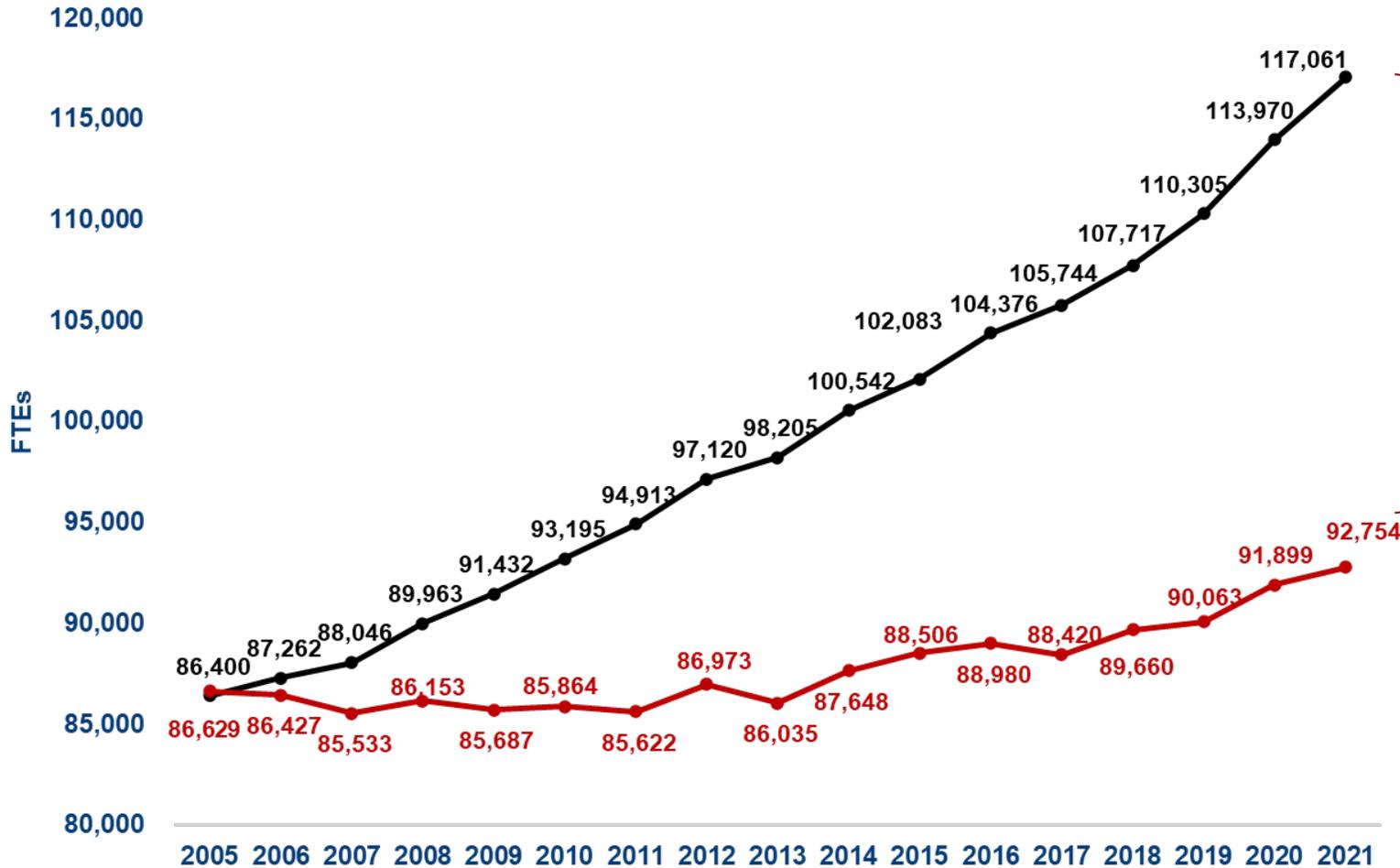
Source: AAMC Analysis of FY2021 Medicare Cost Report data, July 2023 Hospital Cost Reporting Information System (HCRIS) release. If FY2021 data is not available, FY2020 data is used.

Caps on Medicare GME Payments

- Medicare only supports a limited number of resident training positions, referred to as the Medicare GME cap
 - Caps were introduced in the Balanced Budget Act of 1997 (BBA) in response to concerns of physician oversupply
 - Each hospital has its own caps
- Medicare does not pay for residents training over the cap
 - Both DGME and IME are capped
 - Dental and podiatry residents are not capped
- Medicare GME caps are permanent
 - Limited exceptions

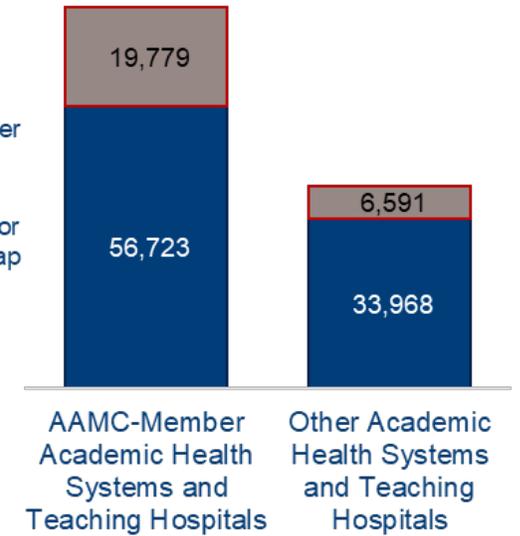
Trends in GME Cap and Count Growth at Academic Health Systems

DGME Cap and Count FY2005 to FY2021 (All Health Systems)



AAMC Members Account for the Majority of DGME Count over the Cap in FY2021

In FY2021 AAMC Members accounted for majority of the DGME FTE count over cap



Source: AAMC's analysis of FY2021 Hospital Cost Reporting Information System (HCRIS) data, July 2023 release.

Note: DGME counts include allopathic and osteopathic residents. Includes redistributed slots under Section 422, Section 5503, and Section 5506. DGME counts are unweighted FTEs.

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Policy Updates: New Medicare Funded GME Slots

CAA, 2021 included 1,000 new Medicare-supported GME positions for hospitals adding new programs or expanding existing programs; first awards were effective as of July 1, 2023

CAA, 2023 Included 200 new Medicare-supported GME positions; at least 100 of the positions must be for psych or psych subspecialty programs. First awards effective as of July 1, 2026

Challenges in Medical Education

- Competency Based Medical Education (CBME)
- Transition to Residency
- Diversity, Equity, and Inclusion (DEI)
- Artificial Intelligence (AI)
- Public and population health
- Transition to Residency (TTR)

Medical School Participation in the 2022 Resident Readiness Survey

Total number of participating MD and DO medical schools

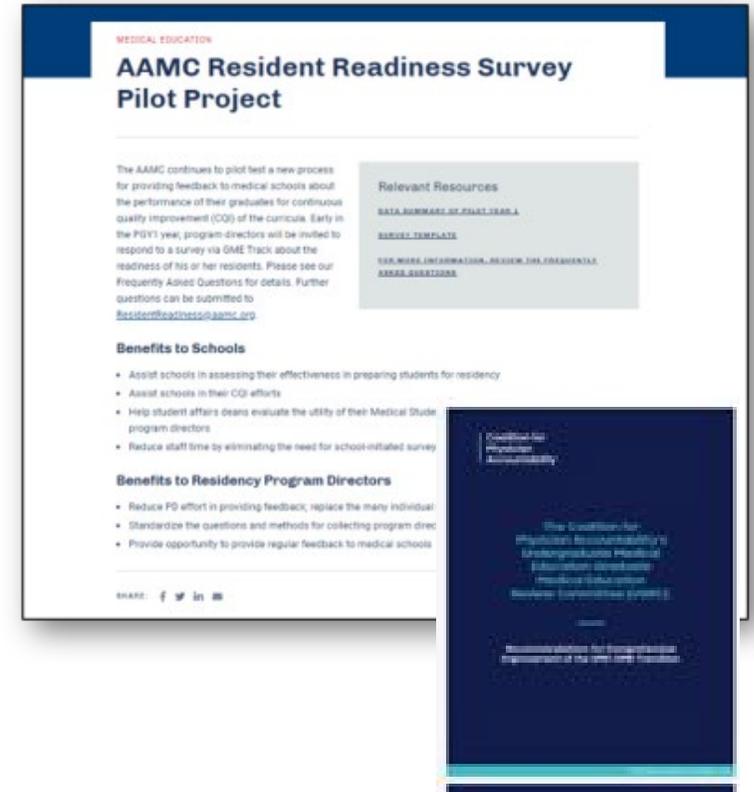
168 (89% of 188 eligible)

Total number of participating residency programs

2,385 (77% of 3,659 invited)

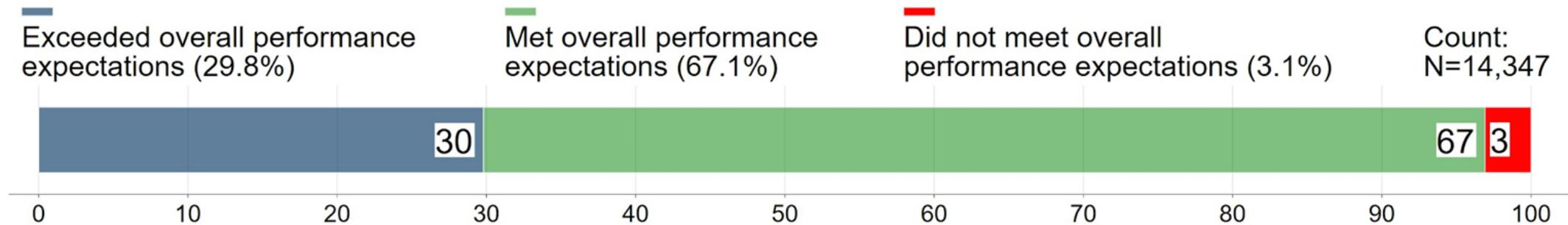
Total number of residents covered

14,461 (65% of 22,242)



Source: Lisa Howley, Douglas Grbic, Mark R. Speicher, Lindsay B. Roskovensky, Amy Jayas, Dorothy A. Andriole; The Resident Readiness Survey: A National Process for Program Directors to Provide Standardized Feedback to Medical Schools About Their Graduates. *J Grad Med Educ* 1 October 2023; 15 (5): 572–581.

Overall Readiness



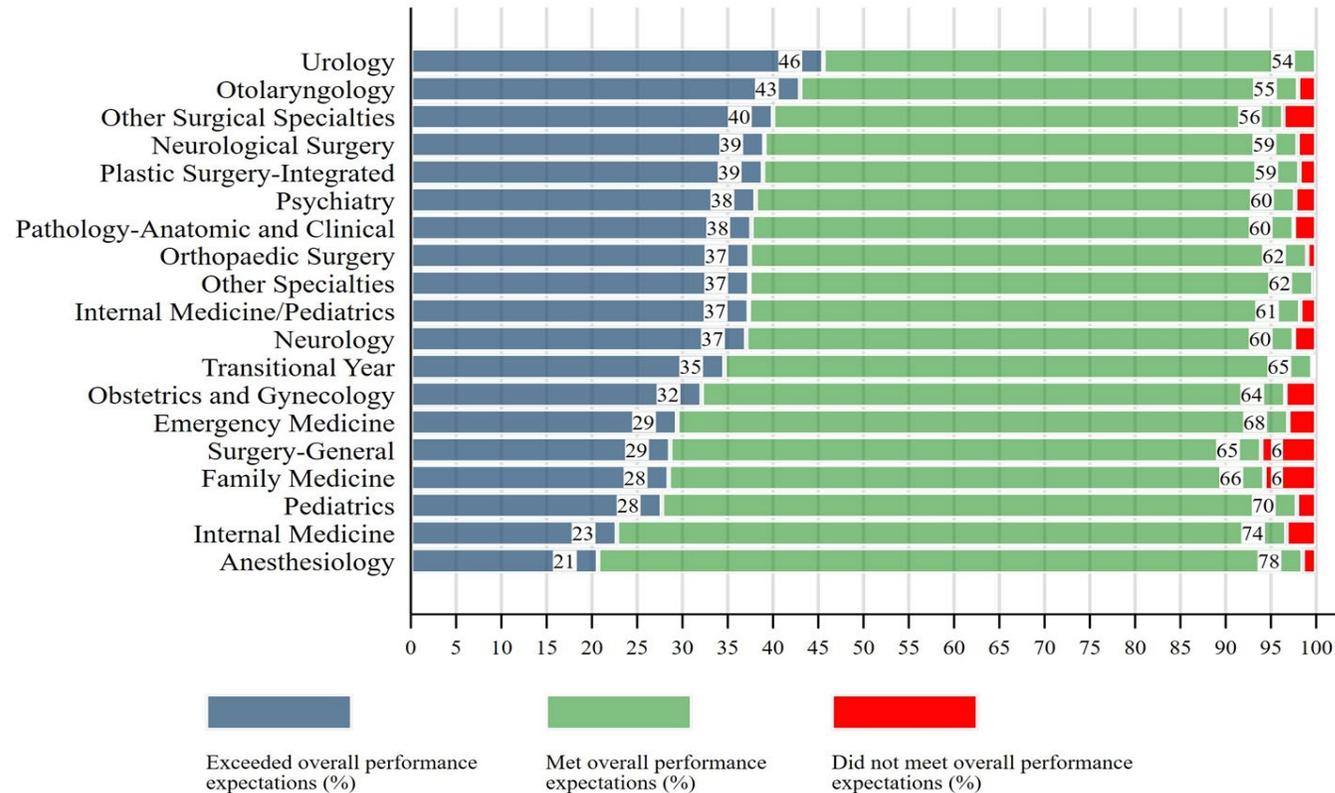
During the transition to GME (0-6 months of PGY-1 year), did this resident meet overall performance expectations?

