Annual Report on Graduate Medical Education in Florida

Submitted By The Graduate Medical Education Committee

In Response to the Provisions of Section 381.0403 (9), Florida Statutes

January 2007

The opinions expressed in this report are those of the Graduate Education Committee and do not necessarily reflect the opinions of the Florida Department of Health or its staff. The agency assumes no responsibility for any statements made in this report.

Dear Friends,

It has been an exciting year for graduate medical education in Florida. As the chair of the Graduate Medical Education (GME) Committee, I am proud that considerable progress has been made toward achieving two of the three goals that the Committee adopted for 2005:

- Establishing a reliable physician workforce database; and
- Work to educate policymakers on the benefit and importance of GME to the delivery of healthcare.

I have spent many years working with my colleagues and GME stakeholders to establish a continuous, reliable data base on Florida allopathic and osteopathic (MD/DO) physicians that would better predict physician manpower surpluses or shortages. I am proud to say that this year took us one step closer to that goal.

A questionnaire was developed in joint partnership with the Florida Department of Health and key GME stakeholders to capture information during the MD/DO physician licensure renewal process. These questions will enable the state to establish a baseline of data relating to the geographic distribution, scope of practice and specialty mix of Florida physicians. Evaluating data derived from this questionnaire will allow policymakers to begin to answer questions about the adequacy of the state's physician workforce.

The capacity of the state's allopathic and osteopathic medical schools was also expanded this year, with the approval of two new allopathic medical schools at the University of Central Florida and Florida International University and a branch campus of the University of Miami Miller School of Medicine at Florida Atlantic University. The creation of these new schools, along with the branch campus of Lake Erie College of Osteopathic Medicine will expand the number of students able to attend medical school in Florida by 2009.

The expansion of Florida's medical schools makes it more imperative then ever before that Florida increase the capacity of its residency programs. Repeated studies have shown that doctors are more likely to practice in the geographic area where they complete their residency program than where they attended medical school. We must expand the capacity of our residency programs to the level necessary to ensure that all of our medical school graduates who desire to do so, can remain in Florida for their residency training. If we are not successful in securing funding for new and expanded residency program capacity in Florida, many of our new medical school graduates will be forced to leave Florida for residency training and will not likely return to Florida to practice. Therefore, it is critical that the GME Committee renew our focus on our third goal- securing adequate funding for residency training - before our new medical schools begin to graduate their first classes. We must find a way to add additional, quality residency positions that will enable us to retain our own medical school graduates and attract the best and the brightest medical school graduates from the rest of the nation and world.

Our ability to assist policymakers in identifying creative approaches to securing adequate funding for GME from all potential local, state, national, public and private sources will be critical in the coming year. The GME Committee will continue to work in collaboration with The Council of Florida Medical School Deans, Florida's Community Hospital Education Council (CHEC), state and federal policymakers, elected officials, academic medicine and the organized medical profession communities to ensure that our state has the ability to educate and train the physicians that Florida will require to provide high quality healthcare for our state's expanding population.

Sincerely,

M L Becker

Mathis L. Becker, M.D.
Chair, Committee on Graduate Medical Education

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Preface

Pursuant to Section 381.0403 (9), Florida Statutes (F.S.), the Graduate Medical Education (GME) Committee, an 11-member work-group appointed by the Governor, is responsible for preparing an annual report on graduate medical education in Florida. This annual report is provided to the Governor, the President of the Senate, and to the Speaker of the House of Representatives on January 15 of each year. The report 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;
(c) The 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; and
(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: (1) create long-range plans and goals to improve the graduate medical education system in Florida; (2) find new and renewed sources of funding; and (3) educate policymakers and the public on the benefits of graduate medical education residency and fellowship programs.

Acknowledgments

The Department of Health extends a sincere thank you 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 and designees are:

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The department would also like to thank the Community Hospital Education Council for its input into the annual report. The council members are:

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Executive Summary

The Graduate Medical Education Committee (GMEC) will prepare a report pursuant to Section 381.0403 (9), Florida Statutes to address graduate medical education and its impact on the delivery of medical care in Florida. The committee evaluates key areas, including the role of residents in the delivery of health care, the impact of residency programs on the state's physician workforce, the costs of training residents and resources and funding for programs throughout Florida.

Graduate medical education is usually referred to as "residency" and, depending on the specialty or subspecialty, can range 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 into a residency program. A residency is the time when the resident will: (1) develop and refine his or her clinical skills and expertise; (2) acquire the expertise required for independent, patient care decision-making; and (3) practice in their actual clinical area under the supervision of physician faculty members. The length of time from medical school through completion of residency is referred to as the "medical education pipeline."

This past year was an important time for Florida in addressing the medical education pipeline as policy makers brought issues concerning Florida's physician workforce to the forefront. The Florida Board of Governors approved proposals for two new medical colleges, bringing Florida's total count of allopathic and osteopathic medical colleges to seven; nine when the branch campuses of Lake Erie College of Osteopathic Medicine and Florida Atlantic University are included. The University of Central Florida and Florida International University submitted proposals to the Board of Governors that targeted the need, demand, and the return on investment for their new medical schools, and detailed the respective schools plans regarding the development of medical residency programs to accommodate medical school graduates.

