Annual Report on Graduate Medical Education in Florida

Submitted By The Graduate Medical Education Committee

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Preface

Pursuant to s. 381.0403 (9), F.S., the Graduate Medical Education (GME) Committee, an 11-member appointed work-group, is responsible for the production of an annual report on graduate medical education in Florida.

Pursuant to section 381.0403 (9), Florida Statutes (F.S.), the Graduate Medical Education (GME) Committee, an 11-member governor's appointed workgroup, is responsible for the production of an annual report on graduate medical education in Florida. This report, provided to the Governor, the President of the Senate and the Speaker of the House of Representatives on January 15, must address the following:

(a)The role of residents and medical faculty in the provision of health care.

(b)The relationship of graduate medical education to the state's physician workforce.

(cThe costs of training medical residents for hospitals, medical schools, and teaching hospitals, including all hospital medical affiliations and practice plans at all of the medical schools and municipalities.

(d)The availability and adequacy of all sources of revenue to support graduate medical education and recommend alternative sources of funding for graduate medical education.

(e)The use of state and federally appropriated funds for graduate medical education by hospitals receiving such funds.

Members of the GME Committee share the dedication and commitment of ensuring access to high-quality health care for the citizens of Florida. The GME Committee, along with the Community Hospital Education Council (CHEC) has worked to create long-range plans and goals to improve the graduate medical education system in Florida, find new and renewed sources of funding, and provide education to policymakers and the public on the benefits and necessity of residency programs.

Acknowledgments

The Department of Health extends thanks to those who give so generously of their time and talents to ensure the continued success of graduate medical education in Florida. The Graduate Medical Education Committee members are:

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In December 2003, the Department of Health met for the first of several visits with the Southeast Regional Center for Health Workforce Studies in Tallahassee. This center, part of the Cecil G. Sheps Center for Health Services Research at University of North Carolina at Chapel Hill, has provided assistance and guidance to the department regarding physician workforce data. The department is appreciative of the Sheps Center's expertise and dedicated staff who have been extremely helpful in the department's mission to understand and better utilize its available data resources.

Executive Summary

The 2005 Annual Report on Graduate Medical Education (GME) in Florida was prepared pursuant to section 381.0403(9), Florida Statutes. Florida's GME Committee held face-to-face meetings and conference calls throughout 2005 that focused on the key issues contained in this report, including the role that graduate medical education has in relationship to the state's physician workforce and to the costs and funding of graduate medical education programs.

Graduate medical education, which is the second phase of formal education after medical school, is usually referred to as a residency. Residencies, depending on the specialty or subspecialty, are from three to six years or more in length. Medical school is the beginning of the physician's education and provides the general competencies for a graduate to enter a residency program. A residency is the time when the resident will develop his or her clinical skills and expertise by working with physician faculty members and treating patients on a one-one-one basis. Residency programs also offer physicians opportunities to network and develop professional contacts.

This report discusses research regarding the location of residency training and the location of a physician's practice after residency is completed. As an example, two Florida physicians, Kim and Vaughn Meiners, moved from Louisiana to Jacksonville, Florida, for their residencies after graduating from medical school. After the Meiners completed their residencies, they remained in Jacksonville (Florida Times-Union, 2005). National and state studies have found that the location of a physician's practice correlates more closely to the geographic location of the residency, rather than to the medical school from which the physician graduated (COGME, 2002).

Residency programs provide access to trained medical professionals for persons who are indigent, uninsured, or underserved. Residency programs also positively affect the quality, specialty or subspecialty mix of the physician workforce, and geographic distribution of physician specialists. More importantly, residency programs are substantial contributors and determinants of the supply and diversity of specialist physicians practicing in Florida. The capacity and quality of Florida's residency programs define and assist the recruitment of hightly qualified resident physician applications to Florida. These applicants may ultimately remain in the state to establish their practices. There are currently 298 allopathic and osteopathic residency programs defined by specialties of training across the state, with over 3,200 resident physicians in training at a given point in time. Even though these numbers are impressive, Florida ranks 44th of 50 in the nation in the ratio of residency training positions per 100,000 population. This is, in part, because most other states have major residency programs spanning at least a century that are larger than Florida's in relation to their populations and because of the late entry to medical training in Florida in the mid-twentieth (AAMC, 2005).

Florida is encountering rapid changes in the aging of its population, which consume a disproportionate share of healthcare resources. Florida ranks second only to California in the percentage of persons age 65 or older per 100,000 population. In 2004, 17.6 percent of Floridians were 65 or older, compared to 12.4 percent nationally. This percentage is anticipated to reach 19 percent by 2020 as baby boomers reach 65 and older (Census Bureau, 2005). As the population ages, so to does the physician workforce. Slightly more than a fifth (22 percent) of Florida's physicians are age 60 or older, and over half (50.1 percent) are older than 50. New physicians are needed to meet the growing healthcare needs of the state.

To meet the growing demand for physician manpower, Florida has been a net importer of physicians. Physicians have been locating in Florida from other states or foreign countries. Physician licensure data indicates that 34 percent of active licensed physicians with a primary practice address in Florida are from foreign medical schools.

Florida's graduate medical education programs produce highly trained residents who often remain in Florida to practice, and which helps the state meet its specialty needs, such as geriatric medicine.

Funding for graduate medical education programs comes from several sources and identified costs vary among individual residency programs, in part dependent upon variable hospital accounting practices. The largest source of funding for graduate medical education is the Federal Medicare Program, which reimburses teaching hospitals for the direct cost of operating these programs (Direct Medical Education or DME costs) and indirect costs (Indirect Medical Education costs or IME). These costs, as reported, vary from hospital to hospital and are difficult to comparatively evaluate because of:

- The variety of settings in which a resident practices (ambulatory care, outpatient clinics, and in the hospital) may be accounted in differing ways or paid from varying sources.
- The multiple responsibilities of faculty members (research, teaching, and patient care) are generally, but not universally, recognized.
- Variable methodologies are used for cost allocation related to the fact that residents might be seeing patients, while receiving training or conducting research.

Tracking reimbursement for graduate medical education programs in hospitals is challenging, because it is hard to isolate specific educational costs, and because of the different ways teaching hospitals fund graduate medical education activities. In addition, Medicare regulations do not require a hospital to distinguish between DME or IME payments for reimbursement. Incentives to collect or analyze data are formula driven, allowing hospitals wide latitude in reporting and assigning costs.

Graduate medical education funding through Medicaid is more complex than through Medicare. The Medicaid program, which is uniquely implemented by each state within board parameters, provides funding through a state and federal partnership. The Medicaid program does not recognize the cost of medical education as a separate entity, but rather there is a great deal of leeway in allotting and tracking monies, including for GME, with potentially significant variation in funding from year to year. The Florida Legislature must provide a plan to the federal government for approval that allows for inpatient and outpatient reimbursements to hospitals through the Agency for Healthcare Administration. Hospitals then provide the Florida Medicaid Program with a cost report twice a year with their calculated

rates based on the actual cost per day of treating a Medicaid patient. The Florida Medicaid Program reimburses teaching hospitals that meet certain requirements for having graduate medical education programs by specifically appropriating monies to the six statutory teaching hospitals under the GME/Disproportionate Share (DSH) Program or by allowing Medicaid GME payments under the upper payment limit (UPL) GME program. The UPL program allows the facility that meets certain requirements to actually be reimbursed at this cost level, up to the cost for a Medicare patient, rather than the lower Medicaid reimbursement rate. While some programs are granted funds for specific types of residency programs for example, children's teaching hospitals, funding remains the major concern of the Graduate Medical Education Committee and other graduate medical education stakeholders. Concerned with the adequacy of graduate medical education funding, the GME Committee focused on an analysis of current funding for graduate medical education, analyzed the changing structure of graduate medical education, and developed recommendations to improve graduate medical education for Florida residents and to meet future physician workforce needs in Florida. The recommendations addressed in this report include:

1. Develop a Central Data Repository to enable the analysis of Florida's future physician workforce needs by specialty and subspecialty distribution and geographic location. The state of Florida currently does not have a central data repository to support physician workforce data. A central database would provide a more comprehensive, valid, and reliable source for physician workforce data, allowing the state policymakers and health-practitioner stakeholders the ability to plan and prepare for the future. The committee recommends and supports the establishment of a database to provide data to facilitate informed decisions regarding programmatic and fiscal issues.