- 29.8% “exceeded”
- 67.1% “met”
- 3.1% “did not meet”

Source: Lisa Howley, Douglas Grbic, Mark R. Speicher, Lindsay B. Roskovensky, Amy Jayas, Dorothy A. Andriole; The Resident Readiness Survey: A National Process for Program Directors to Provide Standardized Feedback to Medical Schools About Their Graduates. *J Grad Med Educ* 1 October 2023; 15 (5): 572–581.

Overall Readiness By Specialty

During the transition to GME (0-6 months of PGY-1 year), did this resident meet overall performance expectations?



“Other specialties” includes, for example, dermatology and radiology

NOTE: N = 14,347

Source: Lisa Howley, Douglas Grbic, Mark R. Speicher, Lindsay B. Roskovensky, Amy Jayas, Dorothy A. Andriole; The Resident Readiness Survey: A National Process for Program Directors to Provide Standardized Feedback to Medical Schools About Their Graduates. *J Grad Med Educ* 1 October 2023; 15 (5): 572–581.

Innovation Transitioning to a Strong Future

2022 FOUNDATION

New Leadership / New Strategy



Selection Tools

- New User Experience
- Product Performance Optimization



Data Analytics

- Institutional Data Dashboards



Thought Leadership & Research

- ERAS Supplemental Application Working Group
- Specialty specific trainings

2023 TRANSITION



Selection Tools

- New **MyERAS**® Content
- **PDWS**® Filter Updates
- Holistic Review Framework



Data Analytics

- Data Dashboards for Schools and Applicants



Thought Leadership & Research

- DEI Assessment
- New Content Refresh

2024 EVOLUTION



Innovation and data integration



Selection Tools

- New Residency Explorer Updates
- Thalamus integration  /  powered by thalamus
- **ERAS**® Pricing
- Decision support tools



Data Analytics

- **Cerebellum**™ for Programs
- **Cerebellum**™ for Institutions
- Data Integration with Thalamus

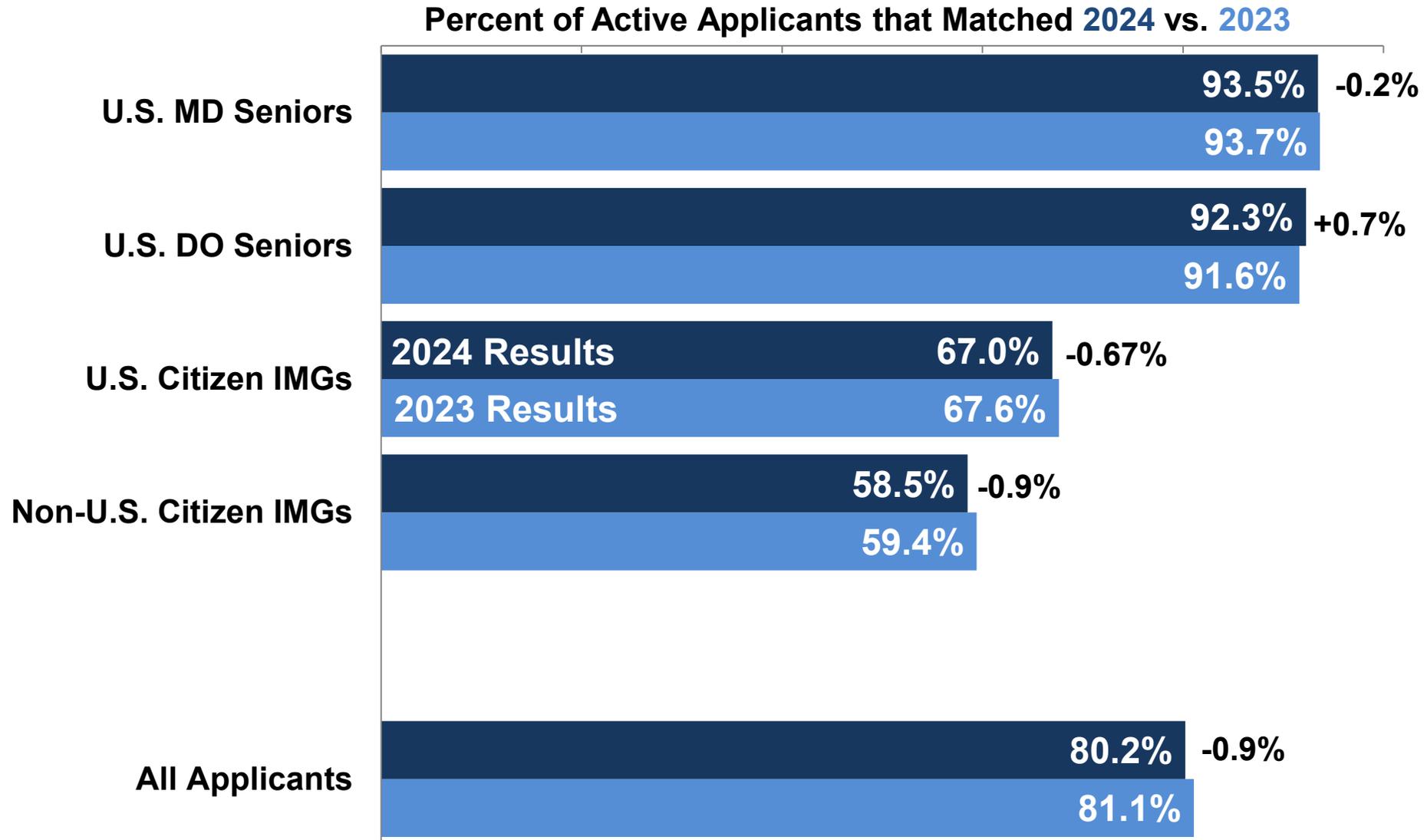


Thought Leadership & Research

- Specialty Workforce

2024 NRMP® Match Data

Main Residency Match results prior to SOAP® week

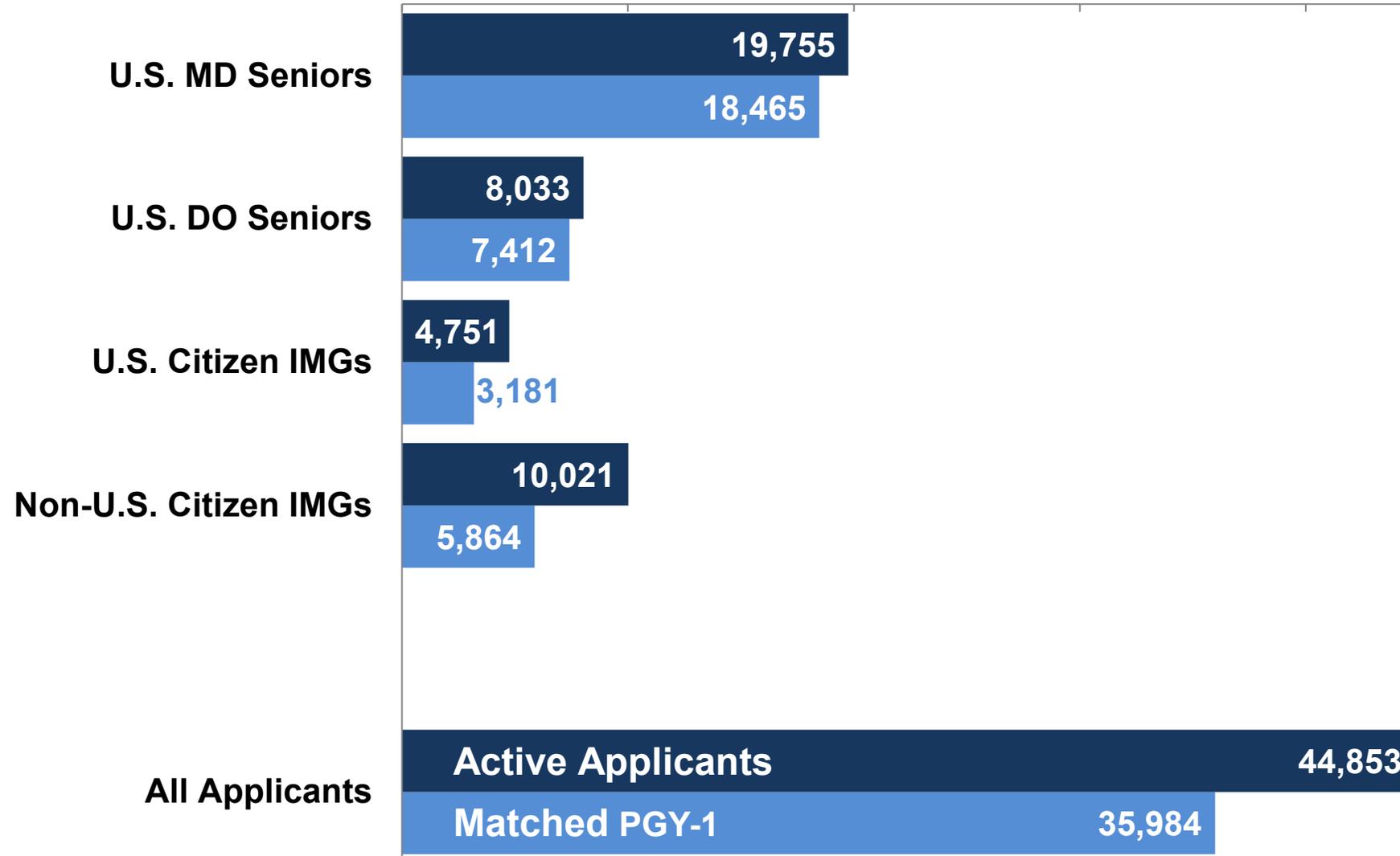


Source: NRMP Advance Tables, 2024 Main Residency Match. "All Applicants" includes minor categories not shown.

2024 NRMP® Match Data

Main Residency Match results prior to SOAP® week

Count of **Active Applicants** and **Matched PGY-1**

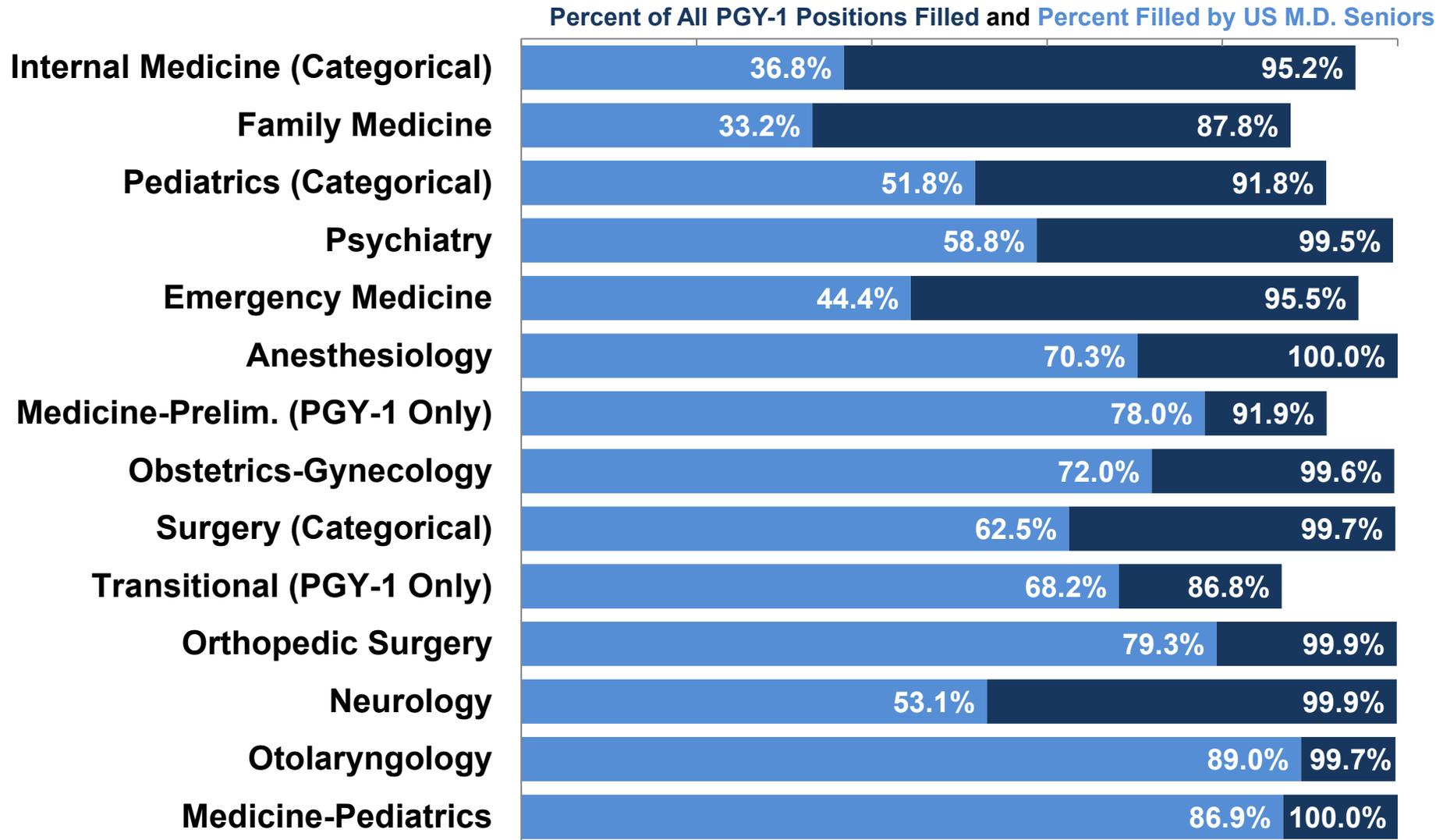


Source: NRMP Advance Tables, 2024 Main Residency Match. "All Applicants" includes minor categories not shown.