The new medical schools plan to collaborate with urban and rural hospitals to expand their residency programs as the first medical school class graduates. Future expansions are then planned in subsequent years to accommodate growth. The additions to residency positions are necessary to ensure that there are sufficient numbers in a variety of residency specialties and subspecialty programs for graduates of both existing and new medical schools. Existing medical schools have plans to increase their capacity by 2009, and new medical schools have their first graduates entering into residency programs by 2013. If residency programs do not see substantial increases, Florida may ultimately be educating students to participate in residency programs in other states because there will not be enough residency positions to support its graduating medical students.

If the number of residency positions stays the same between now and 2013, there will be increased competition for these slots between Florida medical school graduates, graduates from other states and graduates of international medical schools. The potential exists that Florida will be educating students to leave the state for their residencies or, if residency positions are not increased in Florida, then international medical graduates may be replaced by Florida's medical school graduates rather than accommodated in residency planning. International medical school graduates (IMG), like other residency completers, stay in the areas where they complete programs, they often focus in primary care residencies, and IMGs disproportionately locate their practices in medically underserved areas and treat patients who are economically disadvantaged. IMGs are critical to serving rural, medically underserved areas, places that historically Florida has had to recruit physicians in to practice 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.

All residency programs benefit the medically underserved and underinsured in the state. Residency programs frequently staff "clinic" programs that provide access to quality health care to persons who are indigent, uninsured, or underserved. Residency programs also positively affect the quality, specialty, or sub-specialty mix of the physician workforce, and the geographic distribution of physician specialists in Florida. In addition, residency programs are substantial contributors and determinants of the supply and diversity of the specialist physician workforce practicing in Florida. Physicians completing residency programs often remain in Florida to establish practice, evidenced by the fact that 70-75% of physicians completing their residencies remained in the state. Finding ways to recruit and retain residents and physicians is important in Florida due to the state's population growth outpacing increases in the numbers of licensed physicians.

Expanding residency positions is a key component of increased physician manpower and access to care, but several factors influence the ability to create new programs and residency positions within existing programs. The ability to expand residency programs depends on available, qualified faculty to supervise and teach. In addition, expansion is dependent on commitments from hospitals to sponsor programs, which is influenced by the availability of federal and state funds. Another component is the Balanced Budget Act of 1997, which capped the number of resident positions, supported in programs, and stated that any new residency positions in those existing programs would have to find alternative sources of funding. Any new program would fall under the criteria defined in the Balanced Budget Act, and could be a viable option in Florida, particularly for smaller, rural hospitals that have not supported programs in the past. The Board of Governors supports exploring state and federal support for new residency positions (Board of Governors, 2005).

Funding for graduate medical education programs comes from several sources, and the specific costs identified as related to medical education varies among individual residency programs. The largest source of funding for graduate medical education is the federal Medicare Program, which reimburses teaching hospitals for both the direct cost of operating these programs (Direct Medical Education or DME costs) and indirect costs (Indirect Medical Education costs or IME, often considered a surrogate for medically indigent care). Florida's Medicaid program also funds graduate medical education, although it is not as clearly defined as it is in the Medicare Program. As identified in the reports prepared by medical schools, Florida needs to find additional funds to improve and support GME in Florida (Board of Governors, 2005).

Although funding is vital to supporting residency slots, a reliable data set focusing on the geographic distribution and specialty mix of active, licensed Florida physicians would assist policy makers in determining where and what types of medical residency programs should be located. These data could also evaluate demographic indicators of physicians and support recruitment and retention programs across the state. Florida ranks 16th in total physician per 100,000 population, but that number does not account for the fact that over 26% of licensed physicians in the state are over 65 and that many minorities and women are underrepresented compared to the population and national averages. Florida still does not have a reliable, continuous data source to track geographic distribution and specialty mix of Florida physicians, making it difficult to predict shortage or surplus in various specialty areas.

The GME Committee has been an active, ongoing proponent of creating a physician workforce database that would assist the analysis of data related to the issues facing the medical education pipeline and delivery of health care in the state. This was one of the three goals for 2006. Committee members participated in meetings with key legislators and stakeholders to address ways to evaluate physician workforce issues. This group, which included the Governor's Office, the Department of Health, the Council of Medical School Deans, the Florida Medical Association, the Florida Osteopathic Medical Association, and the Board of Governors, developed a questionnaire that the department's Division of Medical Quality Assurance, would include as part of the physician licensing renewal process. The questionnaire included questions designed to assess clinical specialty areas, geographic distribution, hours worked per week, and any plans to retire or reduce scope of practice. The committee will continue to participate in this and other workforce planning opportunities, will track and analyze the data related to these questions, and apply the information to the findings in this report.