2. Florida's residency programs require a stable, accountable, recurring funding source. Current and future funding sources must be designed to incrementally increase the number of graduate medical education positions in Florida in relation to expanding and aging population needs.

   Current and future funding sources need to come with explicit accountability, including the tracking of Medicare and Medicaid funds to facilities, and with an indication of how those funds are dispersed to graduate medical education programs within a hospital. The committee recommends that a cost study be conducted to understand better the economic impact and contributions these programs make at the local and state level. This study would be based on data collected specifically for the evaluation of how Medicare and Medicaid funds are tracked in residency facilities and the value of graduate medical education programs to hospitals and the state. The study should focus as closely as possible on direct costs and assessed costs incurred by both teaching hospitals and medical schools.

3. In conjunction with the Community Hospital Education Council, the committee recommends a concerted effort in the education of policymakers and stakeholders regarding the immediacy of graduate medical education issues relative to the health of Floridians

The mission of the Graduate Medical Education Committee is to enhance the accessibility, quality, and safety of medical care for all Floridians by maintaining, improving, and expanding graduate medical education training opportunities for physicians and training them in Florida upon graduation. The GME Committee promotes this mission by continuing its focus on funding issues, on establishing a quality database, and by educating stakeholders and policymakers regarding the need for strong residency programs in Florida's communities.

Role of Residents and Medical Faculty in the Provision of Health Care

Graduate medical education (GME) is the process of comprehensive specialty training a medical school graduate undertakes to develop and refine skills specialty areas of medicine, such as family practice, internal medicine, pediatrics, obstetrics/gynecology, surgery and dermatology, or subspecialties such as pediatric oncology. This phase of education is known as the "residency" and can be three to six years or more in length, depending upon the complexity of the specialty or subspecialty area. These programs are usually located in teaching hospitals, but there has been an increasing trend towards placing residency programs, mostly in primary care specialties, in rural, and in medically underserved areas, based in outpatient clinics. These placements provide residents with exposure to underserved communities and they provide health care for patients presenting at these clinics who are often poor, uninsured, or underinsured.

The location and number of residency programs is important because these programs play a critical role as "safety net" to Florida's most vulnerable patients. Supervised by faculty, residents disproportionately serve underinsured, indigent patients in underserved areas, offering a specialty mix and comprehensive range of services and treatments to a diverse geographic distribution and population across the state. Florida teaching hospitals and resident physicians provide care to over 75 percent of Florida's medically needy citizens with an annual value of more than $900 million (Report of the Commonwealth Fund Task Force, 2002). Residency programs are accredited nationally by either the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association Council on Postdoctoral Training. Any number of institutions can sponsor GME programs, which must meet certain accreditation standards, but not all are required to have a relationship with a medical school, although many do.

Florida has six hospitals statutorily defined under section 408.07, Florida Statutes, as teaching hospitals: Jackson Memorial Hospital, Mount Sinai Medical Center, Orlando Regional Medical Center, Shands Hospital Gainesville, Tampa General, and Shands Hospital Jacksonville. There are a total of 256 approved allopathic programs with up to 3,205 residency slots and an additional 42 approved osteopathic programs with over 450 internship and residency slots (ACGME, 2004 and AOA, 2005) across the state, with up to 70 percent of residents working in the six teaching hospitals. Florida consistently ranks among the lowest (forty fourth) in the country in terms of residency slots per 100,000 population, and needs approximately 2,500 additional slots to meet the national average (AAMC, 2005).

Residency programs are important in helping to meet physician workforce needs in Florida. Although different sources vary in their estimates of workforce needs and shortages, most GME stakeholders agree that there may not be enough physicians to fulfill demand in the immediate future (AMA, 2004). Florida's population is the fourth largest nationally, and Florida needs to evaluate how best to address physician workforce issues. Florida is already a net importer of physicians; approximately 80 percent of the current, practicing physicians in Florida came from other states or countries. Florida attracts many foreign graduates, with over 34 percent of Florida's physician workforce having attended a foreign medical school.

The Council for Education Policy, Research and Improvement (CEPRI) is a citizen board housed under the Office of Legislative Services that conducts independent policy research and analysis about education issues of statewide concern. In 2004, CEPRI published a report that outlined the cost benefit analysis of adding and expanding new medical school capacity to that of adding and expanding residency programs as a means to offer viable alternatives. The CEPRI study attempted to quantify systematically and define the state's physician workforce needs and conducted cost/benefit analyses on the best alternatives to meet a potential physician workforce shortage. This report found that an accurate estimate of physician shortage could not be addressed at this time due to inadequate data. Among the study's recommendations is the recommended creation of an official statewide physician data repository that would provide reliable, valid data used to better study physician workforce trends and the impact these trends have on graduate medical education.

Many organizations, including the Council on Graduate Medical Education and the American Medical Association, support increasing medical school capacity as a means of addressing future physician shortages. Florida currently ranks forty first nationally in the number of medical school students per 100,000 population, so this is, in part, a viable option. However, the location of the physician's residency is a better predictor of where the physician will practice than the location of his or her medical school. Nationally, approximately 55 percent of physicians ultimately practice in the state where they completed their residency training, with 68 percent of Florida primary care physicians remaining in the state after completing their residencies. Maintaining the quality of residency programs, and developing expanded capacity of residency programs, are strategies that must be developed to address the potential for physician workforce shortage. These strategies can work in collaboration with expanding medical schools enrollment.

Addressing medical school capacity without accounting for expanded or additional residencies does not offer a comprehensive solution to physician shortages nor does it address state physician workforce planning. The answer is not as simple as adding new medical schools or residency slots. GME stakeholders are interested in the long-term recruitment and retention of talented individuals into quality programs to improve access to quality care. Quality residency programs attract top medical school graduates to the state, assuring the most qualified physicians-in-training rendering care. An inadequate number of residency positions in the state, particularly in the large teaching hospitals, can result in a negative impact on access to health care.

GME programs in other states, such as Texas and Utah, have attempted to address access and delivery of healthcare issues by evaluating the recruitment and retention of residents into specific program areas. The American Medical Association (AMA) has discussed the uneven distribution of residents and doctors in specialty areas. Many physician specializing in internal medicine, for example, opt for specialty or subspecialty training, tending to then locate in certain urban areas thus there is a lack of coverage in some areas, particularly rural areas. When primary care physicians, such as internists, become specialists, this may exacerbate access to care problems in certain primary care specialties, such as emergency medicine or obstetrics.

Section 381.0403, Florida Statutes, provides for the Community Hospital Education Program (CHEP) that recommends and approves policies for primary care residencies as part of an effort to maintain community medical education and support increased primary care physicians. The CHEP program supports 59 primary care programs and collects information regarding gender and ethnicity, and graduate destination information for those residents. The 2005 Florida statistics indicated that 69 percent of CHEP residents remain in the state to continue their education or practice, as compared to 46 percent of medical school graduates (See Appendix III).