Overall PGY-1 Positions Filled and Percent filled by US M.D. Seniors

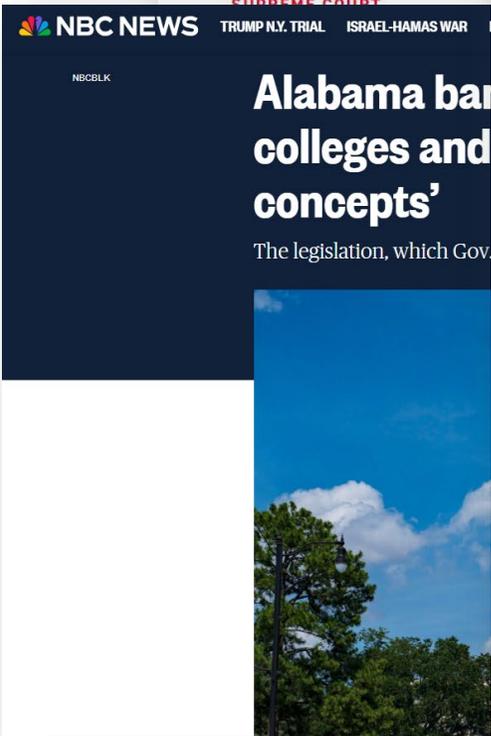
Top 14 Specialties with most US M.D. Seniors

2024 Main Residency Match



Source: NRMP Advance Tables, 2024 Main Residency Match.

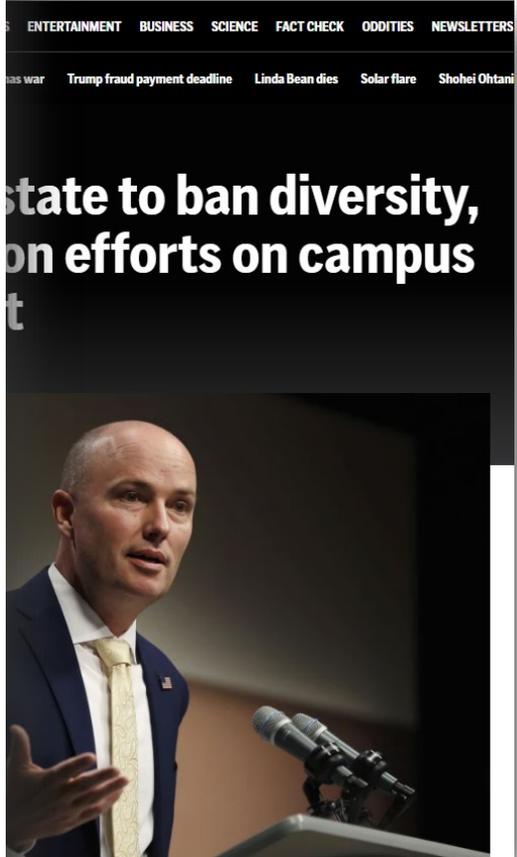
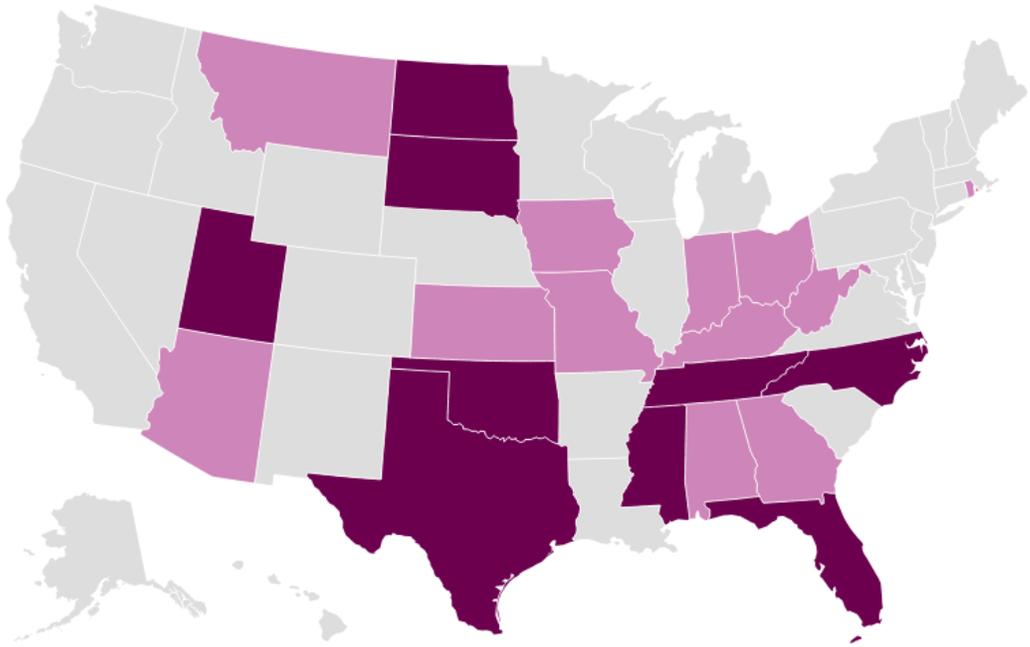
Assaults on DEI in Academic Medicine



States that have proposed legislation limiting DEI programs and offices on college campuses

Since 2021; As of Jan. 29, 2024

Where at least one anti-DEI bill has been: ■ Proposed ■ Passed



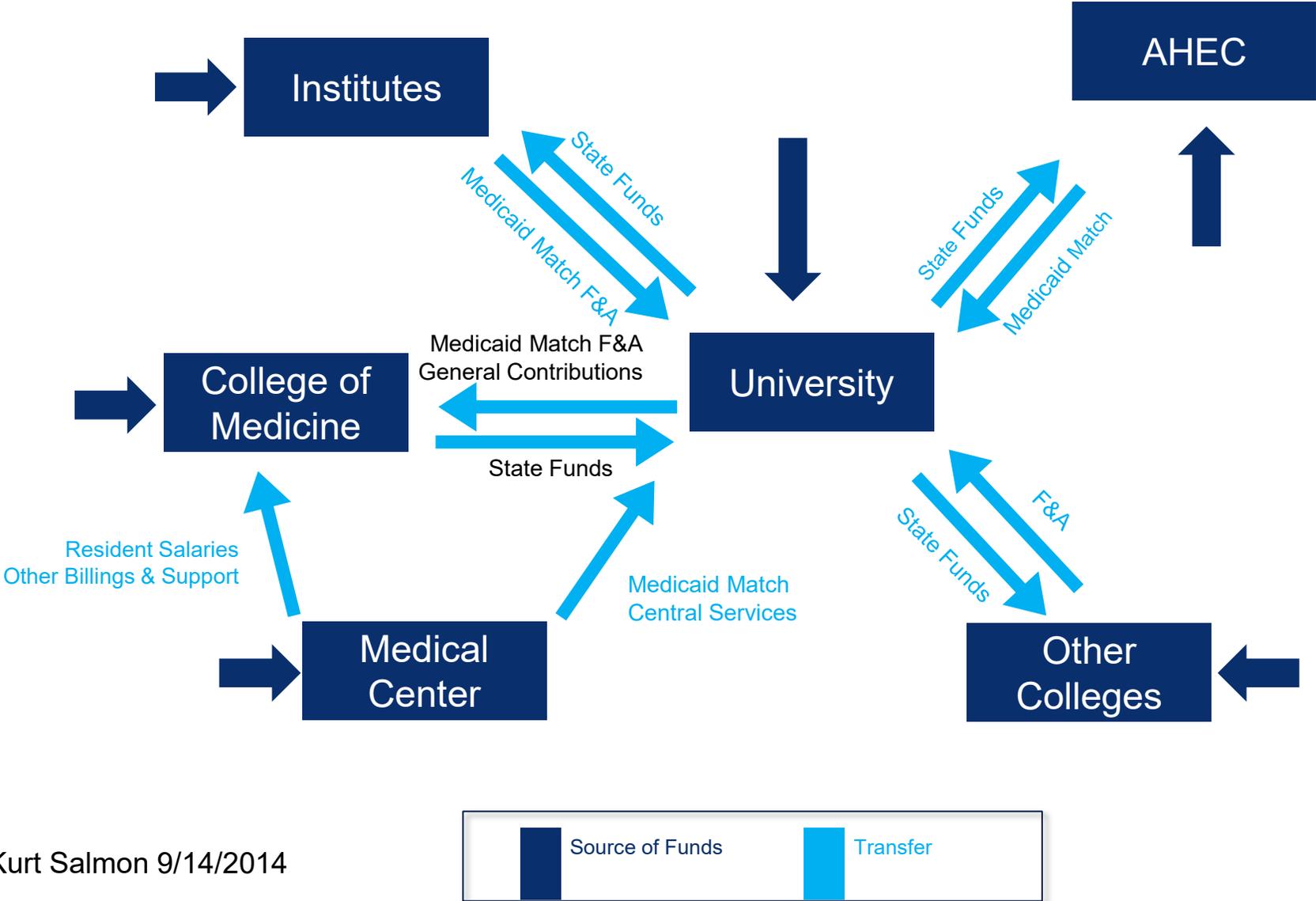
AAMC Center for Health Justice collaborates with public health and community-based organizations, government and health care entities, the private sector, community leaders, and community members. The center builds a case for health justice through research, analysis, and collaborations that drive our efforts to build a better future.



- Develop tools to help institutions and community organizations communicate with each other about their health equity work.
- Guide institutions toward a deeper understanding of equity-focused, person-first language and narratives
- Conduct nationally representative opinion polling to learn how the public feels about health equity and justice.
- Produce original research and analysis to build support for policy and practice changes that have a systemic impact.

Clinical Care: A Mixed Bag

Complexity in Missions and Financing



Slide by Kurt Salmon 9/14/2014

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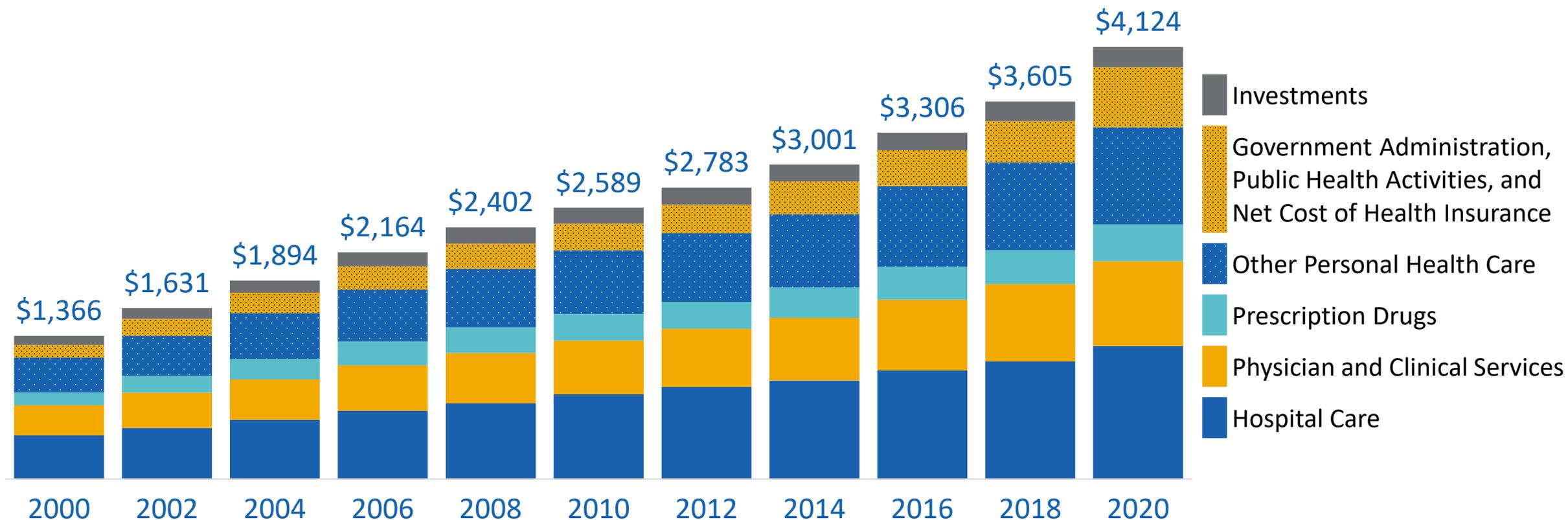


Health Care
Spending

=

(number of services delivered per person)
×
(number of people to whom services are
delivered) ×
(average cost of each service)

National health spending continues to grow, and hospital care remains around 30% of total.