This year the committee continues to support state and national priorities for graduate medical education, including addressing funding and growth. The GME Committee's recommendations for 2007 are:

1. **Florida's residency programs must have a stable, recurring funding source.** Current and future funding sources must be explicitly designed to increase incrementally and strategically the number of graduate medical education positions in Florida. The committee will work with other GME stakeholders and policy makers to evaluate the true cost of residencies and explore funding options.

2. **To validate funding for current and new residency programs, physician workforce supply and demand data must be analyzed and reported.** To address the question of physician workforce supply and demand the focus must remain on the analysis of the Physician Workforce Questionnaire data related to Florida's current and projected physician workforce needs. Analysis will include the actual clinical specialty and subspecialty mix by geographic distribution and scope of practice in Florida. Addressing the supply of physicians is one component of workforce analysis. The second component is using economic indicators and current population and growth estimates, as well as insurance and service delivery data, to evaluate demand in Florida.

3. **The committee recommends conducting a cost survey of residency programs to understand the economic impact and contributions these programs make at the local and state level.** 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. This survey would collect specific data for the evaluation of how Medicare and Medicaid funds are tracked in residency facilities and how they quantify the value of graduate medical education programs to hospitals and the state. The survey should focus, as closely as possible, on direct costs and assess costs that both teaching hospitals and medical schools incur.

4. **In conjunction with other Graduate Medical Education stakeholders, the committee recommends a concerted effort to strategically plan for the growth and funding of graduate medical education, including the education of policymakers and stakeholders.**

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.

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

This was a landmark year for growth in the medical education pipeline with the Florida Board of Governors voting to award two new medical schools to the University of Central Florida and Florida International University. Both schools worked diligently to submit proposals that addressed recruiting top Florida applicants, adding new capacity to the number of students in Florida medical schools and discussion on where medical school graduates could potentially complete their residency training.

Many state and national 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 41st nationally in the number of medical school students per 100,000 population (AAMC, 2006). 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 (CHEP, 2006). Maintaining the quality of residency programs and developing expanded capacity of residency programs are explicit strategies that address the potential for adequate physician workforce. These strategies can work in collaboration with expanding medical school enrollment.

GME stakeholders are interested in the recruitment and retention of talented individuals into residency 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 can result in a negative impact on access to health care, particularly for Florida's most vulnerable citizens. Too few residency positions may also mean that the international medical graduates who contribute to the state's workforce in key underserved or rural communities may lose a residency position to a Florida medical school graduate. This creates an uneven balance in addressing Florida's long-term health care needs.

Residency programs serve the citizens of Florida by providing critical access to care, particularly primary care, and supplementing specialty care across the state. Residents engaging in care and entering the workforce upon completion contribute directly to physician work force shortages or surplus. If residency programs cannot keep up with population growth in the state and with numbers of medical school graduates, Florida will have to continue to rely on the net importation of doctors from other states and countries. 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. Current data indicate that approximately 80 percent of the current, practicing physicians in Florida came from other states or countries. Florida attracts many foreign graduates, with more than 34 percent of Florida's physician workforce having attended a foreign medical school (MQA, 2006).

While many factors influence demand of physicians, key factors include an aging physician workforce, an aging population, and various economic indicators indicate supply triggers (MGT, 1999). Recognizing the role residency programs play in first providing health care to a largely underserved, under-insured community, and secondly how residency completers flow into the state is a starting point in evaluating the state's physician workforce needs. Health care planners need to go one-step further, and evaluate the overall physician workforce in terms of geographic location and specialty mix. 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 GME Committee has worked with partners and stakeholders this past year on a project that will assess the status of those allopathic and osteopathic physicians renewing their licenses in the state. Key GME stakeholders, including the Florida Medical Association, the Florida Osteopathic Medical Association, the Board of Governors, the Council of Medical School Deans, legislators, physicians and volunteers, committed to a project that would serve as a means of capturing essential data on actual clinical practice and geographic location of Florida doctors. This public/private partnership is a significant leap in having a reliable, continuous data source to assist in physician workforce planning.

The Physician Workforce Project will supply data that can address concerns about long and short-term physician specialty projections, and may be used in other important analysis, such as supporting research on the impact of medical malpractice insurance. Stakeholders worked in cooperation with the Department of Health, Division of Medical Quality Assurance (MQA) to write questions and implement the mechanism that would capture initial data. MQA, the entity responsible for physician initial and renewal applications, voluntarily questioned physicians renewing their licenses in either an on-line or paper questionnaire on his or her actual clinical practice areas, amount of time spent practicing in Florida, and primary counties by hours worked. Analysis of this data will begin after the renewal cycle closes in January 2007, but the survey will continue as part of each subsequent renewal cycle. This collection is a promising step in the base lining and trending of physician data that can be used to evaluate physician workforce and project Florida's healthcare needs (See Appendix III).

Current data on active, Florida physicians is limited, but can provide supplemental information on demographics and highlight limited information on board certifications, medical school, and residency programs.