2005 Graduate Destination Report

Community Hospital Education Program

Immediately Entering Practice			Continuing Training			*Other	Total Graduates
In Florida	Out of State	Total	In Florida	Out of State	Total		
185	69	254	142	79	221	21	475
73%	27%		64%	36%			
Total Graduates Remaining in Florida		327	69%				
Total Graduates Leaving Florida		148	31%				

NOTE: The category listed as "Other" includes graduates who are undecided, taking time off, etc.

Relationship of Graduate Medical Education to the State's Physician Workforce

Over the past five years, potential physician workforce shortages have been receiving national attention. Assessing Florida's physician workforce is a difficult task that requires compiling demographic information, specialty mix information, population growth and indicators, geographic distribution of practices and incentives such as loan forgiveness or fair malpractice laws (CEPRI, 2004). In evaluating Florida's current physician workforce, a number of factors indicate there will be increased future demand for physicians, including an aging physician workforce, an aging population, and various economic indicators (MGT, 1999). Understanding Florida's current physician workforce will help identify growth and emphasize the role GME plays in fulfilling the need for physicians, specifically in critical specialty and primary care areas.

The adequacy of the health care workforce (physician manpower, allied health professionals) is currently a topic of critical importance, both nationally and in Florida. Although previous studies attempting to evaluate physician manpower suggested a physician excess, more recent studies have defined a significant shortage (Salsberg, 2003). Florida is currently a net importer of physicians with a limited number of medical schools and a critical bottleneck in graduate medical education resident physician positions. Florida needs to be able to provide a sufficient number of physicians internally, but the lack of consistent, reliable and continuous data has made projecting manpower needs difficult. In this report, some of the limited data available has been used to provide supplemental information; however, it is essential to understand that there are only minimal and often conflicting sources of information available.

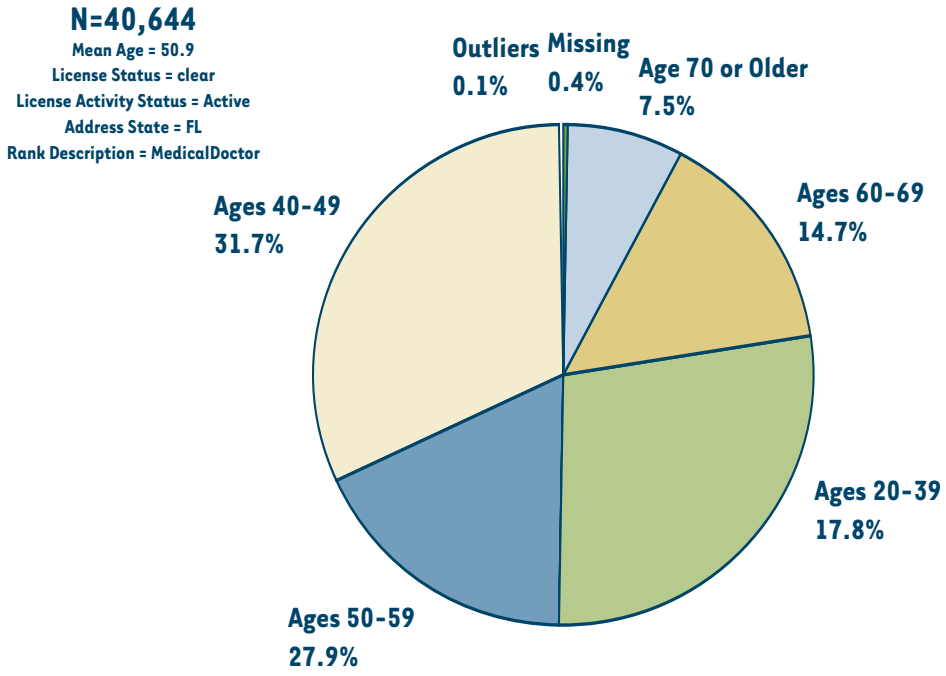
Demographic Information on Florida Physicians

Data used for this report were primarily from the Department of Health's Division of Medical Quality Assurance (MQA) physician licensure data. This data, the primary source for Florida-specific physician data, was supplemented with outside data sources, including the American Medical Association, American Association of Medical Colleges (AAMC) and various reports. The MQA data have the status defined in the MQA data dictionary as physicians that are "active" (have a license to practice in Florida), are "clear of obligations" (no open disciplinary investigations), are either allopathic or osteopathic, and have a primary business address in the state as of August 2005. Data are self-reported to MQA and assume MQA definitions including race/ethnicity definitions, which are limited to the six federally defined selections that include both race and ethnicity.

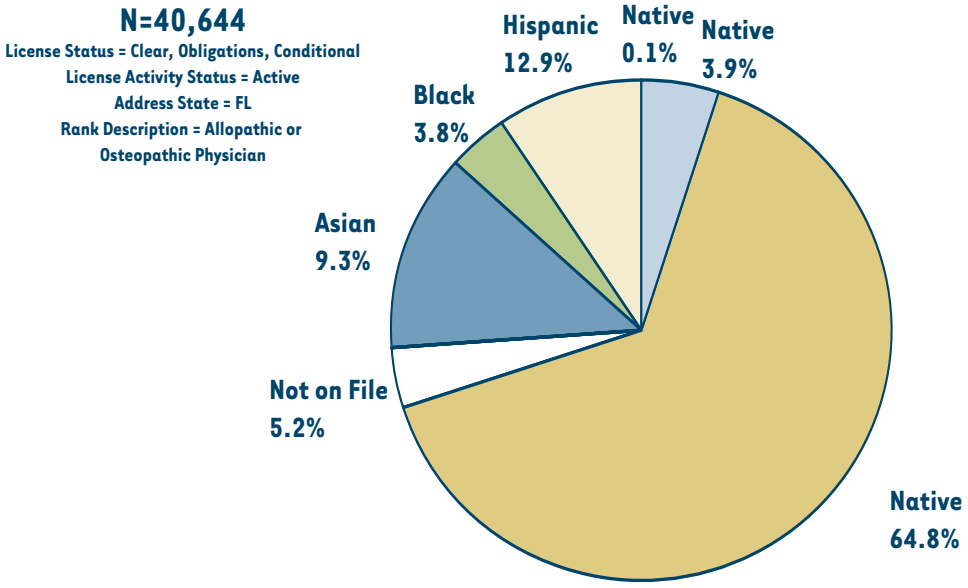
The following graph outlines the age, gender, and race breakdown from the MQA data for active, clear, osteopathic and allopathic physicians with a primary practice address in Florida from August 2005. The mean age of physicians is 50.9 years in Florida. These physicians are 78 percent male and 65 percent white.

	20–39	40–49	50–59	60–69	70 +	Outliers	Missing	Total
White Male	2840	6111	6630	3872	2018	9	59	21539
White Female	1275	1830	1071	277	259	6	7	4725
White Unknown	37	12	6	2	13	0	0	70
Black Male	202	321	275	82	26	0	5	911
Black Female	247	225	113	9	26	0	0	620
Black Unknown	8	5	2	0	0	0	0	15
Hispanic Male	690	1546	967	483	260	1	16	3963
Hispanic Female	351	543	204	55	77	0	5	1235
Hispanic Unknown	30	13	3	1	7	0	0	54
Asian Male	587	712	658	450	107	0	5	2519
Asian Female	340	350	267	195	57	1	4	1214
Asian Unknown	25	13	3	0	6	1	0	48
Native Male	2	11	10	9	1	0	0	33
Native Female	4	4	6	0	0	0	0	14
Native Unknown	0	0	0	0	0	0	0	0
Other Male	255	459	280	108	58	0	2	1162
Other Female	151	137	85	22	14	0	0	409
Other Unknown	6	1	1	1	1	0	0	10
Missing Male	76	412	648	357	126	0	41	1660
Missing Female	41	145	132	42	14	0	7	381
Unknown	25	16	15	9	11	0	4	80
Total	7192	12866	11376	5974	3081	18	155	40662

MQA Data: Age–MDs*



MQA Data: Race–DOs & MDs



Hospitals participating in the Community Hospital Education Program report the gender and ethnicity for all residents. The following table reports the totals and percentages of postgraduate years one through three for all programs.

