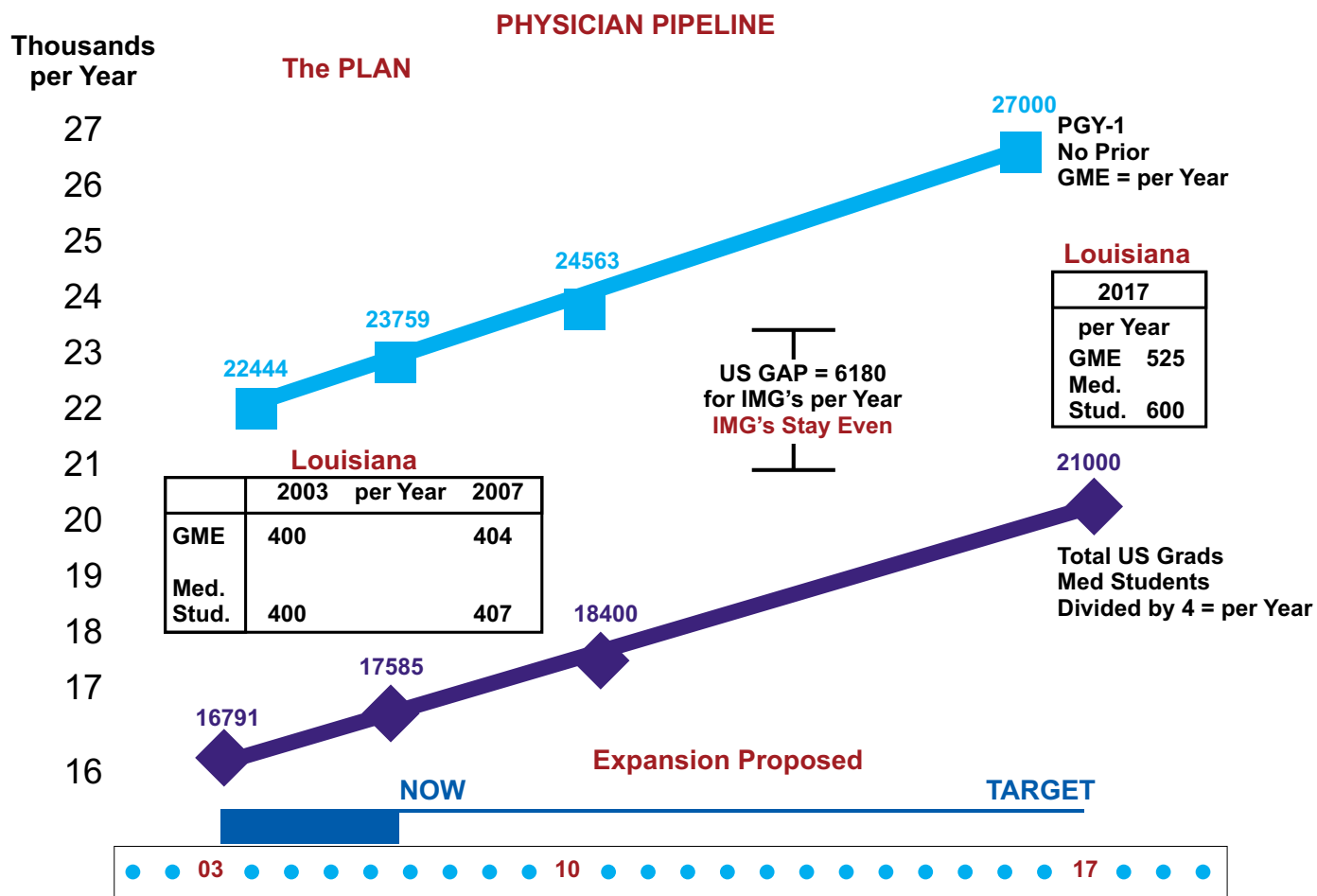


The Medical Education Commission



State of Louisiana

**Twelfth Annual Report:
2009**

The Medical Education Commission



State of Louisiana

**Twelfth Annual Report:
2009**

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The Medical Education Commission