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), Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and various reports. MQA data have the physician's 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 physicians, and have a primary business address in the state as of August 2006. 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.

Data indicate that there are over 40,000 active, licensed Florida allopathic and osteopathic physicians. Of these, 22% are 60 or older and over 50% are older than 50 years of age. Sixty-five percent of Florida physicians are white and 78% are male.

- 15% went to a medical school in Florida
- 49% went to an out of state medical school
- 35% went to an out of country medical school
- 24% completed a Florida residency
- 64% completed an out of state residency
- 11% completed a residency in another country
- Information on board certifications and specialties in incomplete

The successful planning and implementation of the physician workforce project will provide additional information on clinical practice, geographic location, and scope of practice for Florida physicians. The evaluation of this information can provide better resources for planning both the recruitment and retention of physicians, but also provide key data for the planning of expanded and new residency programs to feed into Florida's physician workforce. The ability to accurately plan for residency programs can result in the specific request and allotment of funds for this important training.

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. Residents work under the direct supervision of medical faculty, who provide guidance, training, and oversight, serving as role models to young physicians. Medical faculty is the vital link between providing superior access to care while balancing the demands of educating and training residents. Physicians that assume this role are often juggling demands of patient care, teaching, research and often the policy and budgetary the programs they administer.

The American Association of Medical Colleges notes the importance of medical faculty vitality as essential to the sustained health of medical colleges, teaching hospitals and the overall infrastructure (AAMC, 2005). The AAMC supports increased salaries based on the contribution of faculty, and medical faculty's capability, responsibility to the system and overall support of the community. AAMC 2205 data indicate that Florida has 2,949 full-time, allopathic medical school faculty for the 4 allopathic schools (AAMC, 2005). The American Association of Colleges of Osteopathic Medicine reports that there are 101 full-time osteopathic faculty in Florida.
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 of racial and ethnic diversity 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).

The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates geographic distribution of Florida's population based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements). A Metropolitan Statistical Area must include at least one city with 50,000 or more inhabitants or a Census-Bureau defined urbanized area of at least 50,000 inhabitants and a total metropolitan population of 100,000 or more, and Florida shows over 96% of its population in a metropolitan area. Seventeen percent of those in Metropolitan areas were persons in poverty, defined as those who make less than 100% of the Federal Poverty Level (FPL). The federal poverty level for a family of three in the 48 contiguous states and D.C. was $14,680 in 2003 and $15,067 in 2004 (Kaiser, 2006).

Florida's graduate medical education programs provide highly trained residents who provide care and contribute to the overall specialty needs, such as the care of geriatric patients. Florida has the fourth largest population in the country, and one of the oldest populations, with over 17% of the over 17 million residents 65 or older, compared to 12% nationally. In fact, Florida ranks first in persons age 65 or older (Census Bureau, 2005). An aging population consumes a disproportionate share of health care resources. Florida physicians are also slightly older than the national average, with 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 (MQA, 2006).

The capacity and quality of Florida's residency programs define and assist the recruitment of highly qualified resident physician applicants to Florida. The majority of those completing residency programs ultimately remain in the state to establish practice and to contribute to their respective communities. There are currently 309 allopathic and osteopathic residency programs defined by the individual specialties of training across the state, with more than 3,200 resident physicians in training at a given point in time (ACGME and AOA, 2006). Even though these numbers are impressive in their own right, Florida still ranks only 44th of 50 in the nation in the ratio of residency training positions per 100,000 population (AAMC, 2005).

Florida's residents are working in a variety of settings, although the majority is located in one of the state's six statutory teaching hospitals. There has been a movement in past years to move residency programs into 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.

Community Hospital Education Programs

The Community Hospital Education Program (CHEP) was created in 1971 with the enactment of Section 381.0403, Florida Statutes. The program was to address the critical role that primary care programs play are in the delivery of health care to the citizens of the state. The growth of primary care physicians would provide additional inpatient and outpatient services across Florida and provide a continued supply of highly trained physicians and graduate medical education programs. The program has grown since 1971 to include family practice, internal medicine, pediatrics, combined med/pediatrics programs, obstetrics/gynecology, emergency medicine, psychiatry and osteopathic interns.

Until 2001, CHEP was the only source of state funds specifically appropriated to support graduate medical education. This money provided per capita support for residents in primary care programs and was administered by the Community Hospital Education Council. Residency 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. After 2001, CHEP monies became part of the Medicaid Program's Upper Payment Limit and participating CHEPs had spending caps removed, allowing for reimbursement at a higher rate.

Program requirements include:

- the submission of an educational plan and a training schedule;
- 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; and
- verification that supervision of the educational program is by a physician who is not the hospital administrator.

Over 1,400 residents participate in 58 internship and residency programs located at teaching hospitals around the state. The 2006 Florida statistics indicated that 67 percent of CHEP residents remain in the state to continue their education or practice, as compared to retention of only 46 percent of medical school graduates (See Appendix IV).