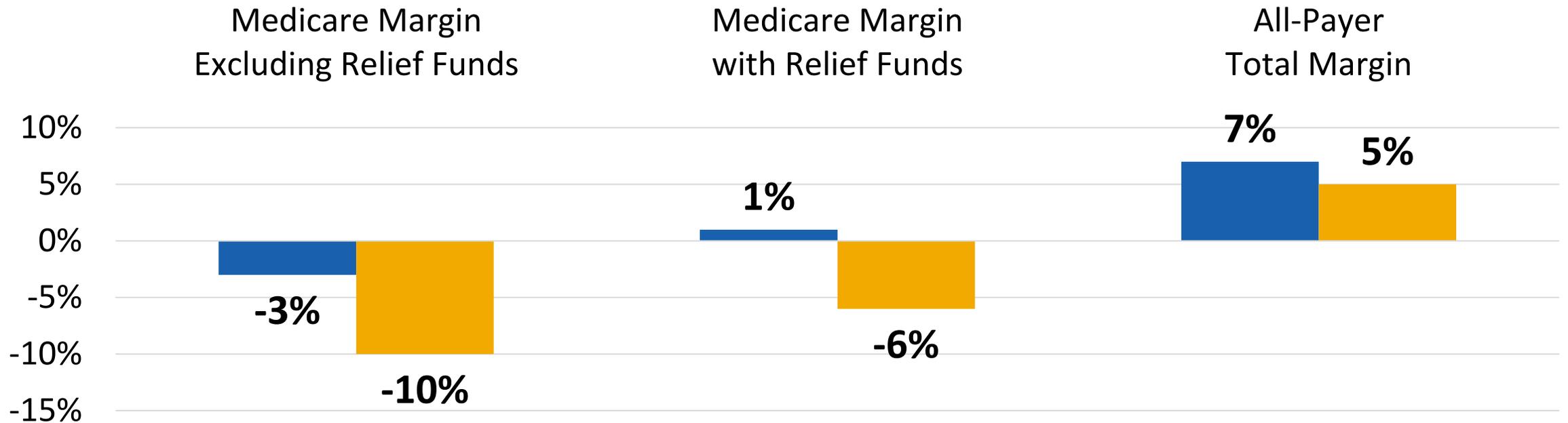
Note: Investments include research and development spending of drug companies and other manufacturers and providers of medical equipment and structures. Other Personal Health Care includes other professional and dental services, home health care, medical equipment and products, nursing care facilities and continuing care retirement communities, and other health, residential, and personal care.

Sources: AAMC analysis of Centers for Medicare & Medicaid Services. National Health Expenditure Data. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet>. Published Dec. 1, 2021. Accessed Feb. 24, 2022.

<https://www.aamcresearchinstitute.org/our-work/issue-brief/health-care-costs-what-s-problem>

Even the most efficient providers lose money on patients with Medicare

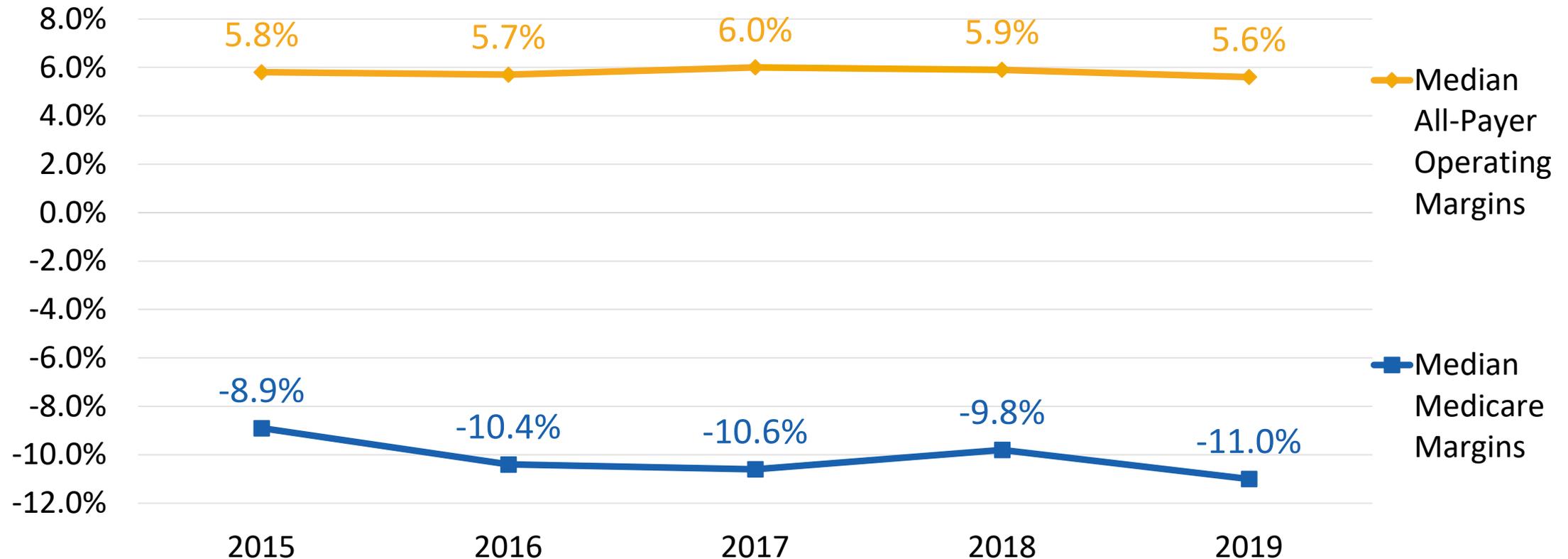
■ Relatively Efficient Hospitals ■ Other Hospitals



Note: Relief funds were those provided during COVID-19.

Source: Medicare Payment Advisory Commission. Medicare Payment Policy: Report to the Congress. https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf. Published March 15, 2022. Accessed March 22, 2022.

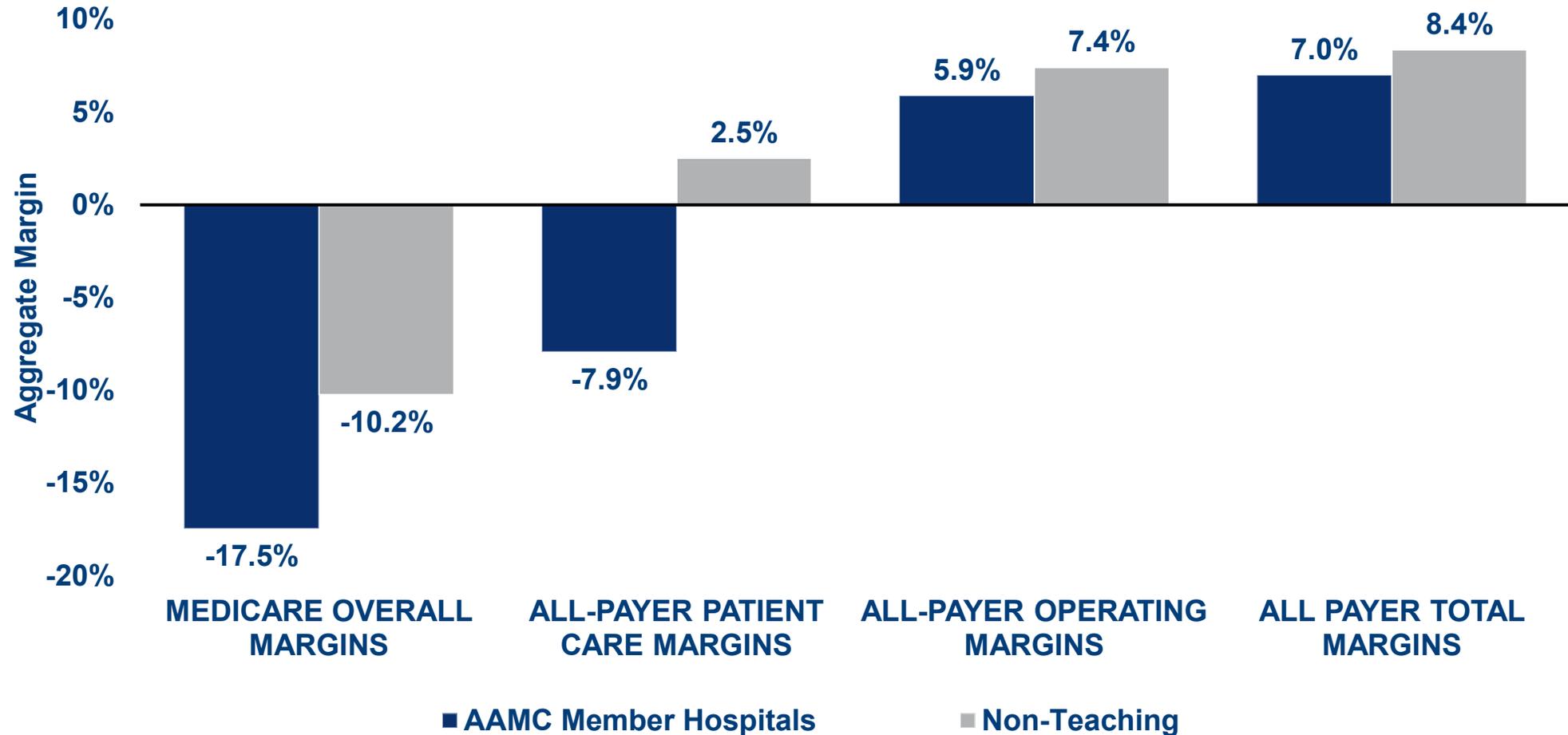
Medicare & All-Payer Margins for U.S. Hospitals, 2015-2019



Note: All margin calculations are based on an AAMC analysis of cost reports between Oct. 1, 2014, and Sept. 30, 2019 for all U.S. hospitals. Margins are as reported after sequestration and exclude costs (both high and low) for outlier institutions. The general formula is as follows: $(\text{revenues} - \text{expenses}) / \text{revenues}$. For the operating margin, revenues include all sources other than contributions, donations, bequests, and investment income and expenses include all hospital expenses.

Source: Hospital Cost Reporting Information System (HCRIS), released Sept. 30 each year, obtained from the Centers for Medicare & Medicaid Services.

Aggregate Margins at AAMC-Member and Non-Member Teaching Hospitals, FY2021

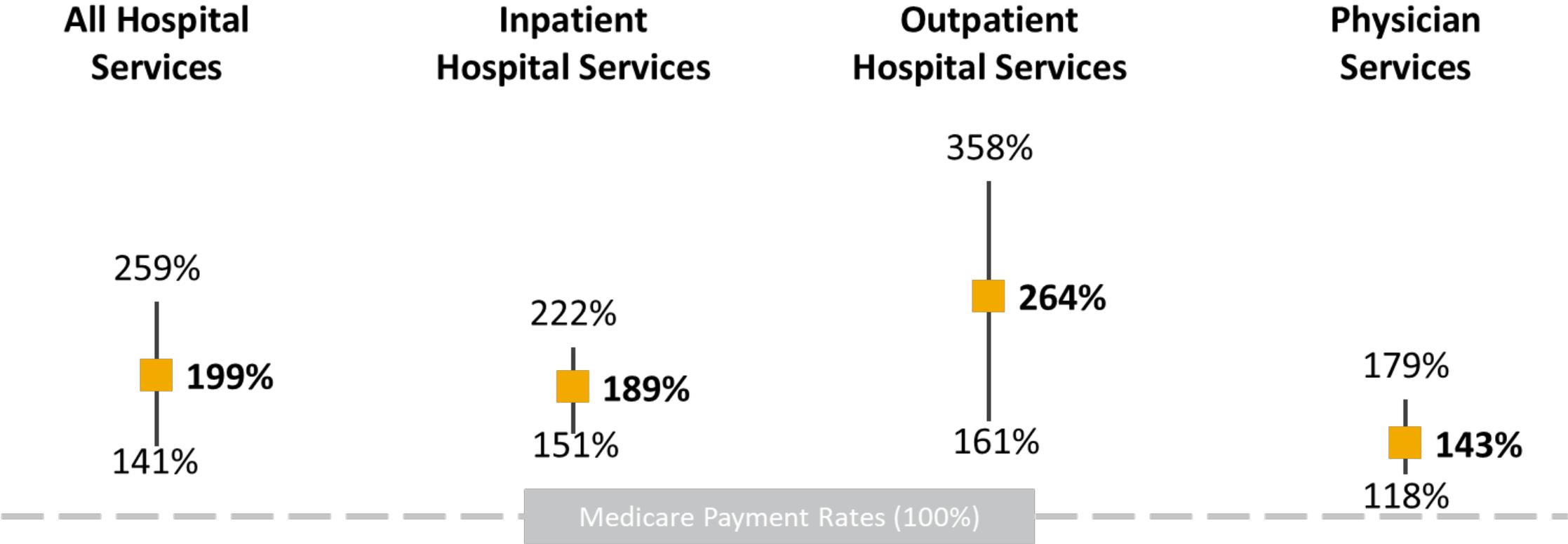


Notes: Margins are as reported, after sequestration, and excludes outlier institutions, both high and low. General formula: (Revenues - Expenses) / Revenues. Operating Margin: revenues include all sources other than “Contributions, Donations, Bequests” and “Investment Income” and expenses include all hospital expenses.