2005 Gender/Ethnicity Report
Community Hospital Education Program

	PGY 1 Male	PGY 1 Female	PGY 2 Male	PGY 2 Female	PGY 3 Male	PGY 3 Female	Total Male	Percent of Total
Black U.S. Citizens	12	31	10	26	13	30	122	8%
White U.S. Citizens	140	141	132	137	121	130	801	52%
American Indian /Alaskan Native U.S. Citizens	2	0	2	1	0	2	7	0.5%
Asian/Pacific Islander U.S. Citizens	40	50	42	36	41	29	238	16%
Hispanic U.S. Citizens	40	48	25	40	37	53	243	16%
Foreign (Non U.S. Citizens Holding Other Visas)	26	30	16	20	10	17	119	8%
Total By Sex (Gender)	260	300	227	260	222	261	1530	100%
Percent	17%	20%	15%	17%	15%	17%	100%	

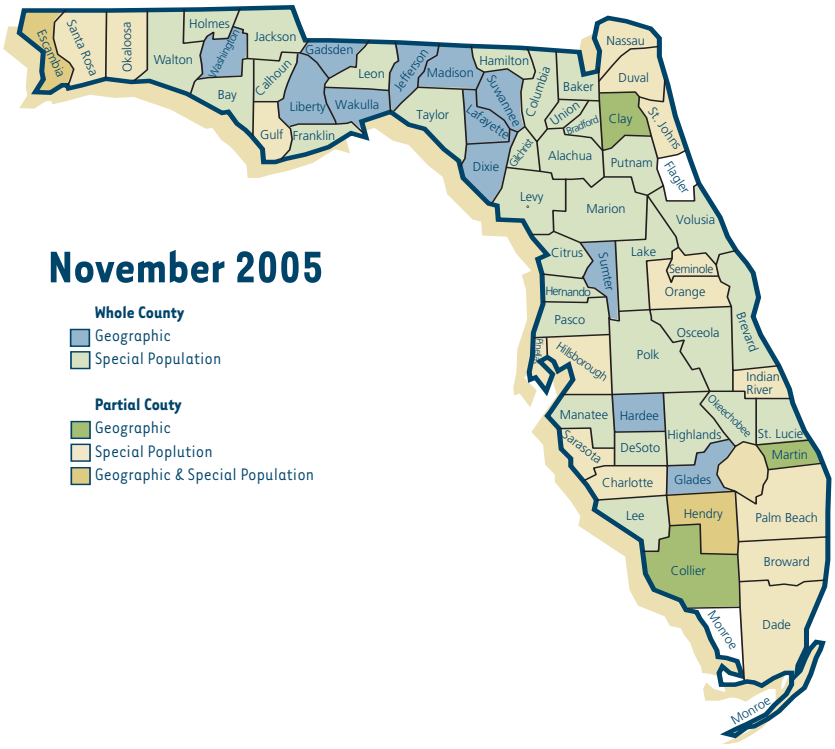
Total Males	709
Total Females	821
Percent Male	46%
Percent Female	54%

In addition to evaluating the demographic statistics of the physician workforce, it is important to analyze practice status, specialty areas and the geographic distribution of physicians in Florida. The American Medical Association Physician Masterfile (2004) ranks Florida fourth in terms of numbers of physicians, but does not account for Florida's aging population or the under representation of minorities to the overall population or accurately depict the proportion active in practice. Florida is one of the fastest growing states in the country with a total population of over 17 million people and projected to grow to over 19 million by 2020. Census data indicates that Florida's population older than 65, which comprises 17 percent of the total population, is greater than the national average of 12 percent, and the 65 and older population are expected to grow (Census Data, 2004). Persons older than age 65 often need a greater number of medical visits and treatments than younger persons, thus increasing the need for physicians in the future. It is difficult to account for minority representation using MQA data due to the limits of the self-reported category, but it appears that licensed physicians who are black are under represented compared to the state's population.

In analyzing physician workforce issues, it is important to look at gender and age. In an AMA physicians' survey, women were found to have the same number of office hours as men, but on average see fewer patients, log fewer hospital hours, and see fewer hospital patients, than their male counterparts. However, women in this survey older than age 50 put in a greater number of hours in all areas then their male counterparts (AMA, 2005). There are a number of studies that evaluate women as physicians, and younger physicians, and account for, at times, reduced hours or patient loads. These may include women in practice who also have family responsibilities, young children, dependent parents, physicians in dual-earner income families, or physicians of childbearing age taking maternity leave (COGME, 2004). Gender, race, and age remain important factors in evaluating physician supply issues. Understanding physician practice characteristics and coverage can help in determining effective methods to recruit and retain doctors, including specific programs aimed at gender issues, such as job sharing.

Health Professional Shortage Areas

More important, and with one exception, every Florida county either has a health professional shortage designation or is a medically underserved area. Finding incentives to recruit and retain physicians and residents to rural and underserved communities using federal and state programs is important to graduate medical education in Florida. Many physicians chose specialty areas or geographic locations that serve a specific area. The increased demand for specialists' services, combined with managed-care models, can influence practice characteristics. Focusing on quality residency programs that provide exposure to these areas increases the likelihood of a resident choosing to practice in that area. Having timely and accurate data becomes critical in reporting on specialty areas, practice locations, and practice characteristics.



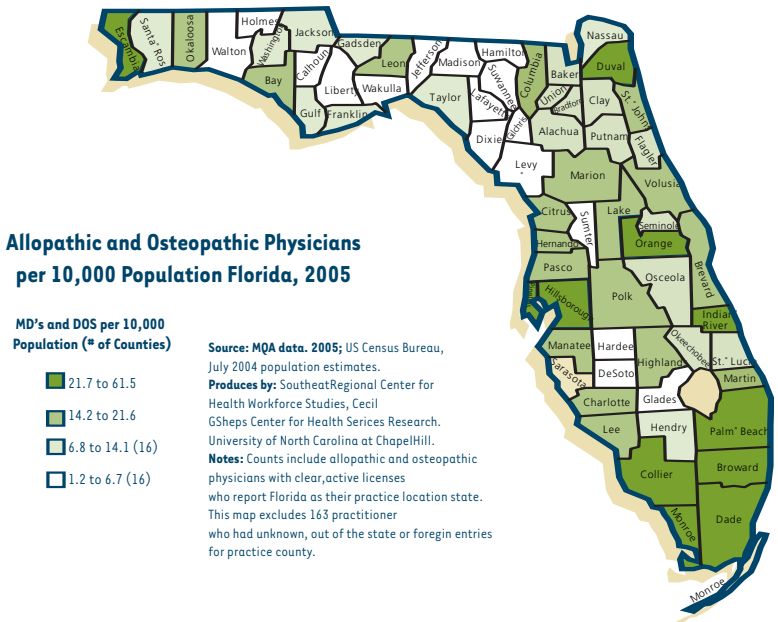
Physician Specialty Information

Using the MQA data to evaluate other physician workforce and demographic issues is limited to self-reported specialty areas and practice status. These data cannot account for a physician having multiple specialty areas or practice settings. AMA data indicates that 75 percent of Florida's physicians are involved in some capacity with direct patient care, but this is also self-reported information limited to AMA members and does not quantify hours or scope of practice. MQA data used for this report includes only "active, clear" licenses with a primary mailing address in Florida. This means a physician may have an active license, but does not necessarily practice in the state of Florida. The MQA reporting forms do not currently have a field for practice location, primary or secondary. This results in a limited measurement of physician scope of practice.