The Economic Impact of Graduate Medical Education

THE COSTS OF TRAINING MEDICAL RESIDENTS

Training medical residents involves education, research, and the provision and documentation of patient care. Traditionally, two categories of GME costs are reported, 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 resident programs. These costs are adjusted annually and usually determined as the cost per resident. Direct costs vary widely by program and cannot be systematically tracked across programs, even for the six statutory teaching hospitals in Florida. The reported direct costs of teaching hospitals include resident costs, faculty cost attributions, and overhead costs, vary greatly by the size of the program, as well as by geographic location. Some of the cost differential is due to the hospital's size in comparison to the size of their residency programs; and some hospitals share the resident costs with other facilities that participate in the residents' training, and so only a portion of the costs may be claimed. These costs, as reported in 1999, but not audited by a common reproducible methodology, ranged from $39,554 to $141,107 per resident physician.

Indirect costs can be even more variable as these costs more closely relate to a hospital's case mix. 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 case mix of the hospital. Teaching hospitals also usually have higher staff-to-patient ratios and they conduct more research and have the additional task of educating young physicians, which may mean longer diagnostic exams, greater surgery times, or even longer inpatient hospitalization if 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 uses a reimbursement formula 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). Most teaching hospitals have greater charity care costs and see a larger number of Medicaid patients than do non-teaching hospitals, and since Medicare DME and IME adjustments are only made for Medicare patients, teaching hospitals with low Medicare volume receive very little GME reimbursement as compared to teaching hospitals with higher Medicare volumes.

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, they were funded. Teaching hospitals received more Medicare funding per resident, particularly for those in more highly specialized or extended programs. Congress expressed its concern that this funding mechanism was perceived to provide hospitals with incentives to expand the size of residency programs and to train more subspecialists. With the passage of the Act, open-ended payments that rewarded teaching hospitals for adding new resident programs and positions 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 programs and slots over their caps. The Balanced Budget Act will be an important factor to consider as new medical schools graduate greater numbers of students looking to Florida's high quality programs for placement. Addressing increased graduate medical education capacity will be a priority for stakeholders and policymakers.

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 though Medicaid payments, Florida includes graduate medical education costs in its base per diems as well as part of the Upper Payment Limit (UPL) program and usually as part of the Disproportionate Share (DSH) 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 the public the benefit of a hold-harmless payment or a safety net payment but without specific graduate medical education accountability.

Reimbursement under the UPL program cannot exceed the cost of services provided to Medicaid and uninsured persons. Hospitals are usually reimbursed under Medicaid at a rate which is calculated to be approximately 65% of their costs This payment is based on the previous year's cost report. The payment 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; these hospitals are paid approximately 95% of their costs.

The Legislature approved Florida Medicaid Reform legislation in December 2005, and began enrollment in Broward and Duval Counties in September 2006. The reform includes key elements such as new options and choices for Medicaid eligible individuals, different financing, outreach efforts and the Low Income Pool (LIP). The Medicaid Reform Waiver, Low Income Pool, was established to ensure continued government support for the provision of health care services to Medicaid and underinsured populations. Under Medicaid Reform, the UPL program becomes the Lower Income Pool. Funding for LIP over the 5-year waiver period is $1 billion per year for a total of $5 billion. The LIP Council was created, per statute, to advise the Agency for Health Care Administration, the Governor and the Legislature on funding methodologies and allocation of LIP funds.

LIP Reimbursement and Funding Methodology was submitted to the Centers for Medicare and Medicaid Services in June 2006, defining the allocation and monitoring of funds. The allocation of funds is contingent upon local tax support for non-federal share and LIP funds will be distributed to hospitals serving a significant portion of Florida's Medicaid, underinsured and uninsured populations. These hospitals include safety net hospitals, pediatric hospitals, primary care hospitals, rural hospitals, and trauma hospitals. While the LIP Council discusses the funding of CHEP hospitals and while there are plans to add additional categories for the allocation of funds, at this time the CHEP hospitals are still exempt from caps under UPL and remain outside LIP, with no impact to their current funding (Florida Medicaid Reform, 2006).

ALTERNATIVE SOURCES OF FUNDING

Other sources of funding for graduate medical education in Florida 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 their training and hence, 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 through 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 related to chronic renal disease and certain other chronic diseases, such as cystic fibrosis, 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 in the education portion of their training programs, additional support expenses, such as travel, books, journals, 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, include:

- Supporting GME Stakeholders in asking the Legislature to fund a percentage of each new residency position;
- 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;
- Exploring the renewed funding to Florida's existing "Innovations" program defined in section 381.0403 (4), Florida Statutes;
- Explore concepts like Utah's detailed demonstration project to addressed finding Medicare monies earned, but unclaimed by teaching hospitals, and awarding then them these funds;
- 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 recommendations are:

1. Florida's residency programs must have a stable, recurring funding source. Current and future funding sources must be explicitly designed to increase incrementally and strategically the number of graduate medical education positions in Florida. The committee will work with other GME stakeholders and policy makers to evaluate the true cost of residencies and explore funding options.