State of Louisiana

**Twelfth Annual Report:
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CHANCELLOR'S REPORT



OFFICE OF THE CHANCELLOR

SCHOOL OF ALLIED HEALTH PROFESSIONS
SCHOOL OF DENTISTRY
SCHOOL OF GRADUATE STUDIES
SCHOOL OF NURSING
SCHOOL OF MEDICINE IN NEW ORLEANS
SCHOOL OF PUBLIC HEALTH

Alan Levine, Secretary
Department of Health & Hospitals
P.O. Box 629
Baton Rouge, LA

Dear Secretary Levine:

The Medical Education Commission is issuing this Twelfth Annual Report 2009. The value of this cooperating working group is evident in illustrating a dynamic process, with clarity of information on Graduate Medical Education (GME) in the entire state of Louisiana. The institutions in Louisiana comprising the medical schools and teaching hospitals, also comprise the Medical Education Commission.

The member representatives from LSU Health Sciences Center, Tulane University Health Sciences Center, Alton Ochsner Clinic Foundation, and the Department of Health and Hospitals, have worked to consistently promote a partnership of understanding and trust focused on GME activity in our Teaching Hospitals. While changes in institutional leadership have occurred practically everywhere, I would like to commend the steady and excellent work of Kurt Braun, Ph.D. in preparation of these reports.

The Commission reports the multiyear changes in data on GME after the biggest traumatic event ever in Louisiana – Katrina. The changes in GME are detailed to show in a public/private partnership the steady and excellent past record compared with change and uncertainty from the storm, slowly improving. The institutions mounted a courageous and innovative response in geographic and infrastructure relocation, and now are moving forward in return and reengineering. The individual decisions over time have incrementally proceeded to put GME in Louisiana on the path to track the United States National Averages. This plan continues and is featured in this report; increases in Louisiana medical students are underway, more GME slots are needed, and recovery from Katrina requires more trainees to get back on track.

I am pleased to endorse this report and the work of the Commission, and encourage your acceptance and ongoing support to connect a bright present with a brighter future; the benefits of this cooperative venture will accrue not only to the individuals in training and our patients, but also the institutions involved and the people of the State of Louisiana. The restitution of Medical School and GME numbers is progressing in the right direction for recovery, but there is more to be done to respond to the physician shortages, in the United States and Louisiana.

Sincerely,

A handwritten signature in black ink that reads "Larry Hollier, M.D." The signature is written in a cursive, flowing style.

Larry Hollier, M.D.
Chancellor

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ANNOUNCEMENT

THE MEDICAL EDUCATION COMMISSION HAS ADDED TO OUR ANNUAL REPORT PRESENTATIONS. THE 2008-2009 COMPREHENSIVE FTE ANNUAL DATA WILL BE PUT ON THE WEBSITE. WE HAVE INCLUDED SOME 2008 DATA PIECES AS REPEATS. FOR BOTH WEBSITE AND PUBLISHED VERSIONS.

The website is the expanded version, with color, at lsuhsc.edu/administration. We now annually submit a scientific article for publication in the Journal of the Louisiana State Medical Society. A bibliography of recent publications is included:

- 1) Rigby PG, Pinsky W, Braun K, Wiese J, et al. The Medical Education Commission Report 2007: GME is recovering from Katrina. J LA State Med Soc. 2009; Vol. 161:32-40
- 2) Rigby PG. Physician Production is at a Steady Supply, but Demand for Physician Services is Increasing. J LA State Med Soc March/April 2004; 156:89-92
- 3) Sessions BA, Hilton CW, Chauvin SW, et al. Forecasting Change in Louisiana Physician Age Cohorts: 1994-2020. J LA State Med Soc March/April 2006; 158:81-84
- 4) Rigby PG, Pinsky WW, Amedee R, et al. The Medical Education Commission Report 2004: The Competition for Physician Recruitment is Increasing. J LA State Med Soc March/April 2005; 157:103-109
- 5) Rigby PG, Foulks E, Pinsky WW, et al. The Medical Education Commission Report 2003: GME Production Renews Physician Supply. J LA State Med Soc 2003; 155:271-278
- 6) Rigby PG, Foulks E, Pinsky WW, et al. The Medical Education Commission Report on Trends of Graduate Medical Education in 2002. J LA State Med Soc 2002; 154:262-268
- 7) Rigby PG, Foulks E, Riddick FA, et al. The Medical Education Commission Report on Trends in Graduate Medical Education in 2001. J LA State Med Soc 2001; 154:411-418
- 8) Rigby PG, Foulks E., Riddick FA, et al. The Medical Education Commission Report at the Turn of the New Millennium 2000. J LA State Med Soc 2000; 152:386-391
- 9) Hilton CW, Plauche' WG, Rigby PG. Projecting Physician Supply at a State Level: Physicians in Louisiana in 2001 and 2006. So Med J 1998; 91:914-918

INTRODUCTION 2009

The Twelfth Annual Report of the Medical Education Commission (MEC) provides a comprehensive view of Graduate Medical Education (GME) with an emphasis on trends and changes post-Katrina in recovery and restoration. The institutional plan for future increases in both medical students and GME is presented, as four years after the enormous trauma of Katrina; the data presented in our twelfth report updates the recovery after the initial responses, and the hope of continued improvement and restoration initiated by the AAMC countrywide. The plan in Louisiana has begun to increase the numbers of medical students, and then proposed for GME, as is the AAMC plan for the U.S.

The MEC is using revised information to explain the structure and function of GME as a dynamic process, constantly changing but within a framework of continuity, essential and important to the State of Louisiana. This work on Graduate Medical Education (GME) documents the nature and scope of all training programs for the post-doctoral residents and fellows in Louisiana. The effect of Katrina was significant; recovery is planned to get back on track. The report illustrates the interrelated workload and workforce production in and by the Health Care Services Division Hospitals and the Academic Medical Centers: Louisiana State University Health Sciences Center, Tulane University Health Sciences Center, and Alton Ochsner Clinic Foundation. The twelfth report provides new information and trends on Physician Supply in the United States and in Louisiana. The most immediate priority is to meet the Southern Regional Average for the annual stipends to promote recruitment and retention of the best residents and fellows in the troubled context and recovery process based on Katrina; we need to catch-up again.

The report has been written and collated by the members of the MEC: Dr. Perry Rigby (LSUHSC) Chairman, Dr. Jeffrey Weise (Tulane), Dr. William Pinsky (Ochsner), Staff Member: Dr. Kurt Braun (HCSD), and by Dr. Charles Hilton (LSUHSC), Dr. Andy Chesson (LSUHSC), Dr. Henry Gremillion (LSUHSC), Dr. Jimmy Guidry (DHH).

This report is added to our website, while keeping prior narrative and data bases for comparison. Reports are also published as papers in the Journal of the Louisiana State Medical Society, yearly as accepted by the journal.

More information may be obtained from the MEC members, listed below, who have made these reports possible and useful.

Perry G. Rigby, M.D., Chair, LSUHSC
Kurt Braun, Ph.D., HCSD
William Pinsky, M.D., Ochsner
Jeff Weise, M.D., Tulane
Charles Hilton, M.D., LSUHSC-NO
Andy Chesson, M.D., LSUHSC-Shreveport

Contact Louise Baker for questions and requests.

lbaker@lsuhsc.edu

GME IN LOUISIANA

Executive Summary

The success of graduate medical education (GME) in Louisiana has been recognized nationally and internationally for more than 100 years. The growth of GME in Louisiana and the U.S. had been continuous in quality and quantity; a dynamic process based on the reputation, expertise, capacity, and commitment of the States academic institutions. Katrina interceded and interrupted GME in LA; challenging the continuity, shifting the geography, and altering the kinetics of operation and support. Recovery from losses in not yet complete, but well underway.