Specialty areas in MQA are limited to self-reported data to the specialty board from which the physician received his or her board certificate and in what specialty area. From the MQA data, there were over 177 specialty certificates recorded with the greatest concentration in:

- Internal Medicine-Internal Medicine 17 percent
- Family Practice 9 percent
- Pediatrics-Pediatrics 7 percent
- Anesthesiology 5 percent
- Obstetrics and Gynecology 4 percent
- General Surgery 4 percent
- Emergency Medicine 3 percent
- Internal Medicine-Cardiovascular Disease 3 percent

Enhancing Florida graduate medical education capacity, either through additional residency funded positions or by ensuring adequate, recurring funds, attracts talented residents. Providing incentives to remain in Florida for residency programs can help assure that, upon completion of residency training, physicians completing training remain in Florida for their practice location. These strategies would be particularly important in counties with low physician-to-population ratios. The figure below shows physician per 10,000 population data by county.



The Economic Impact of Graduate Medical Education

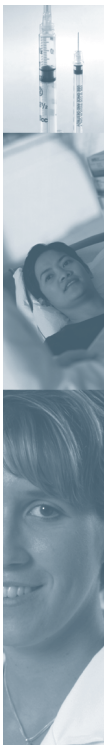
The Costs of Training Medical Residents

The cost of educating residents in programs involves education, research, and providing and documenting patient care. Traditionally, GME costs are reported in two categories, direct medical education (DME) and indirect medical education (IME). Direct costs include salaries and benefits, faculty costs, and administrative or overhead costs related directly to the program. These costs are usually determined as the cost per resident per year and are adjusted annually. Direct costs vary widely by program and cannot be systematically tracked across programs, even for the six statutory teaching hospitals in Florida. In a 1999 study, the reported direct costs of teaching hospitals included resident costs, faculty cost attributions, and overhead costs, which varied greatly by the size of the program. The smaller the hospital, the more administrative costs were distributed over a smaller number of residents. These costs, as reported but not audited by a reproducible methodology, ranged from $39,554 to $141,107 per resident physician.

Indirect costs can be even more variable and difficult to fully identify relative to contribution, as they more closely relate to a hospital's case mix. Most teaching hospitals have greater charity care costs and see a larger number of Medicaid patients than do non-teaching hospitals. Patients in teaching hospitals tend to have more complex patient conditions that may require advanced testing and costly treatments not directly related to the direct costs of medical education, but rather the programs and the case mix of the hospital. Teaching hospitals also usually have higher staff-to-patient ratios. Teaching hospitals conduct more research and have the additional task of educating young physicians, which may mean longer diagnostic exams or even longer inpatient hospitalization of not adjusted for acuity of care and risk. Calculating these factors into indirect cost is specific to each facility without a rigorously defined terminology and methodology, and in the same 1999-cost study, the numbers ranged from $65,000 to $154,000 per resident physician. It is important to note that although hospitals with residency programs may report higher cost per case, they are incredibly beneficial to the patient, the hospital, and the state. These hospitals not only provide safety net services, but also serve in the development and dissemination of new technology applied to patient care, translational research related to improved methods of patient care, and enhance quality of care.

Revenue Sources and the Use of State and Federally Appropriated Funds

The two major sources of funding for graduate medical education are the federal Medicare program, which provides direct graduate medical education subsidies and indirect medical education adjustments, and Medicaid, which is a federal-state partnership.



The Medicare program has a reimbursement formula that is based on hospital costs per resident, multiplied by the number of residents. The Direct Graduate Medical Education (DGME) subsidy covers some salary and benefits for residents and faculty members, and teaching and overhead costs. The Indirect Medical Education payments are additional funds to cover higher inpatient care and are based on adjustments made to the Diagnosis-Related Groups (DRG) for which hospitals bill. It is difficult to assess Medicare payments made to Florida hospitals, but the most recent available data indicate that, for only the six statutory teaching hospitals, direct graduate medical education and indirect medical education funding ranged from $25,000 to $125,000 per resident physician per year (AAMC, 2005).

Prior to the Balanced Budget Act of 1997, Medicare had no limits placed on the number of residents it supported, as long as the residents were enrolled in approved graduate medical education programs. Teaching hospitals received more Medicare funding per resident, particularly those in more highly specialized or extended programs. Congress expressed its concern that this funding opportunity was perceived to provide hospitals with incentives to expand the size of residency programs and to train more subspecialists, and passed the Balanced Budget Act. Since the passage of the Balanced Budget Act, open-ended payments that rewarded teaching hospitals were curtailed. Significant changes to programs were made, including caps on the number of residents supported and reductions of the Medicare Indirect Medical Education adjustments, as well as no Direct Graduate Medical Education payments to residents in non-hospital settings. Many of the teaching hospitals in Florida continue to support additional residency physician positions over their caps. For example, Tampa General Hospital's current cap is 199 resident physicians for reimbursement purposes from the Federal Government through Medicare, but they funded 259 resident physicians without additional reimbursement.

Medicaid is currently the only other source of graduate medical education funding in Florida. While there is no statutory requirement that the state support graduate medical education through Medicaid payments, Florida includes graduate medical education as part of the Upper Payment Limits (UPL) program and usually as part of the Disproportionate Share (DSH) program, as it has been consolidated in the UPL program. This funding relies heavily on intergovernmental fund transfers from local governments to match with federal dollars, which offsets general revenue in other parts of the state budget. These programs, approved by the Legislature and the federal government, allow for cost-based reimbursements derived from cost reports completed by hospitals. The DSH program has a ceiling for the total amount of inpatient and outpatient services for which reimbursement will be provided, and there are other county specific caps on reimbursements for specific procedures. The DSH program allows appropriations to the statutorily defined graduate medical education programs, but last year an appropriation for DSH was not made. Rather, it was shifted to the public hospital DSH payments, and hospitals may have seen the benefit as a hold-harmless payment or as a safety net payment, but without specific graduate medical education accountability.

Although the UPL program does not have spending caps, spending should not reasonably exceed the cost of services under Medicare. UPL is based on several formulas. Hospitals are usually reimbursed at the lowest rate rather than what their cost is; but, allowing for the removal of the requirement to pay the lowest cost, the higher costs of indigent care services are recognized, and up to 150 percent of what Medicare payments can be reimbursed at this rate. This payment is based on the previous year's cost report and is an estimate of what will be spent. It relies on the Medicaid costs divided by the number of Medicaid days to calculate the rate. The CHEP hospitals and statutory teaching hospitals are eligible to be exempt from the lower rate. This past year, this rate was reduced from 100 percent to 92 percent as a means to make up the difference between Medicare and Medicaid funding based on an estimate of what would be spent.

For fiscal year 2004-2005 (House Bill 1835, Line 202), $75,164,984 from the Grants and Donations Trust Fund and $107,351,655 from the Medical Care Trust Fund were appropriated to eliminate the inpatient reimbursement ceilings for teaching, specialty, CHEP hospitals and Level III neonatal intensive care units that met certain criteria. For fiscal year 2005-2006 (Senate Bill 2600, Specific Appropriation 190), appropriated $88,966 — 122 from the Grants and Donations Trust Fund and $127,443,907 from the Medical Care Trust Fund — to eliminate the inpatient reimbursement ceilings for teaching, specialty, CHEP hospitals and Level III neonatal intensive care units that met certain criteria. These funds are contingent upon grants and donations from state, county, or other government funds providing the state share.