2. To validate funding for current and new residency programs, physician workforce supply and demand data must be analyzed and reported. To address the question of physician workforce supply and demand the focus must remain on the analysis of the Physician Workforce Questionnaire data related to Florida's current and projected physician workforce needs. Analysis will include the actual clinical specialty and subspecialty mix by geographic distribution and scope of practice in Florida. Addressing the supply for physicians is one component of workforce analysis. The second component is using economic indicators and current population and growth estimates, as well as insurance and service delivery data, to evaluate demand in Florida.

3. The committee recommends conducting a cost survey of residency programs to understand the economic impact and contributions these programs make at the local and state level. 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. This survey would collect specific data for the evaluation of how Medicare and Medicaid funds are tracked in residency facilities and how they quantify the value of graduate medical education programs to hospitals and the state. The survey should focus, as closely as possible, on direct costs and assess costs that both teaching hospitals and medical schools incur.

4. In conjunction with other Graduate Medical Education stakeholders, the committee recommends a concerted effort to strategically plan for the growth and funding of graduate medical education, including the education of policymakers and stakeholders.

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 include formal 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

PHYSICIAN WORKFORCE QUESTIONNAIRE

The items below relate to very important questions regarding Florida's current and future physician workforce. Your responses will be instrumental in shaping Florida's health care and physician workforce policies. Secretary of the Department of Health, M. Rony François, M.D., M.S.P.H., Ph.D., and the Council of Florida Medical School Deans, Florida Graduate Medical Education Committee, Florida Medical Association and Florida Osteopathic Medical Association appreciate your time and effort in responding to the eight questions below.

Name: *FirstName MI. LastName* **License Number:** *ME 123456789*

1. Do you practice medicine at any time during the year in Florida?

   Note: If you check 'No' then please stop here. ◯ Yes ◯ No

2. How many months/year do you practice medicine in Florida?

   ◯ 1-4 Months ◯ 5-8 Months ◯ 9-12 Months

3. In what Florida counties do you practice?(may select up to 5 counties)
   Please note - County Names and Numeric Codes are listed on the **back side of the form.**
   Please print or type County Names and Numeric Codes below.

	County Name	Numeric Code	1-20 Hrs/Wk	21-40 Hrs/Wk	More than 40 Hrs/Wk
a.			◯	◯	◯
b.			◯	◯	◯
c.			◯	◯	◯
d.			◯	◯	◯
e.			◯	◯	◯

4. Is more than twenty percent (20%) of your practice non-clinical? (i.e. research, teaching, administration)

   ◯ Yes ◯ No

5. Are you a resident or fellow?

   ◯ Yes ◯ No

6. What is the primary specialty area(s) of your current clinical practice?(may select up to 5 different areas)
   Please note - Specialty Areas and Numeric Codes are listed on the **back side of the form.**
   Please print or type Specialty Areas and Numeric Codes below.

	Specialty Area	Numeric Code	1-20%	21-40%	41-60%	61-80%	81-100%
a.			◯	◯	◯	◯	◯
b.			◯	◯	◯	◯	◯
c.			◯	◯	◯	◯	◯
d.			◯	◯	◯	◯	◯
e.			◯	◯	◯	◯	◯

7. Do you plan to retire, relocate outside of the state of Florida, or significantly reduce the scope of your practice within the next five years?

   ◯ Yes ◯ No

8. Do you currently take emergency call or otherwise work clinically in a hospital emergency department or provide for the immediate, acute care of trauma patients?

   ◯ Yes ◯ No

ME0123456789

County Names and Numeric Codes (Reference for question # 3)

11 ALACHUA	25 DIXIE	39 HILLSBOROUGH	53 MARTIN	67 SANTA ROSA
12 BAKER	26 DUVAL	40 HOLMES	54 MONROE	68 SARASOTA
13 BAY	27 ESCAMBIA	41 INDIAN RIVER	55 NASSAU	69 SEMINOLE
14 BRADFORD	28 FLAGLER	42 JACKSON	56 OKALOOSA	70 SUMTER
15 BREVARD	29 FRANKLIN	43 JEFFERSON	57 OKEECHOBEE	71 SUWANNEE
16 BROWARD	30 GADSDEN	44 LAFAYETTE	58 ORANGE	72 TAYLOR
17 CALHOUN	31 GILCHRIST	45 LAKE	59 OSCEOLA	73 UNION
18 CHARLOTTE	32 GLADES	46 LEE	60 PALM BEACH	74 VOLUSIA
19 CITRUS	33 GULF	47 LEON	61 PASCO	75 WAKULLA
20 CLAY	34 HAMILTON	48 LEVY	62 PINELLAS	76 WALTON
21 COLLIER	35 HARDEE	49 LIBERTY	63 POLK	77 WASHINGTON
22 COLUMBIA	36 HENDRY	50 MADISON	64 PUTNAM	78 UNKNOWN
23 DADE	37 HERNANDO	51 MANATEE	65 ST.JOHNS	79 OUT OF STATE
24 DESOTO	38 HIGHLANDS	52 MARION	66 ST.LUCIE	80 FOREIGN