Source: AAMC analysis of FY2021 the Hospital Cost Reporting Information System (HCRIS) released on July 30, 2023. AAMC membership data, September 2023.

Private insurance payment rates are about twice the rate Medicare pays

■ Average Private Insurance Rates as a Percentage of Medicare Rates, Across Studies Using 2010-2017 Data



Private insurance payment rates relative to Medicare payment rates for hospital and physician services.
Source: Lopez E, Neuman T, Jacobson G, et al. How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature. Executive Summary. San Francisco, CA: The Henry J. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>. Published April 15, 2020. Accessed Feb. 10, 2022.

"So-called" Site Neutral Payments – Solution?

Proponents claim it will save millions in Medicare, but opponents say outpatient sites offer higher level of care that comes with additional licensing, accreditation, and regulatory requirements not offered in physician offices, as well as account for other costs hospitals incur

Major hospital groups (like AAMC) are fighting back

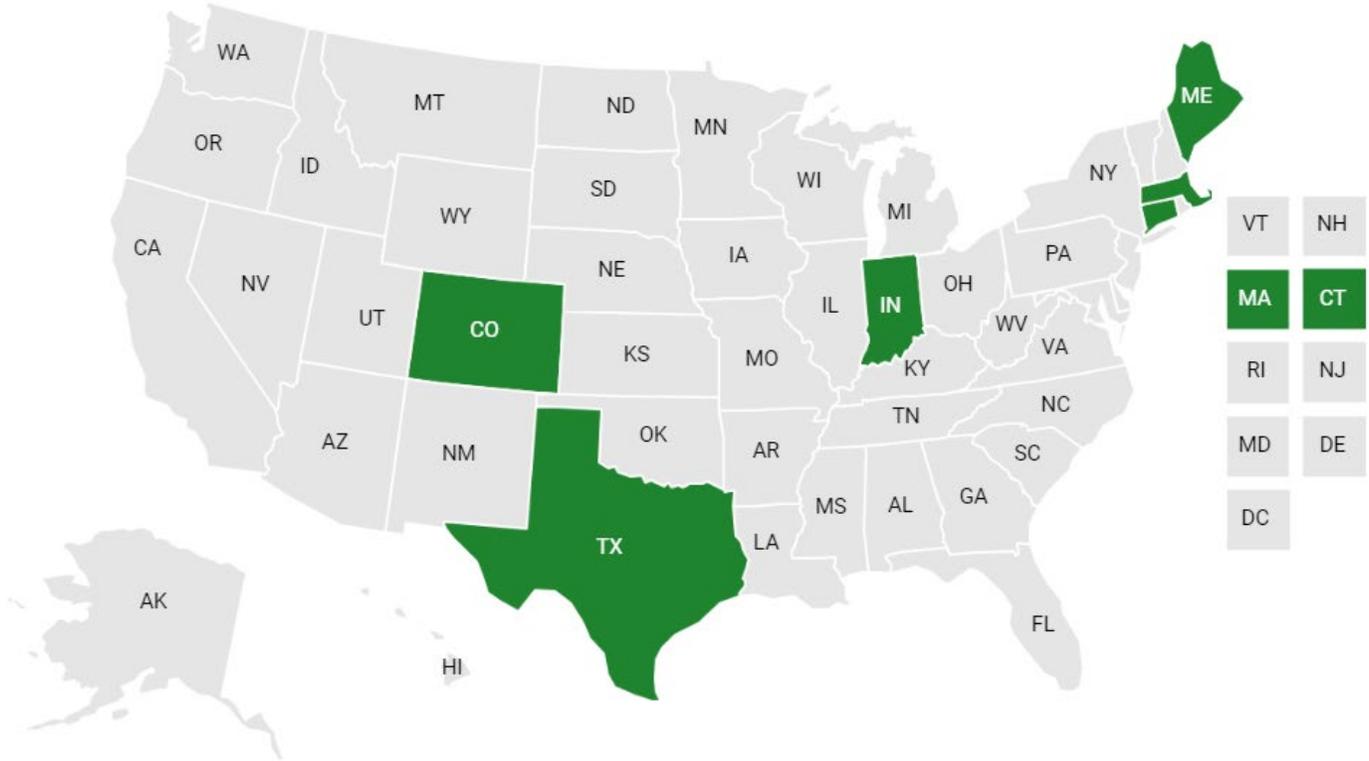
- Site Neutral Payments disproportionately impact teaching hospitals and reduce access to care for Medicare beneficiaries
- Smaller hospitals, rural hospitals, government-run, and safety net hospitals will see a greater drop in Medicare revenue



State Tracker of Legislative Bills on Facility Fees

Facility Fees

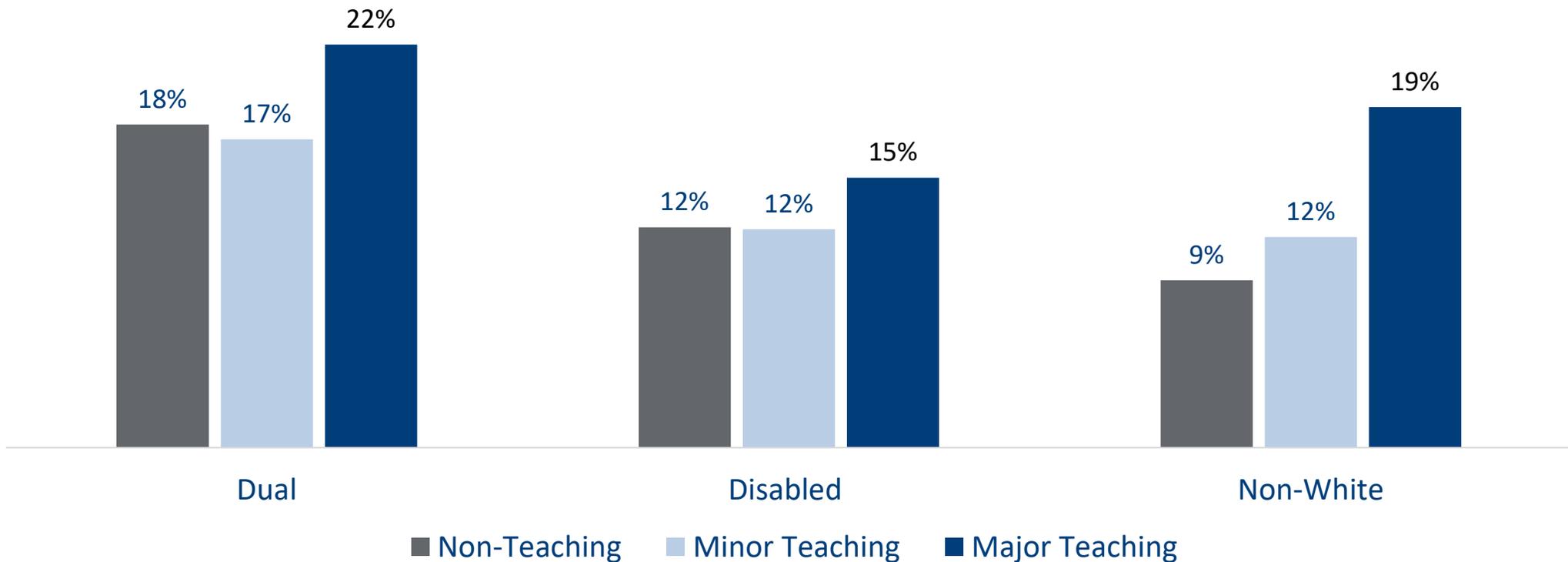
Yes (10 bills in 6 states) No



Source: National Academy for State Health Policy (NASHP) 2023.

Major Teaching Hospitals Serve Proportionately More Vulnerable Patients at all HOPDs

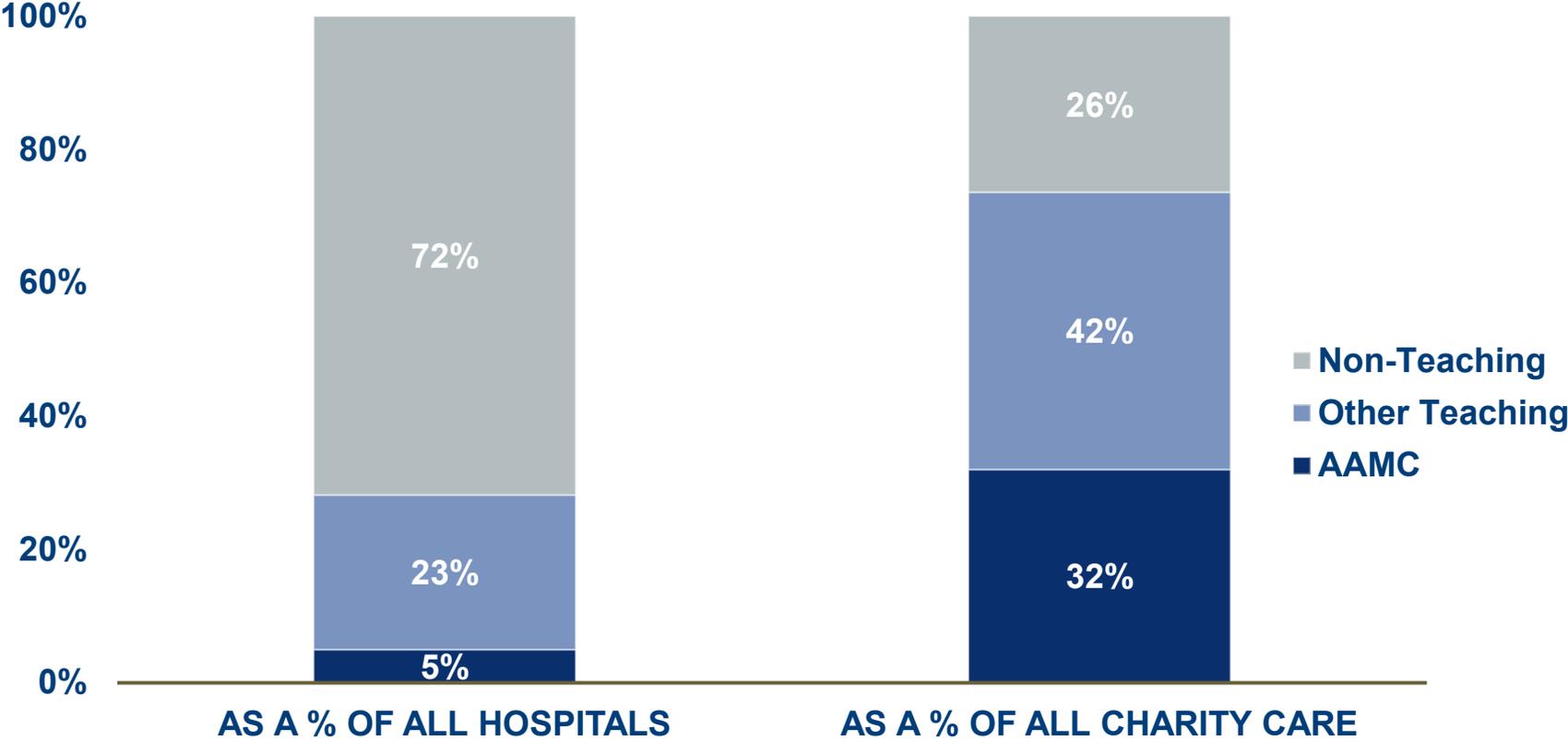
Percent Hospital Outpatient Visits by Patient Population



Note: Major Teaching are defined as having intern and resident to bed ratios (IRB) equal to or greater than 0.25. Minor teaching are defined as having IRB of less than 0.25 and Non-Teaching are defined as having IRB equal 0.

Source: AAMC Analysis of 2021 5% Medicare Standard Analytic File.

Proportion of Charity Care Costs Provided at Hospitals by Teaching Status, 2022



Notes: Data reflect short-term, general, nonfederal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members. Charity care is defined as the revenue forgone as a result of care provided without the expectation of payment. As these labels are rounded percentages, the totals for each bar may not add up to 100%.
Source: AAMC analysis of FY2022 American Hospital Association data. AAMC membership data, December 2023.



By Jill R. Horwitz and Austin Nichols

Hospital Service Offerings Still Differ Substantially By Ownership Type

ABSTRACT Nonprofit, for-profit, and government hospitals are all more likely to offer services when they are relatively profitable than when they are relatively unprofitable. However, for-profit hospitals are considerably more likely than others to provide services based on profitability. After hospital and market characteristics are adjusted for, nonprofit hospitals offer relatively unprofitable services more than for-profit hospitals and less than government hospitals. Profitable services typically exhibit the opposite pattern. For-profit hospitals are also more likely to adopt or discontinue services consistent with changes in service profitability than are nonprofits, which in turn are more likely to do so than government hospitals. These results are similar to those we found before passage of the Affordable Care Act, when many more patients were uninsured. Policy makers and researchers tend to focus on whether nonprofit hospitals provide sufficient free care to justify tax benefits, thereby overlooking the significance of ownership for service provision, which likely has critical health and spending consequences.