The Community Hospital Education Council oversees the CHEP and recommends program standards and policies to the Department of Health. The Department of Health has historically established standards and policies for the use and expenditure of CHEP funding, which was the only source of explicit state funding to support graduate medical education, with the intent to increase the number of primary care physicians practicing in Florida. The Florida Legislature made an annual appropriation to CHEP until state fiscal year 2000-2001.

While the CHEP continues to collect data related to primary care programs, including the geographic distribution of resident physicians completing training, the benefit of receiving direct support for being a CHEP participant has limits. Unlike a direct appropriation made directly to a CHEP provider, the benefit of removal from reimbursement caps is more difficult to account. If a hospital has more than one Community Hospital Education Participant, it is still only exempt from the limits once. A hospital may also qualify under another program, including more than 11 percent charity and Medicaid days, or it is a statutory teaching hospital, and is only exempt once. Cost estimates from the Agency for Health Care Administration are not tracked through a state agency once distributed to the hospitals. There is no mechanism at the state level to identify if hospital funds received via this means are used for graduate medical education or for CHEP purposes. The Agency for Health Care Administration provides an aggregate estimate of the funding that supports CHEP hospitals in Florida through enhanced Medicaid payments based on estimates of cost reports.

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Alternative Sources of Funding

Other sources of funding for graduate medical education in Florida may include the Veterans Administration funding to the state's veterans medical centers in Miami, Tampa, Gainesville, and Bay Pines. The National Heath Service Corps, as part of the Health Resources and Services Administration, offers individual assistance for residents and physicians in underserved or designated shortage areas after the completion of the training. This program is not a direct contributor to defray the direct costs of graduate medical education in Florida's resident physician training programs. In fact, this program is used principally for repayment of medical school tuition loans through a program of debt forgiveness.

The area health education centers also support programs though the medical schools in Florida and in specific program activities the centers sponsor. In addition, children's hospitals, which frequently have limited Medicare participation, primarily only related to chronic reanl disease and certain other chronic diseases, have access to other designated funding streams through DSH funding that provides support for direct and indirect costs, although at a lower rate than the average per-resident Medicare payment.

Florida medical schools receive no specific funding for graduate medical education to support the internal costs incurred by sponsoring programs, such as faculty support for the time and effort spent in teaching resident physicians, additional support expenses, such as travel and books, and administration. Medical schools may receive some support from teaching hospitals for faculty services not directly related to the graduate medical education programs. There are other contractual agreements that individual, but not all, medical schools may participate in to help absorb or share these costs.

Recommended funding sources for graduate medial education, which have been discussed at GME Committee meetings, include:

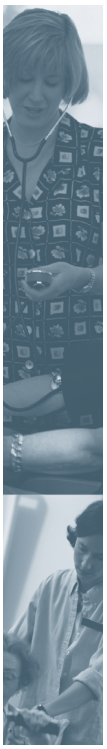
- Exploring a "carve out" or amount calculated as representing DME and IME adjustments within Medicaid fee-for-service payments. In other states, formulas have been created to use this money as a support for existing GME programs, for primary care programs, and as grants for innovative proposals related to GME.

- Florida currently has an "Innovations" program defined in section 381.0403 (4), Florida Statutes, which has no funding allocated to it. Utah has conducted a detailed demonstration project, part of which addressed finding Medicare monies earned, but unclaimed by teaching hospitals.

- Tapping into managed care organizations in the form of capitated payment rates may be another option. Since graduate medical education costs are included in inpatient rates, the value of these could be "carved out" of managed care premiums and paid to teaching hospitals and medical schools for the allocated direct costs of programs. There are other incentives for this type of managed care carve out, one of which allows teaching hospitals to become competitive with non-teaching hospitals, because their costs for graduate medical education are now being paid for through this incentive. Utah, through carve out, has increased its state's federal match by $5 million.

Recommendations

The Graduate Medical Education Committee has supported the continuous improvement of graduate medical education programs in the state, assuring quality and fiscal support for expanding, or creating new, programs. The GME Committee's issues of concern have been reiterated and solidified in the CEPRI report and by the growing concern over physician workforce issues.



The GME Committee's recommendations are:

1. The state of Florida currently does not have a central data repository to support physician workforce data. This central database would provide a more comprehensive, valid, and reliable source for physician workforce data, allowing the state policymakers and health-practitioner stakeholders the ability to plan and prepare for the future. The committee recommends and supports the establishment of this database for informed decisions regarding programmatic and fiscal issues.

2. Florida's residency programs must have a stable, recurring funding source. Current and future funding sources need to have accountability, including the tracking of Medicare and Medicaid funds to facilities, and with an indication of how those funds are dispersed to each graduate medical education program within a hospital. To understand the economic impact and contributions these programs make at the local and state level, the committee recommends conducting a cost study. This study would be based on data collected specifically for the evaluation of how Medicare and Medicaid funds are tracked in residency facilities and the value of graduate medical education programs to hospitals and the state. The study should focus, as closely as possible, on direct costs and assess costs that both teaching hospitals and medical schools incurred.

3. In conjunction with the Community Hospital Education Council, the committee recommends a concerted effort in the education of policymakers and stakeholders regarding graduate medical education issues.

Appendix I

s. 381.0403, F.S., The Community Hospital Education Act.—

(1) SHORT TITLE. This section shall be known and cited as "The Community Hospital Education Act."

(2) LEGISLATIVE INTENT.—
(a) It is the intent of the Legislature that health care services for the citizens of this state be upgraded and that a program for continuing these services be maintained through a plan for community medical education. The program is intended to provide additional outpatient and inpatient services, a continuing supply of highly trained physicians, and graduate medical education.

(b) The Legislature further acknowledges the critical need for increased numbers of primary care physicians to provide the necessary current and projected health and medical services. In order to meet both present and anticipated needs, the Legislature supports an expansion in the number of family practice residency positions. The Legislature intends that the funding for graduate education in family practice be maintained and that funding for all primary care specialties be provided at a minimum of $10,000 per resident per year. Should funding for this act remain constant or be reduced, it is intended that all programs funded by this act be maintained or reduced proportionately.

(3) PROGRAM FOR COMMUNITY HOSPITAL EDUCATION; STATE AND LOCAL PLANNING.—
(a) There is established under the Department of Health a program for statewide graduate medical education. It is intended that continuing graduate medical education programs for interns and residents be established on a statewide basis. The program shall provide financial support for primary care specialty interns and residents based on policies recommended and approved by the Community Hospital Education Council, herein established, and the Department of Health. Only those programs with at least three residents or interns in each year of the training program are qualified to apply for financial support. Programs with fewer than three residents or interns per training year are qualified to apply for financial support, but only if the appropriate accrediting entity for the particular specialty has approved the program for fewer positions. Programs added after fiscal year 1997–1998 shall have 5 years to attain the requisite number of residents or interns. When feasible and to the extent allowed through the General Appropriations Act, state funds shall be used to generate federal matching funds under Medicaid, or other federal programs, and the resulting combined state and federal funds shall be allocated to participating hospitals for the support of graduate medical education. The department may spend up to $75,000 of the state appropriation for administrative costs associated with the production of the annual report as specified in subsection (9), and for administration of the program.

(b) For the purposes of this section, primary care specialties include emergency medicine, family practice, internal medicine, pediatrics, psychiatry, obstetrics/gynecology, combined pediatrics and internal medicine, and other primary care specialties the council and Department of Health may include.

(c) Medical institutions throughout the state may apply to the Community Hospital Education Council for grants-in-aid for financial support of their approved programs. Recommendations for funding of approved programs shall be forwarded to the Department of Health.