The interesting and unique feature of this arrangement in Louisiana is the major role of the State public hospitals in a statewide healthcare delivery system inextricably linked with health professional students and GME programs. Sixty percent of all residents and fellows in Louisiana had been assigned and trained in these public and private hospitals at any one time, and practically all at some time in the course of their training programs. The patient care in these hospitals could not be provided in any other cost-effective way. The hospitals in New Orleans suffered severe damage from Katrina, closing Medical Center of Louisiana at New Orleans (MCLANO). The other hospitals swelled with patients and accommodated many more students and residents. These GME programs still are the major source of future physicians in Louisiana. The continuity, stability and quality improvement in GME are essential for the academic institutions, the public hospitals, and for enlightened public policy. A recent positive event, the signing of the memorandum of understanding (MOU), is key to building the new University Hospital and realizing its' potential.

The State of Louisiana, meets the national averages regarding the ratio of residents and fellows/total physicians (14%), the ration of primary care physicians/total physicians (about one-third, 34%, and the ration of physicians/100,000 population (295/100,000). Louisiana exceeded national averages in the retention of trainees into practice sites in the state. New post Katrina data shows the differences with recovery so far, included data will show many statistics indicating that Louisiana is like the respective national average and norms.

The Medical Education Commission was established by Act 3 of the Louisiana Legislature in 1997. The report and these recommendations are to describe the work of the Commission, the nature, number, recruitment, location, workload, variety, and complexity of GME. The national settings, background, and other parameters are detailed, as well as the overall and individual academic programs in the teaching hospitals.

The Twelfth Annual Report of the data on GME has been constructed to be accurate and detailed for the year, 2009, and to be recurring. It is similar in content to the prior reports of the MEC. The issues raised by collecting and reviewing the data from many sources are ongoing concerns of the Medical Education Commission, i.e. recovery and reconstruction, education, primary care, workforce and workload, resident hours, distribution and funding. The main information on total and primary care GME has been updated, and trends on the match have been

included. The recommendations are to maintain the stipends at the level of the Southern Regional Average for recruitment of the highest quality future physicians, and to return to pre-Katrina levels and quality. Every year Louisiana's residency training programs must compete with others throughout the nation to recruit the young physicians through the matching program. This process is compromised each time the State of Louisiana allows the stipends for residents to drop lower than other states and institutions. The future overall plan for more physicians in Louisiana is revealed, and target goals are set.

The meetings of the Medical Education Commission were held on the following dates:

First Report Dates	Second Report Dates	Third Report Dates	Fourth Report Dates	
July 30, 1997	January 21, 1998	March 2, 1999	January 25, 2000	
August 27, 1997	February 10, 1998	May 6, 1999	March 29, 2000	
October 1, 1997	March 23, 1998	August 17, 1999	May 30, 2000	
November 19, 1997	June 9, 1998	September 28, 1999	August 22, 2000	
	July 30, 1998			
	August 26, 1998			
	September 30, 1998			
	November 4, 1998			
Fifth Report Dates	Sixth Report Dates	Seventh Report Dates	Eighth Report Dates	Ninth Report Dates
April 24, 2001	January 28, 2002	January 28, 2003	May 11, 2004	December 15, 2005*
July 12, 2001	July 22, 2002	July 29, 2003	September 27, 2004	June, 2006*
December 17, 2001	October 28, 2002	August 26, 2003	November 23, 2004	July 24, 2006
Tenth Report Dates	Eleventh Report Dates	Twelfth Report Dates		
September 6, 2007	October 6, 2008	April 6, 2009		
May 21, 2007	June 3, 2008	October 5, 2009		

*Telephone Conferences

MEDICAL EDUCATION COMMISSION

The Match

The success of the match in Louisiana this year 2009 is a sign of continuing resurgence of GME in LA after Katrina. The Medical Education Commission (MEC) therefore provides expanded and updated information on the details and importance of the events of the last six years, portraying the trends of GME in Louisiana as annually compiled by the MEC of filled positions.