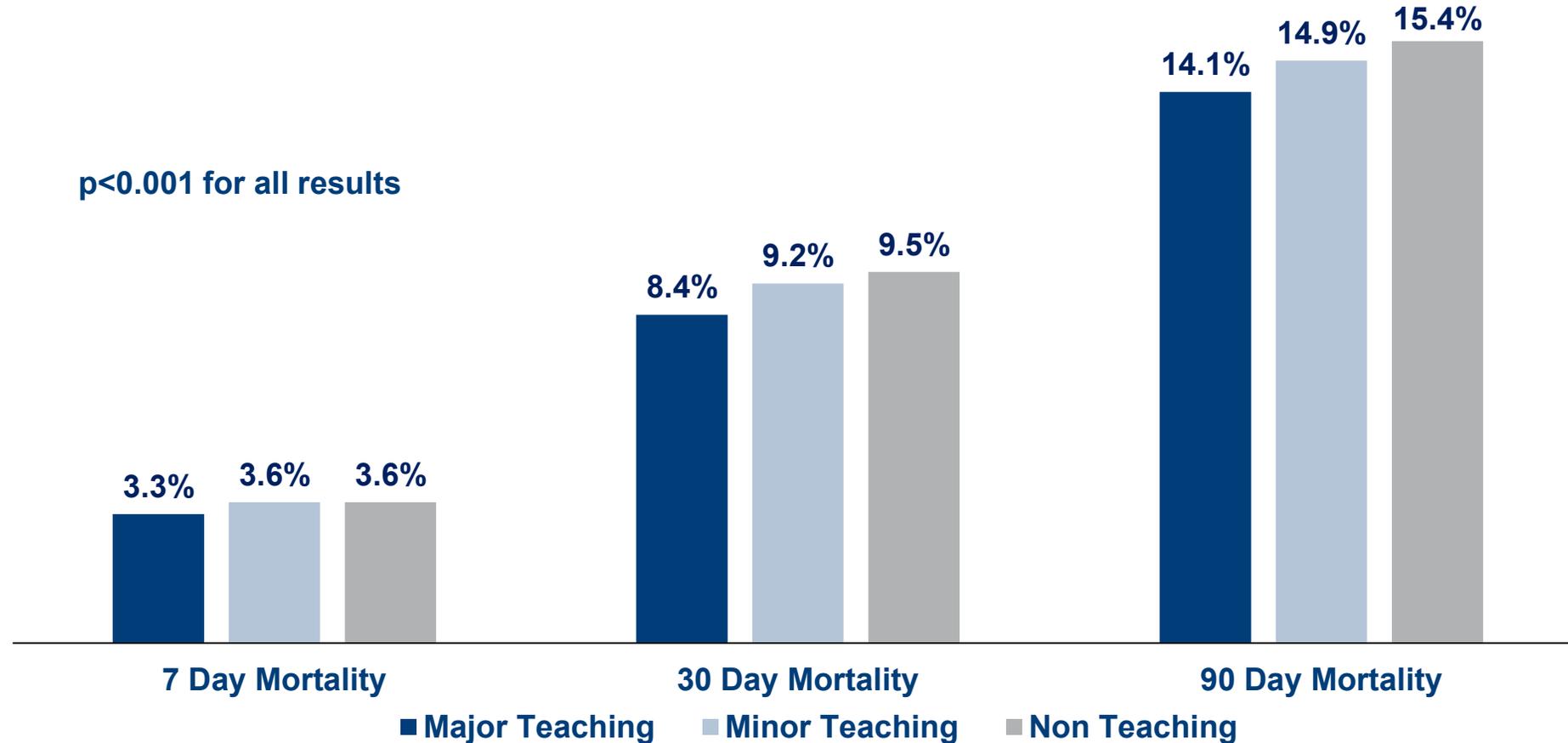
DOI: 10.1377/hlthaff.2021.01115
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NO. 3 (2022): 331-340
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Austin Nichols, Abt Associates, Rockville, Maryland.

March 2022 *Health Affairs* article finds nonprofits were 6% and government hospitals were 9% more likely than comparable for-profits to offer unprofitable services.

Value: Patient Mortality is Lower at Teaching Hospitals



Notes: Model includes state fixed effects and adjusted for correlation of patients at the hospital level. Patient characteristic adjustments include principal discharge Diagnosis Related Group Weight, age, sex, Medicaid eligibility, and Hierarchical Condition Category. Hospital characteristic adjustments include profit status, rural/urban location, and volume of hospitalizations.

Source: Burke, Laura G., Austin B. Frakt, Dhruv Khullar, E. John Orav, and Ashish K. Jha. "Association Between Teaching Status and Mortality in US Hospitals." *JAMA* 317, no. 20 (2017): 2105-2113.

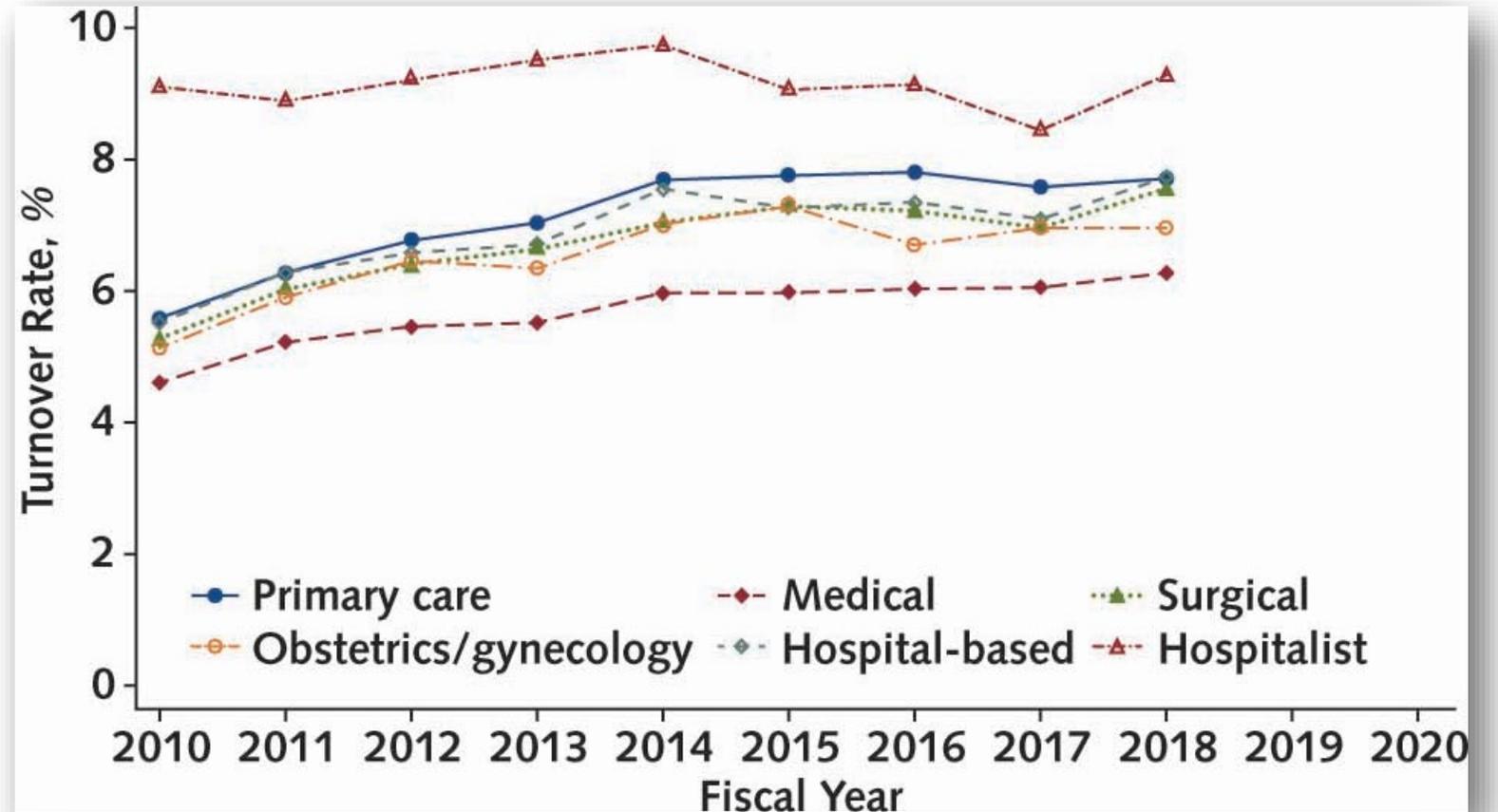
What Are The Uncompensated Costs?

Patient Care	example
-Standby costs of personnel, facilities	Trauma team, dedicated rooms on hold
-Services that are loss leaders	Mental health, primary care, inpt psych, Trauma
-Services that lose \$\$\$ depending upon payer	Medicaid and Medicare losses
-Advancing new models of care	Inter-professional/interdisciplinary care
-Uncaptured complexity of care	MCC and complex/acute pts in MS-DRG
Research	example
-Start up and recruitment funds	Bridge funding, recruitment pkgs
-Ongoing personnel costs	Salary cap gap funding

**Where are costs rising?
Labor, drug and supply acquisition?
How does it affect losses?**

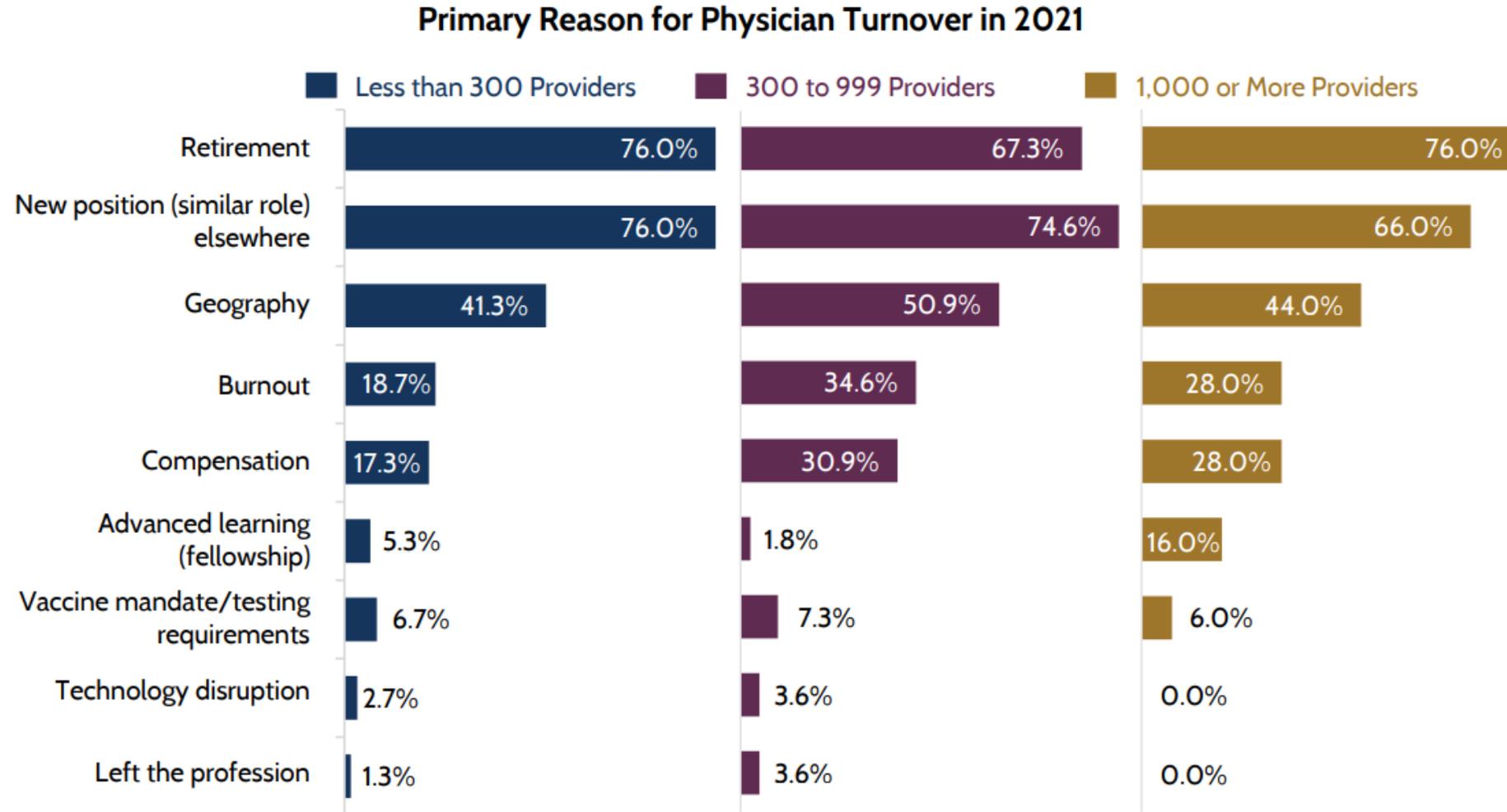
Physician Turnover Rates Increase Costs

July 2023 *Annals of Internal Medicine* study finds annual physician turnover has risen steadily with rates from 5.3% to 7.6% between 2010 - 2018



Source: Amelia M. Bond, Lawrence P. Casalino, Ming Tai-Seale, et al. Physician Turnover in the United States. *Ann Intern Med.*2023;176:896-903.