Specialty Areas and Numeric Codes (Reference for question # 6)

000 NO CLINICAL PRACTICE	305 BLOOD BANKING/TRANSFUSION MEDICINE
020 ALLERGY AND IMMUNOLOGY	306 CHEMICAL PATHOLOGY
040 ANESTHESIOLOGY	307 CYTOPATHOLOGY
045 CRITICAL CARE MEDICINE	310 FORENSIC PATHOLOGY
048 PAIN MEDICINE	311 HEMATOLOGY
042 PEDIATRIC ANESTHESIOLOGY	314 MEDICAL MICROBIOLOGY
060 COLON AND RECTAL SURGERY	315 NEUROPATHOLOGY
080 DERMATOLOGY	316 PEDIATRIC PATHOLOGY
100 DERMATOPATHOLOGY	301 SELECTIVE PATHOLOGY
081 PROCEDURAL DERMATOLOGY	**320 PEDIATRICS**
110 EMERGENCY MEDICINE	321 ADOLESCENT MEDICINE
118 MEDICAL TOXICOLOGY	329 NEONATAL-PERINATAL MEDICINE
114 PEDIATRIC EMERGENCY MEDICINE	325 PEDIATRIC CARDIOLOGY
116 SPORTS MEDICINE	323 PEDIATRIC CRITICAL CARE MEDICINE
119 UNDERSEA AND HYPERBARIC MEDICINE	324 PEDIATRIC EMERGENCY MEDICINE
120 FAMILY MEDICINE	326 PEDIATRIC ENDOCRINOLOGY
125 GERIATRIC MEDICINE	332 PEDIATRIC GASTROENTEROLOGY
127 SPORTS MEDICINE	327 PEDIATRIC HEMATOLOGY/ONCOLOGY
140 INTERNAL MEDICINE	335 PEDIATRIC INFECTIOUS DISEASES
141 CARDIOVASCULAR DISEASE	328 PEDIATRIC NEPHROLOGY
154 CLINICAL CARDIAC ELECTROPHYSIOLOGY	330 PEDIATRIC PULMONOLOGY
142 CRITICAL CARE MEDICINE	331 PEDIATRIC RHEUMATOLOGY
143 ENDOCRINOLOGY, DIABETES, AND METABOLISM	333 PEDIATRIC SPORTS MEDICINE
144 GASTROENTEROLOGY	336 DEVELOPMENTAL-BEHAVIORAL PEDIATRICS
151 GERIATRIC MEDICINE	**340 PHYSICAL MEDICINE AND REHABILITATION**
145 HEMATOLOGY	341 PAIN MEDICINE
155 HEMATOLOGY AND ONCOLOGY	346 PEDIATRIC REHABILITATION
146 INFECTIOUS DISEASE	345 SPINAL CORD INJURY MEDICINE
152 INTERVENTIONAL CARDIOLOGY	**360 PLASTIC SURGERY**
148 NEPHROLOGY	361 CRANIOFACIAL CURGERY
147 ONCOLOGY	363 HAND SURGERY
149 PULMONARY DISEASE	**380 PREVENTIVE MEDICINE**
156 PULMONARY DISEASE AND CRITICAL CARE MEDICINE	399 MEDICAL TOXICOLOGY
150 RHEUMATOLOGY	398 UNDERSEA AND HYPERBARIC MEDICINE
157 SPORTS MEDICINE	**400 PSYCHIATRY**
130 MEDICAL GENETICS	401 ADDICTION PSYCHIATRY
190 MOLECULAR GENETIC PATHOLOGY	405 CHILD AND ADOLESCENT PSYCHIATRY
160 NEUROLOGICAL SURGERY	406 FORENSIC PSYCHIATRY
180 NEUROLOGY	407 GERIATRIC PSYCHIATRY
185 CHILD NEUROLOGY	402 PAIN MEDICINE
187 CLINICAL NEUROPHYSIOLOGY	409 PSYCHOSOMATIC MEDICINE
183 NEUROMUSCULAR MEDICINE	**420 RADIOLOGY DIAGNOSTIC**
186 NEURODEVELOPMENTAL DISABILITIES	421 ABDOMINAL RADIOLOGY
181 PAIN MEDICINE	429 CARDIOTHORACIC RADIOLOGY
188 VASCULAR NEUROLOGY	422 ENDOVASCULAR SURGICAL NEURORADIOLOGY
200 NUCLEAR MEDICINE	426 MUSCULOSKELETAL RADIOLOGY
220 OBSTETRICS AND GYNECOLOGY	423 NEURORADIOLOGY
240 OPHTHALMOLOGY	425 NUCLEAR RADIOLOGY
260 ORTHOPAEDIC SURGERY	424 PEDIATRIC RADIOLOGY
261 ADULT RECONSTRUCTIVE ORTHOPAEDICS	427 VASCULAR AND INTERVENTIONAL RADIOLOGY
262 FOOT AND ANKLE ORTHOPAEDICS	**430 RADIATION ONCOLOGY**
263 HAND SURGERY	**520 SLEEP MEDICINE**
270 MUSCULOSKELETAL ONCOLOGY	**440 SURGERY-GENERAL**
268 ORTHOPAEDIC SPORTS MEDICINE	443 HAND SURGERY
267 ORTHOPAEDIC SURGERY OF THE SPINE	445 PEDIATRIC SURGERY
269 ORTHOPAEDIC TRAUMA	442 SURGICAL CRITICAL CARE
265 PEDIATRIC ORTHOPAEDICS	450 VASCULAR SURGERY
280 OTOLARYNGOLOGY	**460 THORACIC SURGERY**
286 NEUROTOLOGY	**480 UROLOGY**
288 PEDIATRIC OTOLARYNGOLOGY	485 PEDIATRIC UROLOGY
300 PATHOLOGY-ANATOMIC AND CLINICAL	**999 OTHER**