THE MATCH DANCE

The national resident matching program (main match) for first year residents is the focal point for the annual cycle of recruitment and appointment in graduate medical education. Newly graduated physicians begin their residencies on July 1st each year, but budgetary and institutional commitment both precedes and follows this date. Decision as to the number of positions to be offered by the institution must be made in the spring of the preceding year; interviewing and recruitment occurs during the preceding summer and fall, and the institution makes a commitment about number of positions offered by October. The process begins in the senior year of medical school when each student officially signs up for the match, gathers information, visits, interviews, analyzes then enters the choices in priority order for open positions (slots) in an array of residency programs. Both institutions and applicants submit selection lists in February and the results are announced in March of each year. The institution has a binding commitment to provide a residency position for the trainee accepted for the entire three to seven years of Residency training depending on the specialty.

The match is an annual event, accomplished by a national computerized program, the National Residency Matching Program (NMRP), through a process of aligning each senior's prioritized list of choices to the ordered list of choices by institutions providing opportunities for residency positions. Several subspecialty matches also occur. A NMRP match signifies a contract of acceptance by both parties. The immediate results are recorded in NMRP publications including each position offered, filled and open. Some slots are filled outside the match programs. The array of applicants include not only U.S. medical school seniors, but also U.S. graduates from prior years who have delayed matching, international medical graduates (IMG'S, both U.S. nationals and foreign nationals), osteopathic graduates, and those seeking reentry into a new specialty, etc.

2009 RESULTS AND TRENDS

The results of the 2004 and 2009 matching processes are represented in the following tables and graphics: The offered residency positions in GME, PGY-1 and PGY-2, by GME programs in Louisiana show the number of matched and filled positions for the particular year. Pie charts depict institutional proportions on the match in 2009. Present numbers are equal to or better than the 10 year average.

The 2009 year after Katrina and Rita in 2005 showed continuing recovery, with some increases compared with past years; the PGY-2 deficit remains.

Total LA PGY-1 slots filled (436) after the scramble were back up. PGY-2 recruitment in the NMRP match was up 2, (17) for a grand total of 453 for 2009.

MEDICAL EDUCATION COMMISSION

The Match 2009

(continued)

The number of graduating seniors in Louisiana from the three medical schools increased to 407, drawing equal to past totals.

Of these 407 graduates, 167 were retained in GME slots in LA. Moreover, 269 additional USMG's and IMG's were recruited, similar to last year.

Of interest is that the PGY-1 places (about 436 slots) offered are now more than the number of senior graduates, and the graduating seniors leaving (242) are more than equally replaced (269) by recruitment of out-of-state medical graduates.

INTERSTATE KINETICS OF GME:

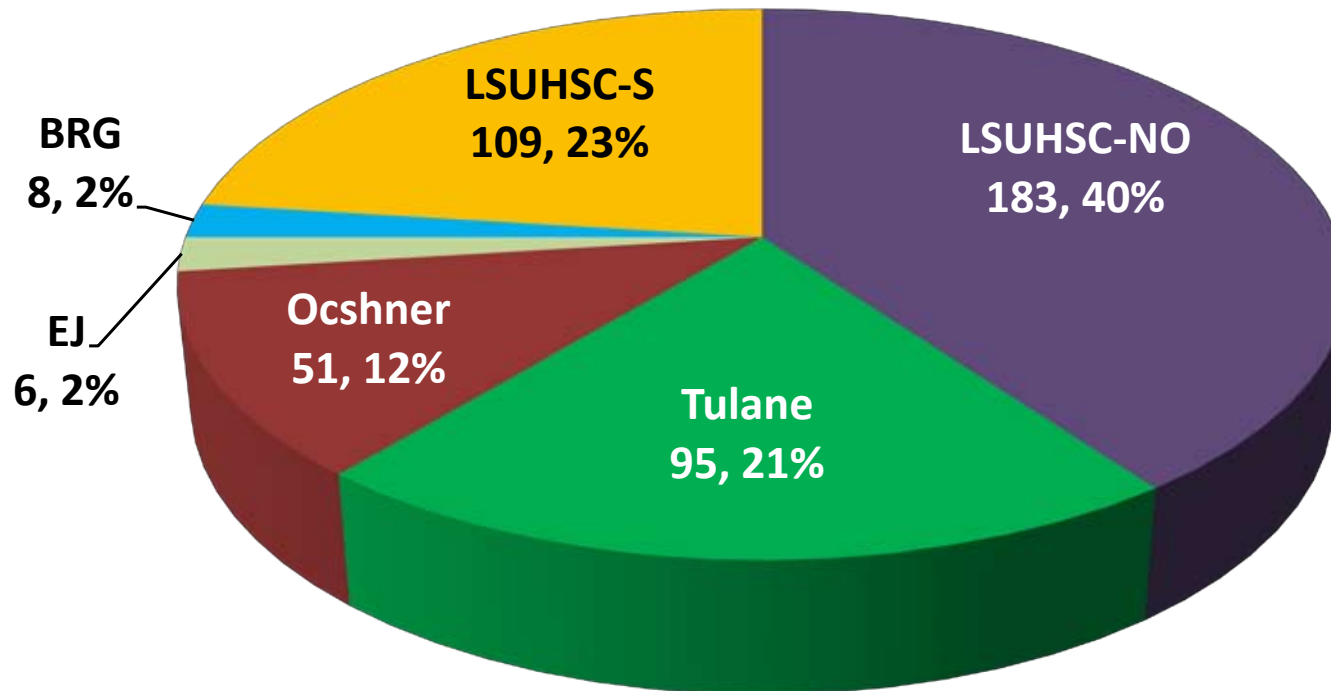
To reach a decision about the brain gain or brain drain in Louisiana, the following quantitative factors need to be considered:

- a) the number of medical school senior graduates per year (407)
- b) the number of these retained in LA for PGY-1 (167)
- c) the number of outside MD's recruited for PGY-1 (269)
- d) the number of retained after finishing GME in LA
- e) the number of those senior graduates who left later returning to practice
- f) the number of those finishing GME who later are returning to practice
- g) the retention of practicing physicians in Louisiana who stay for all or part of their practice span
- h) others that are uncounted or in other categories, i.e. VA, US Military, Public Health, etc.
- i) accounting for the kinetic mobility in each year as well as over several or many years

THE MATCH 2009

Medical Students	Program	First year Filled Positions (PGY-1)				Second Year filled Positions (PGY-2)		
	PGY-1	Quota 2009	Filled	Open	Total	Quota 2009	Filled	Open
152	LSUHSC-New Orleans	114	114	0	122	8	8	0
	Earl K. Long	34	33	0	34			
	UMC	16	16	0	16			
	Lake Charles	8	8	0	4			
	Bogalusa	4	3	1	3			
	<i>Subtotal</i>	176	175	1	183			
93	LSUHSC-Shreveport	92	90	2	93	3	3	0
	N. Caddo	2	2	0	2			
	E.A. Conway	7	7	0	8			
	Alexandria	6	6	0	6			
	<i>Subtotal</i>	108	106	2	109			
	LSUHSC TOTAL	284	281	3	292			
	Leonard J. Chaubert		5	0	5			
148	Private							
	Tulane	89	89	0	95	6	6	0
	Ochsner	51	51	0	51			0
	Baton Rouge General	4	4	0	4			
	East Jefferson	6	6	0	6			
	<i>Private Total</i>	150	150	0	156			
	PGY-1	439	436	0				
	PGY-2	17	17		↓	17	17	0
Total PGY-1 & PGY-2	456	453	3	453				

MATCH-FILLED POSITIONS 2009 PGY-1 AND PGY-2



Filled Total

***453**

***After Scramble numbers from Institutions**

Pie Chart I depicts the institutional slices and the percentages of the total NRMP Main Match. The numbers may increase slightly as programs add residents after the match and scramble. This 453 total is one fourth of the overall estimated GME; this proportion of match to total is typical of GME across the United States.