Why Are Physician Turnover Rates Increasing?

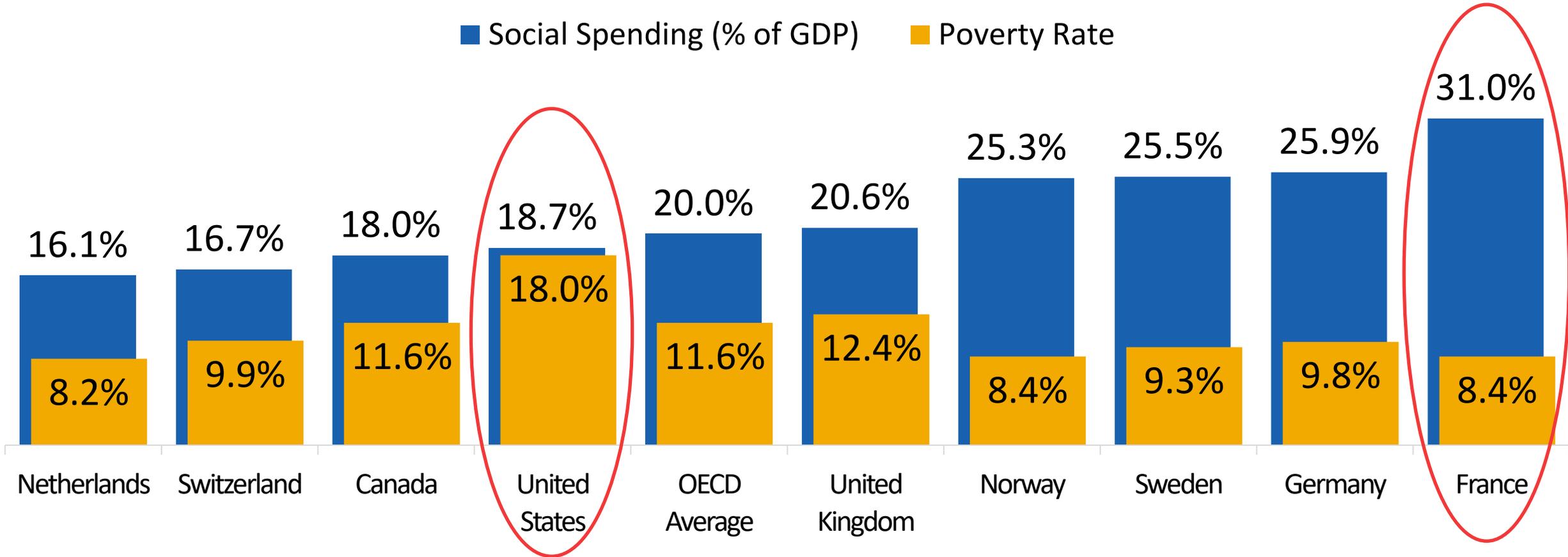


Source: [Physician and Provider Retention and Turnover Report, 2022](#). Association for Advancing Physician and Provider Recruitment (AAPPR)

Social Determinants Drive Mortality

The U.S. spends less than other countries on social services despite higher poverty rates

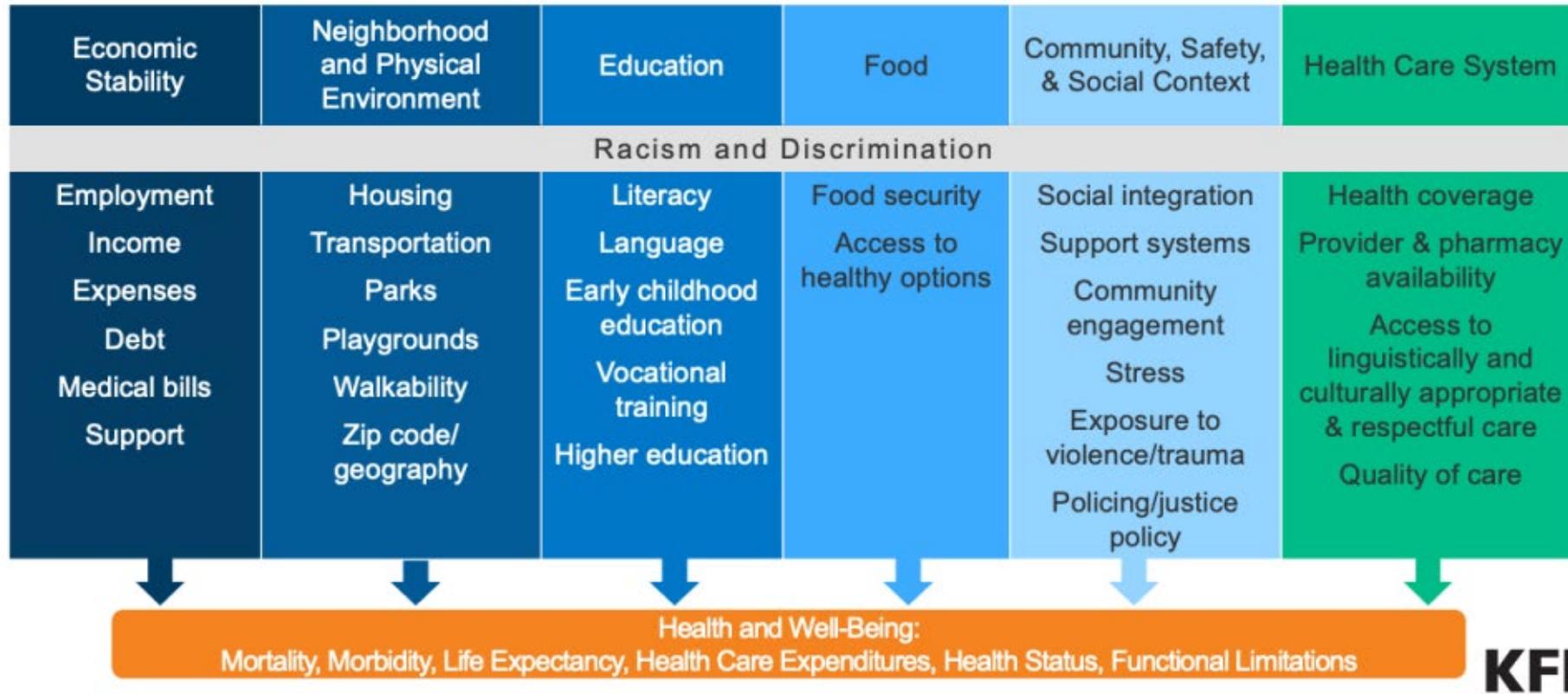
■ Social Spending (% of GDP) ■ Poverty Rate



Note: Values for Canada and Switzerland are from 2018; data for all other countries are from 2019.
Source: OECD (2022), Social spending (indicator). doi: 10.1787/7497563b-en (Accessed on 25 March 2022).

Figure 4

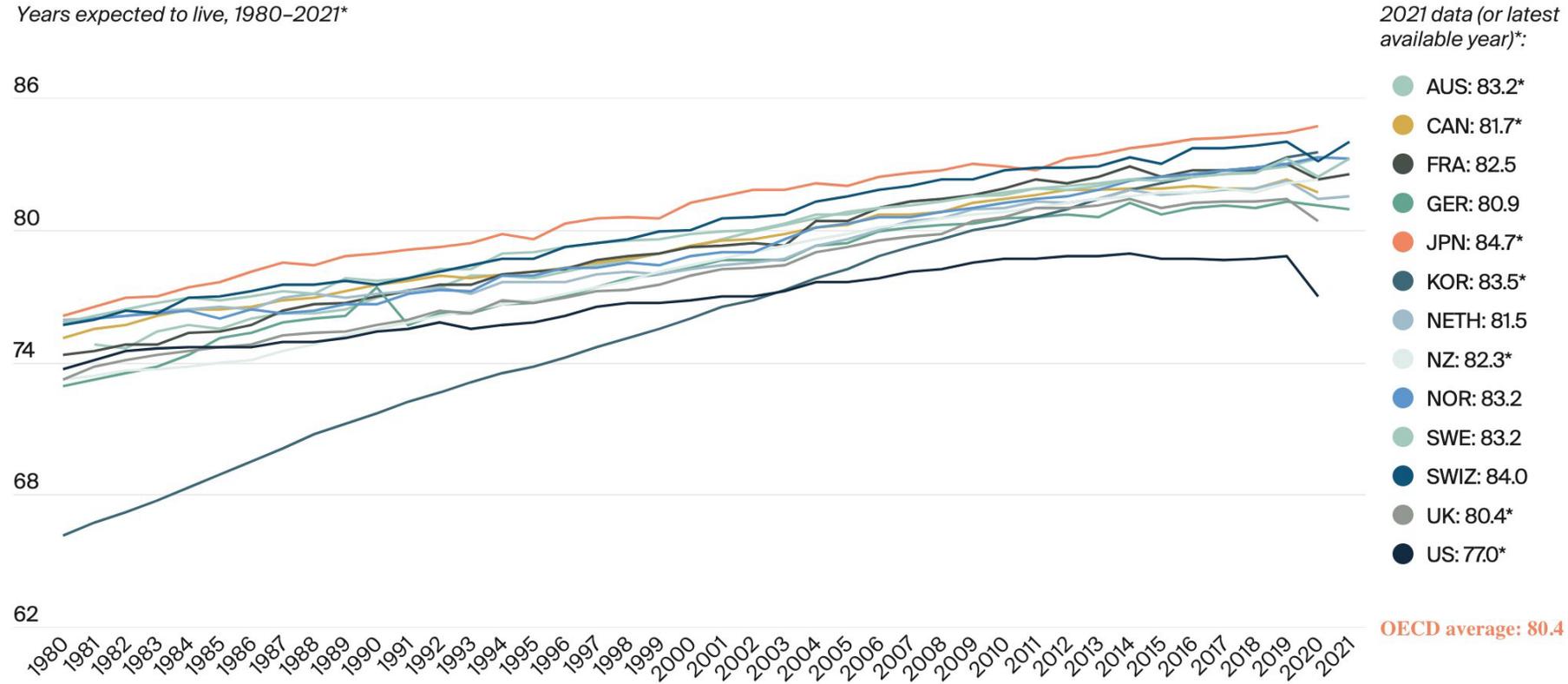
Health Disparities are Driven by Social and Economic Inequities



Source: Ndugga, N, Artiga, S. *Disparities in Health and Health Care: 5 Key Questions and Answers*. KFF Health News, 2023.

U.S. life expectancy at birth is three years lower than the OECD average.

Years expected to live, 1980–2021*



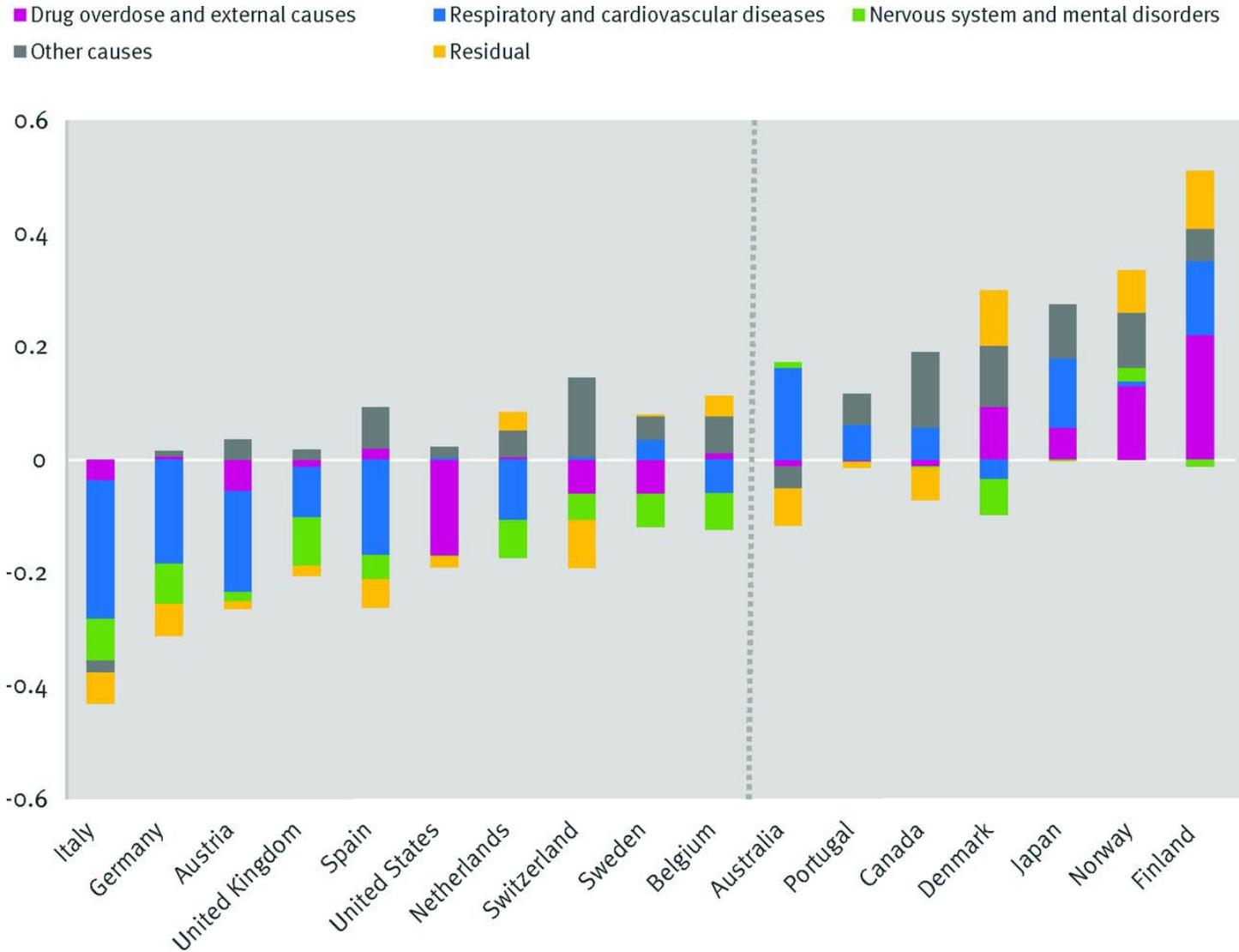
[Download data](#)

Note: * 2020 data. Total population at birth. OECD average reflects the average of 38 OECD member countries, including ones not shown here. Because of methodological differences, JPN and UK data points are estimates.