(d) The program shall provide a plan for community clinical teaching and training with the cooperation of the medical profession, hospitals, and clinics. The plan shall also includeformal teaching opportunities for intern and resident training. In addition, the plan shall establish an off-campus medical faculty with university faculty review to be located throughout the state in local communities.

(4) PROGRAM FOR GRADUATE MEDICAL EDUCATION INNOVATIONS.—
(a) There is established under the Department of Health a program for fostering graduate medical education innovations. Funds appropriated annually by the Legislature for this purpose shall be distributed to participating hospitals or consortia of participating hospitals and Florida medical schools or to a Florida medical school for the direct costs of providing graduate medical education in community-based clinical settings on a competitive grant or formula basis to achieve state health care workforce policy objectives, including, but not limited to:

1. Increasing the number of residents in primary care and other high demand specialties or fellowships;
2. Enhancing retention of primary care physicians in Florida practice;
3. Promoting practice in medically underserved areas of the state;
4. Encouraging racial and ethnic diversity within the state's physician workforce; and
5. Encouraging increased production of geriatricians.

(b) Participating hospitals or consortia of participating hospitals and Florida medical schools or a Florida medical school providing graduate medical education in community—based clinical settings may apply to the Community Hospital Education Council for funding under this innovations program, except when such innovations directly compete with services or programs provided by participating hospitals or consortia of participating hospitals, or by both hospitals and consortia. Innovations program funding shall provide funding based on policies recommended and approved by the Community Hospital Education Council and the Department of Health.

(c) Participating hospitals or consortia of participating hospitals and Florida medical schools or Florida medical schools awarded an innovations grant shall provide the Community Hospital Education Council and Department of Health with an annual report on their project.

(5) FAMILY PRACTICE RESIDENCIES.—In addition to the programs established in subsection (3), the Community Hospital Education Council and the Department of Health shall establish an ongoing statewide program of family practice residencies. The administration of this program shall be in the manner described in this section.

(6) COUNCIL AND DIRECTOR.—
(a) There is established the Community Hospital Education Council, hereinafter referred to as the council, which shall consist of 11 members, as follows:
1. Seven members must be program directors of accredited graduate medical education programs or practicing physicians who have faculty appointments in accredited graduate medical education programs. Six of these members must be board certified or board eligible in family practice, internal medicine, pediatrics, emergency medicine, obstetrics-gynecology, and psychiatry, respectively, and licensed pursuant to chapter 458. No more than one of these members may be appointed from any one specialty. One member must be licensed pursuant to chapter 459.
2. One member must be a representative of the administration of a hospital with an approved community hospital medical education program;
3. One member must be the dean of a medical school in this state; and
4. Two members must be consumer representatives.
All of the members shall be appointed by the Governor for terms of 4 years each.

(b) Council membership shall cease when a member's representative status no longer exists. Members of similar representative status shall be appointed to replace retiring or resigning members of the council.

(c) The secretary of the Department of Health shall designate an administrator to serve as staff director. The council shall elect a chair from among its membership. Such other personnel as may be necessary to carry out the program shall be employed as authorized by the Department of Health.

(7) DEPARTMENT OF HEALTH; STANDARDS.—
(a) The Department of Health, with recommendations from the council, shall establish standards and policies for the use and expenditure of graduate medical education funds appropriated pursuant to subsection (8) for a program of community hospital education. The Department of Health shall establish requirements for hospitals to be qualified for participation in the program, which shall include, but not be limited to:
1. Submission of an educational plan and a training schedule.
2. A determination by the council to ascertain that each portion of the program of the hospital provides a high degree of academic excellence and is accredited by the Accreditation Council for Graduate Medical Education of the American Medical Association or is accredited by the American Osteopathic Association.
3. Supervision of the educational program of the hospital by a physician who is not the hospital administrator.

(b) The Department of Health shall periodically review the educational program provided by a participating hospital to assure that the program includes a reasonable amount of both formal and practical training and that the formal sessions are presented as scheduled in the plan submitted by each hospital.

(c) In years that funds are transferred to the Agency for Health Care Administration, the Department of Health shall certify to the Agency for Health Care Administration on a quarterly basis the number of primary care specialty residents and interns at each of the participating hospitals for which the Community Hospital Education Council and the department recommends funding.

(8) MATCHING FUNDS.—State funds shall be used to match funds from any local governmental or hospital source. The state shall provide up to 50 percent of the funds, and the community hospital medical education program shall provide the remainder. However, except for fixed capital outlay, the provisions of this subsection shall not apply to any program authorized under the provisions of subsection (5) for the first 3 years after such program is in operation.

(9) ANNUAL REPORT ON GRADUATE MEDICAL EDUCATION; COMMITTEE.—The Executive Office of the Governor, the Department of Health, and the Agency for Health Care Administration shall collaborate to establish a committee that shall produce an annual report on graduate medical education. The committee shall be comprised of 11 members: five members shall be deans of the medical schools or their designees; the Governor shall appoint two members, one of whom must be a representative of the Florida Medical Association who has supervised or currently supervises residents or interns and one of whom must be a representative of the Florida Hospital Association; the Secretary of Health Care Administration shall appoint two members, one of whom must be a representative of a statutory teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns; and the Secretary of Health shall appoint two members, one of whom must be a representative of a statutory family practice teaching hospital and one of whom must be a physician who has supervised or is currently supervising residents or interns. With the exception of the deans, members shall serve 4-year terms. In order to stagger the terms, the Governor's appointees shall serve initial terms of 4 years, the Secretary of Health's appointees shall serve initial terms of 3 years, and the Secretary of Health Care Administration's appointees shall serve initial terms of 2 years. A member's term shall be deemed terminated when the member's representative status no longer exists. Once the committee is appointed, it shall elect a chair to serve for a 1-year term. The report shall be provided to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 15 annually. Committee members shall serve without compensation. The report shall address the following:
(a) The role of residents and medical faculty in the provision of health care.
(b) The relationship of graduate medical education to the state's physician workforce.
(c) The costs of training medical residents for hospitals, medical schools, teaching hospitals, including all hospital-medical affiliations, practice plans at all of the medical schools, and municipalities.
(d) The availability and adequacy of all sources of revenue to support graduate medical education and recommend alternative sources of funding for graduate medical education.
(e) The use of state and federal appropriated funds for graduate medical education by hospitals receiving such funds.

(10) RULEMAKING.—The department has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this section.
History.—s. 1, ch. 71-311; ss. 1-4, ch. 72-137; s. 1, ch. 74-135; s. 1, ch. 74-358; s. 1, ch. 76-63; s. 1, ch. 82-46; s. 45, ch. 82-241; s. 2, ch. 83-265; s. 6, ch. 84-94; s. 2, ch. 88-291; ss. 1, 2, 3, ch. 91-129; s. 50, ch. 91-297; s. 5, ch. 91-429; s. 25, ch. 92-173; s. 658, ch. 95-148; s. 29, ch. 99-5; s. 27, ch. 2000-163; s. 2, ch. 2001-222.
Note.—Former s. 381.503.