Appendix III

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

COMMUNITY HOSPITAL EDUCATION PROGRAM ANNUAL REPORTS

The 2006 Gender Ethnicity Report is self-reported program data listing the breakout of ethnicity as defined under the federal definitions of the Health Professional Shortage Areas by program year and gender.

2006 GENDER/ETHNICITY REPORT
COMMUNITY HOSPITAL EDUCATION PROGRAM

	PGY1 Male	PGY 1 Female	PGY 2 Male	PGY 2 Female	PGY 3 Male	PGY 3 Female	Total	Percent of Total
Black U.S. Citizens	15	56	15	30	7	32	**155**	**10%**
White U.S. Citizens	118	149	121	118	138	134	**778**	**51%**
American Indian/ Alaskan Native U.S. Citizens	0	0	2	3	2	1	**8**	**0.5%**
Asian/Pacific Islander U.S. Citizens	34	38	37	48	37	33	**227**	**15%**
Hispanic U.S. Citizens	46	45	34	42	21	32	**220**	**14%**
Foreign (Non U.S. Citizens Holding Other Visas)	18	26	16	34	22	21	**137**	**9%**
Total By Sex (Gender)	**231**	**314**	**225**	**275**	**227**	**253**	**1525**	**100%**

Percent	**15%**	**21%**	**15%**	**18%**	**15%**	**17%**	**100%**

Total Males	**683**
Total Females	**842**
Percent Male	**45%**
Percent Female	**55%**

The 2006 Graduate Destination Reports is a self-reported documentation of whether each completing resident in participating programs will continue education or enter practice in or out of Florida.

2006 GRADUATE DESTINATION REPORT
COMMUNITY HOSPITAL EDUCATION PROGRAM

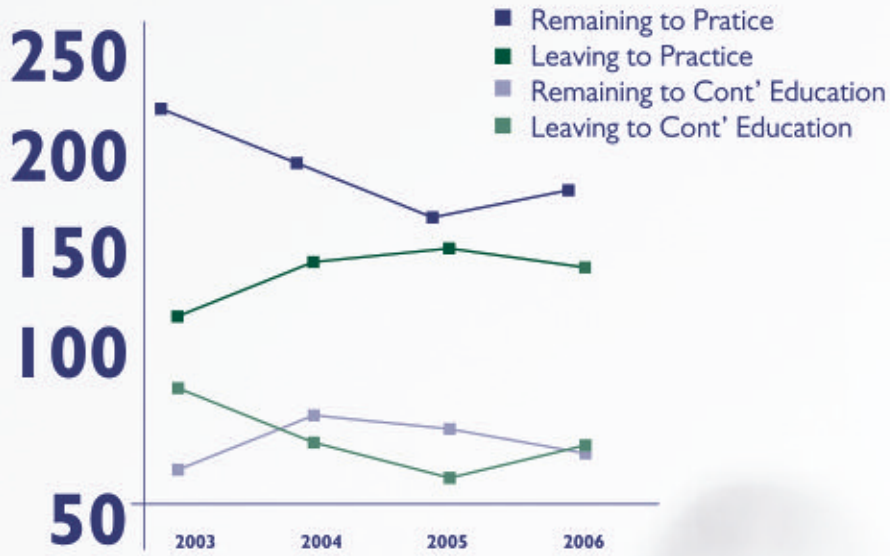
Immediately Entering Practice			Continuing Training			*Other	Total Graduates
In Florida	Out of State	Total	In Florida	Out of State	Total		
190	73	263	128	68	196	28	487
72%	28%		65%	35%			

Total Graduates Remaining in Florida	318	65%
Total Graduates Leaving Florida	141	29%

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

The following graph highlights graduate destination as reported by participating CHEPs from 2003-2006.

2003-2006 Graduate Destination Totals



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