Data: OECD Health Statistics 2022.

Source: Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes* (Commonwealth Fund, Jan.

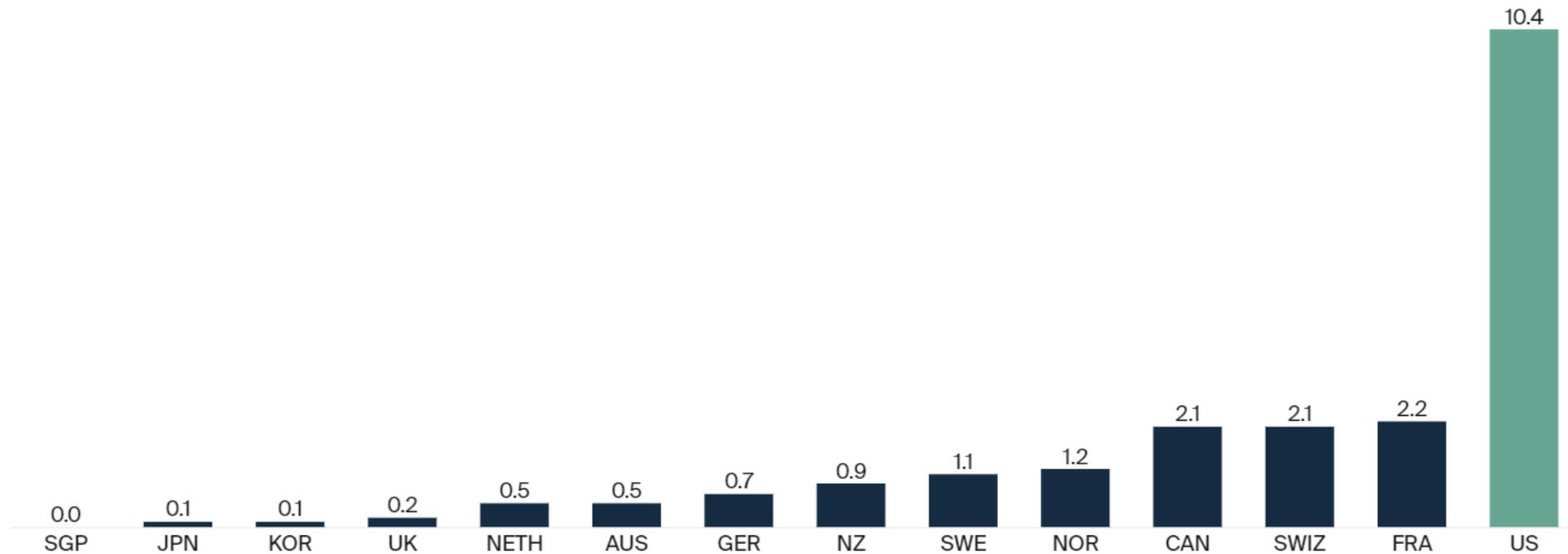
US Life Expectancy Declines By Cause of Death



Source: Ho J Y, Hendi A S. Recent trends in life expectancy across high income countries: retrospective observational study BMJ 2018; 362:k2562
 doi:10.1136/bmj.k2562 <https://www.bmj.com/content/362/bmj.k2562>

The U.S. has the highest rate of firearm deaths, nearly five times that of the second-highest country, France.

Age-standardized rate of death because of firearms per 100,000 people, 2019



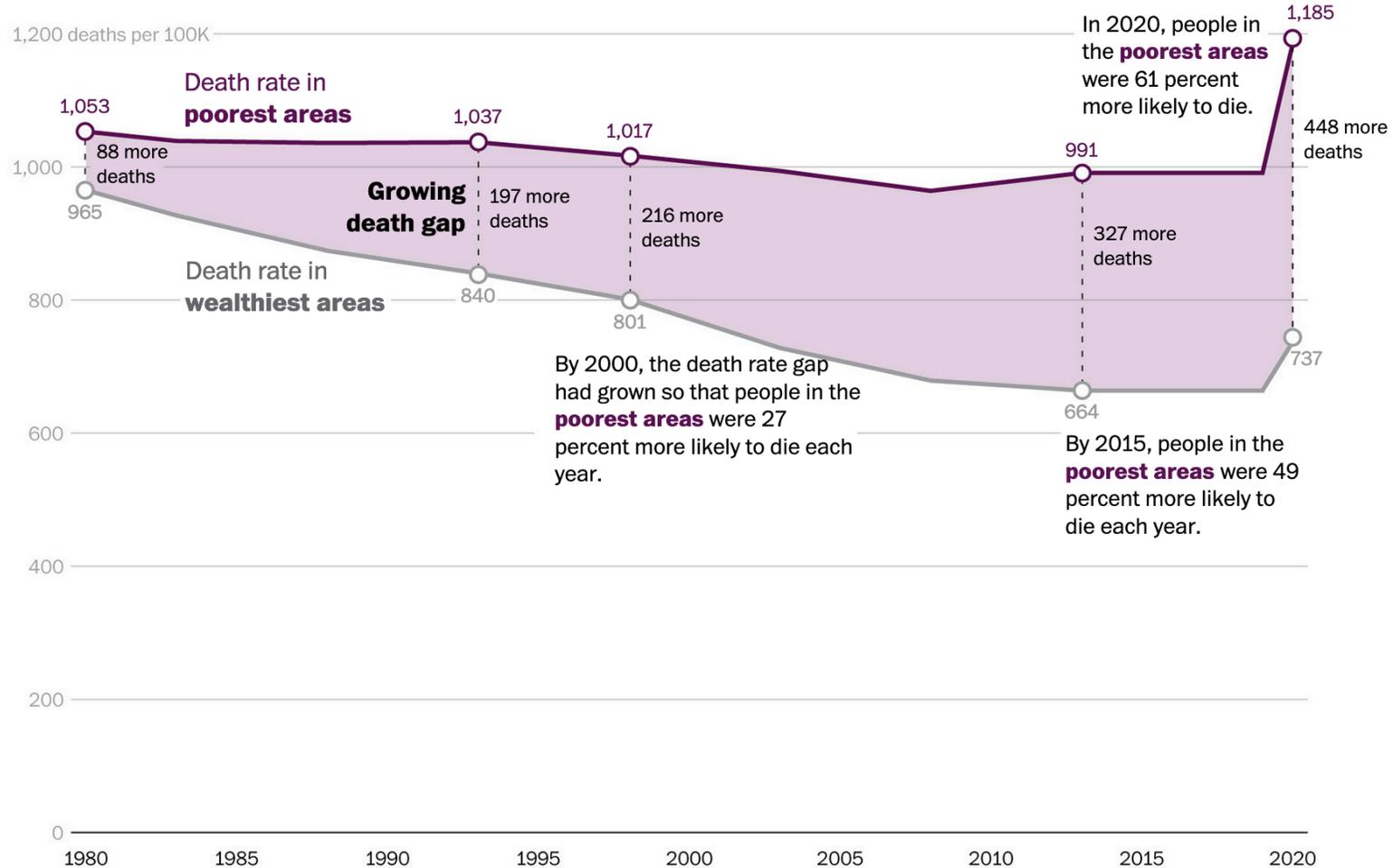
 Download data

Source: The Commonwealth Fund. April 20, 2023. <https://www.commonwealthfund.org/publications/2023/apr/health-costs-gun-violence-how-us-compares-other-countries#1>



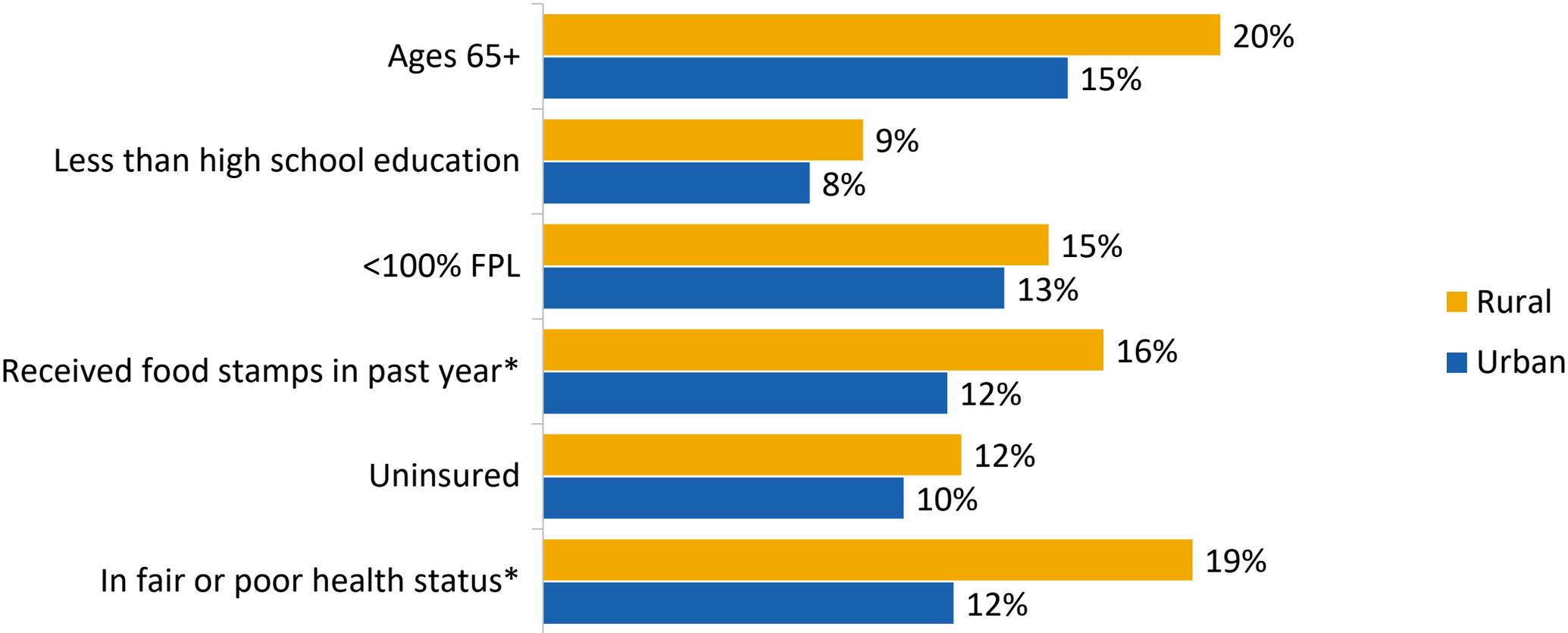
SMALL DEATH GAP HAS GROWN WIDE
Death rates of poorest and richest counties

In the early 1980s, people in the poorest areas were 9 percent more likely to die each year, with 88 more deaths per 100,000 people than their wealthy counterparts. That gap has widened significantly over time.



Note: Income differences are adjusted for inflation.

Rural areas have higher shares of people ages 65+, with incomes below poverty, and in fair or poor health than urban areas



Note: * Indicates comparison is between nonmetro (labeled Rural) and metro (labeled Urban). Uninsured rates are for those ages 0 to 64. Educational attainment is among those ages 35 and older. Health status is self-reported.
Source: 2021 American Community Survey and 2021 National Health Interview Survey



Real health care problems deserve realistic policy solutions

Straightforward analysis of the nation's health care and how to improve it.

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"Our attempts at creating value have, on net, cost more than they've saved in the short term."

Executive Director Atul Grover, MD, PhD, on value-based care

Questions?

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