Appendix II

s. 408.07 (44), F.S., Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term:

(44)"Teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.
(45)History.—s. 71, ch. 92-33; s. 75, ch. 92-289; s. 13, ch. 93-129; s. 39, ch. 93-217; s. 17, ch. 95-144; s. 38, ch. 97-103; s. 2, ch. 98-14; s. 2, ch. 98-21; s. 14, ch. 98-89; s. 44, ch. 2000-153; s. 28, ch. 2000-163; s. 2, ch. 2000-227; s. 2, ch. 2003-258

Appendix IV

2005 Gender Ethnicity Report
Community Hospital Education Program by Specialty

Emergency Medicine

	PGY 1M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	0	1	0	0	0	0	1	1%
White	19	9	22	9	22	10	91	88%
American Indian/Alaskan Native U.S. Citizens	0	0	1	0	0	0	1	1%
Asian/Pacific Islander U.S. Citizens	0	0	2	0	2	0	4	4%
Hispanic	1	0	2	1	0	2	6	6%
Foreign (Non U.S. Citizens Holding Other Visas)	0	0	0	0	0	1	1	1%
Totals	20	10	27	10	24	13	104	
Total Females	33	32%						
Total Males	71	68%						

Family Practice

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	7	6	5	11	8	18	55	13%
White	33	31	39	36	39	39	217	52%
American Indian/Alaskan Native U.S. Citizens	0	0	0	1	0	0	1	0%
Asian/Pacific Islander U.S. Citizens	9	13	13	10	11	13	69	17%
Hispanic	8	7	5	8	8	14	50	12%
Foreign (Non U.S. Citizens Holding Other Visas)	6	9	3	2	2	4	26	6%
Totals	63	66	65	68	68	88	418	
Total Females	222	53%						
Total Males	196	47%						

Internal Medicine

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	3	9	3	2	3	2	22	5%
White	41	30	39	24	33	24	191	47%
American Indian/Alaskan Native U.S. Citizens	2	0	0	0	0	0	2	0%
Asian/Pacific Islander U.S. Citizens	18	23	22	12	20	6	101	25%
Hispanic	15	17	9	6	19	11	77	19%
Foreign (Non U.S. Citizens Holding Other Visas)	6	4	3	3	0	0	16	4%
Totals	85	83	76	47	75	43	409	
Total Females	173	42%						
Total Males	236	58%						

Internship

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	1	1	0	0	0	0	2	3%
White	22	15	2	4	1	3	47	66%
American Indian/Alaskan Native U.S. Citizens	0	0	0	0	0	0	0	0%
Asian/Pacific Islander U.S. Citizens	3	1	1	2	1	0	8	11%
Hispanic	3	3	0	1	2	5	14	20%
Foreign (Non U.S. Citizens Holding Other Visas)	0	0	0	0	0	0	0	0%
Totals	29	20	3	7	4	8	71	
Total Females	35	49%						
Total Males	36	51%						

Combined Med/Ped

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	0	2	0	2	0	0	4	13%
White	1	3	0	5	5	1	15	47%
American Indian/Alaskan Native U.S. Citizens	0	0	0	0	0	1	1	3%
Asian/Pacific Islander U.S. Citizens	1	1	1	1	0	1	5	16%
Hispanic	1	2	0	2	1	1	7	22%
Foreign (Non U.S. Citizens Holding Other Visas)	0	0	0	0	0	0	0	0%
Totals	3	8	1	10	6	4	32	
Total Females	22	69%						
Total Males	10	31%						

OB/GYN

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	0	5	0	3	1	3	12	11%
White	4	15	3	17	4	18	61	58%
American Indian/Alaskan Native U.S. Citizens	0	0	1	0	0	1	2	2%
Asian/Pacific Islander U.S. Citizens	0	3	0	3	0	1	7	7%
Hispanic	3	3	4	5	0	0	15	14%
Foreign (Non U.S. Citizens Holding Other Visas)	2	2	2	2	0	0	8	8%
Totals	9	28	10	30	5	23	105	
Total Females	81	77%						
Total Males	24	23%						

Pediatrics

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	0	6	2	7	1	4	20	6%
White	14	35	18	32	12	29	140	45%
American Indian/Alaskan Native U.S. Citizens	0	0	0	0	0	0	0	0%
Asian/Pacific Islander U.S. Citizens	7	7	2	8	4	7	35	11%
Hispanic	6	13	3	13	3	17	55	18%
Foreign (Non U.S. Citizens Holding Other Visas)	10	14	7	12	7	11	61	20%
Totals	37	75	32	72	27	68	311	
Total Females	215	69%						
Total Males	96	31%						

Psychiatry

	PGY 1 M	PGY 1 F	PGY 2 M	PGY 2 F	PGY 3 M	PGY 3 F	TOTAL	Percent of Total
Black	1	1	0	1	0	3	6	8%
White	6	3	9	10	5	6	39	49%
American Indian /Alaskan Native U.S. Citizens	0	0	0	0	0	0	0	0%
Asian/Pacific Islander U.S. Citizens	2	2	1	0	3	1	9	11%
Hispanic	3	3	2	4	4	3	19	24%
Foreign (Non U.S. Citizens Holding Other Visas)	2	1	1	1	1	1	7	9%
Totals	14	10	13	16	13	14	80	
Total Females	40	50%						
Total Males	40	50%						

Note: PGY stands for Post Graduate Year

2005 Graduate Destination Report
Community Hospital Education Program by Specialty

Emergency Medicine

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out of State	Total	Other
17	13	30	1	0	1	0
57%	43%		100%	0%		
Total Emergency Medicine Graduates Remaining in Florida				18	58%	
Total Emergency Medicine Graduates Leaving Florida				13	42%	

Family Practice

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
76	16	92	27	15	42	7
83%	17%		64%	36%		
Total Family Practice Graduates Remaining in Florida				103	77%	
Total Family Practice Graduates Leaving Florida				31	23%	

Internal Medicine

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
31	10	41	49	21	70	8
76%	24%		70%	30%		
Total Internal Medicine Graduates Remaining in Florida				80	72%	
Total Internal Medicine Graduates Leaving Florida				31	28%	

Internship

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
1	0	1	25	11	36	0
100%	0%		69%	31%		
Total Internship Graduates Remaining in Florida				26	70%	
Total Internship Graduates Leaving Florida				11	30%	

Combined Med/Ped

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
2	4	6	3	1	4	0
33%	67%		75%	25%		

Total Combined Med/Ped Graduates Remaining in Florida	5	50%
Total Combined Med/Ped Graduates Leaving Florida	5	50%

OB/GYN

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
20	7	27	3	6	9	0
74%	26%		0%	67%		

Total OB/GYN Graduates Remaining in Florida	23	64%
Total OB/GYN Graduates Leaving Florida	13	36%

Pediatrics

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
26	14	40	21	23	44	4
65%	35%		48%	52%		

Total Pediatrics Graduates Remaining in Florida	47	56%
Total Pediatrics Graduates Leaving Florida	37	44%

Psychiatry

Physicians Immediately Entering Practice			Physicians Continuing Training			
In Florida	Out of State	Total	In Florida	Out	Total	Other
12	5	17	13	2	15	2
71%	29%			87%	13%	

Total Psychiatry Graduates Remaining in Florida	25	78%
Total Psychiatry Graduates Leaving Florida	7	22%

NOTE: The category listed as "Other" includes graduates who are undecided, taking time off, etc.

This table shows the variation between quarters of residents in the various primary care Community Hospital Education Programs. Numbers are reported and verified directly from the programs each quarter.

CHEP Quarterly Reports 2004–2005
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	INT	FP	EM	IM	OB	PED	PSY	M/P	Total
TOTAL FIRST QTR	54	407	105	382	115	308	82	28	1481
TOTAL SECOND QTR	70	384	104	390	107	308	79	27	1469
TOTAL THIRD QTR	57	388	103	386	112	302	81	32	1461
TOTAL FOURTH QTR	59	387	103	358	107	301	80	34	1429

LEGEND: INT - Internship; FP - Family Practice; EM - Emergency Medicine; IM - Internal Medicine; OB - Obstetrics/Gynecology; PED - Pediatrics; PSY - Psychiatry; M/P Combined Internal Medicine/Pediatrics

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FLORIDA DEPARTMENT OF HEALTH

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