MATCH 2009 AFTER THE SCRAMBLE

Family Medicine – Louisiana

	Quota	Match	Scramble	Total
LSUNO	6	6	0	6
UMC	7	7	0	7
LAKE CHARLES	8	8	0	8
BOGALUSA	4	1	2	4
	<hr style="width: 100%; border: 0.5px solid black;"/> 25	<hr style="width: 100%; border: 0.5px solid black;"/> 22	<hr style="width: 100%; border: 0.5px solid black;"/> 2	<hr style="width: 100%; border: 0.5px solid black;"/> 25
LSU-SHR	5	5	0	5
FM – N. CADDO	2	1	1	2
EMS – FM	2	2	0	2
ALEX – RAPIDS	6	3	3	6
EAC	8	8	0	8
	<hr style="width: 100%; border: 0.5px solid black;"/> 23	<hr style="width: 100%; border: 0.5px solid black;"/> 19	<hr style="width: 100%; border: 0.5px solid black;"/> 4	<hr style="width: 100%; border: 0.5px solid black;"/> 23
LSU Combined	48	41	6	48
EJ	6	5	1	6
BRG	4	4	0	4
TOTAL	<hr style="width: 100%; border: 0.5px solid black;"/> 58	<hr style="width: 100%; border: 0.5px solid black;"/> 50	<hr style="width: 100%; border: 0.5px solid black;"/> 7	<hr style="width: 100%; border: 0.5px solid black;"/> 58

HOSPITAL/INSTITUTIONAL MATCH 2004-2009

PGY-1 AND PGY-2

SIX YEAR MATCH COHORTS SEQUENCE

Med. School Senior Grads.	Program	PGY-1						PGY-2						Total 2009	
		First Year Filled Positions						Second Year Filled Positions							
		2004	2005	2006	2007	2008	2009	Difference 05/09	2004	2005	2006	2007	2008	2009	2009
166	LSUHSC-New Orleans	128	113	101	106	112	114		13	13	5	5	5	8	122
	Earl K. Long	27	26	27	34	35	34								
	UMC	16	15	17	18	14	16								
	Lake Charles	5	6	6	5	4	8								
	Bogalusa						3								
	Subtotal	169	160	151	163	165	175	+15							183
104	LSUHSC-Shreveport	63	74	81	84	79	90		2	3	3	3	4	3	93
	N. Caddo	2	2	2	2	1	2								
	E.A. Conway	8	8	8	8	8	8								
	Alexandria	6	5	5	4	5	6								
	Subtotal	79	89	96	98	93	106	+17							109
	LSUHSC Total	248	249	247	261	258	281	+32	16	16	8	8	9	11	297
	Leonard J. Chaubert						5	+5							5
137	Private														
	Tulane	94	94	54	66	84	89		11	11	7	5	6	6	95
	Ochsner	47	47	52	48	50	51					2			
	Baton Rouge General	8	8	7	8	8	4								
	East Jefferson	6	6	8	6	6	6								
	Private Total	155	155	121	128	148	150	-5	11	11	7	7	6	6	156
	PGY-1	403	404	368	389	406	436	+32							
	PGY-2	26	27	15	15	15	17	-10	26	27	15	15	15	17	
	Total PGY-1 & PGY-2	429	431	383	404	421	453								453
407	Change from Prior Year		+2	-48	+21	+17	+32	+22		-1	-12	0	0	+2	

MEDICAL EDUCATION COMMISSION CONSIDERATIONS

MEDICINE PRELIMINARY PGY-1 MATCH DATA

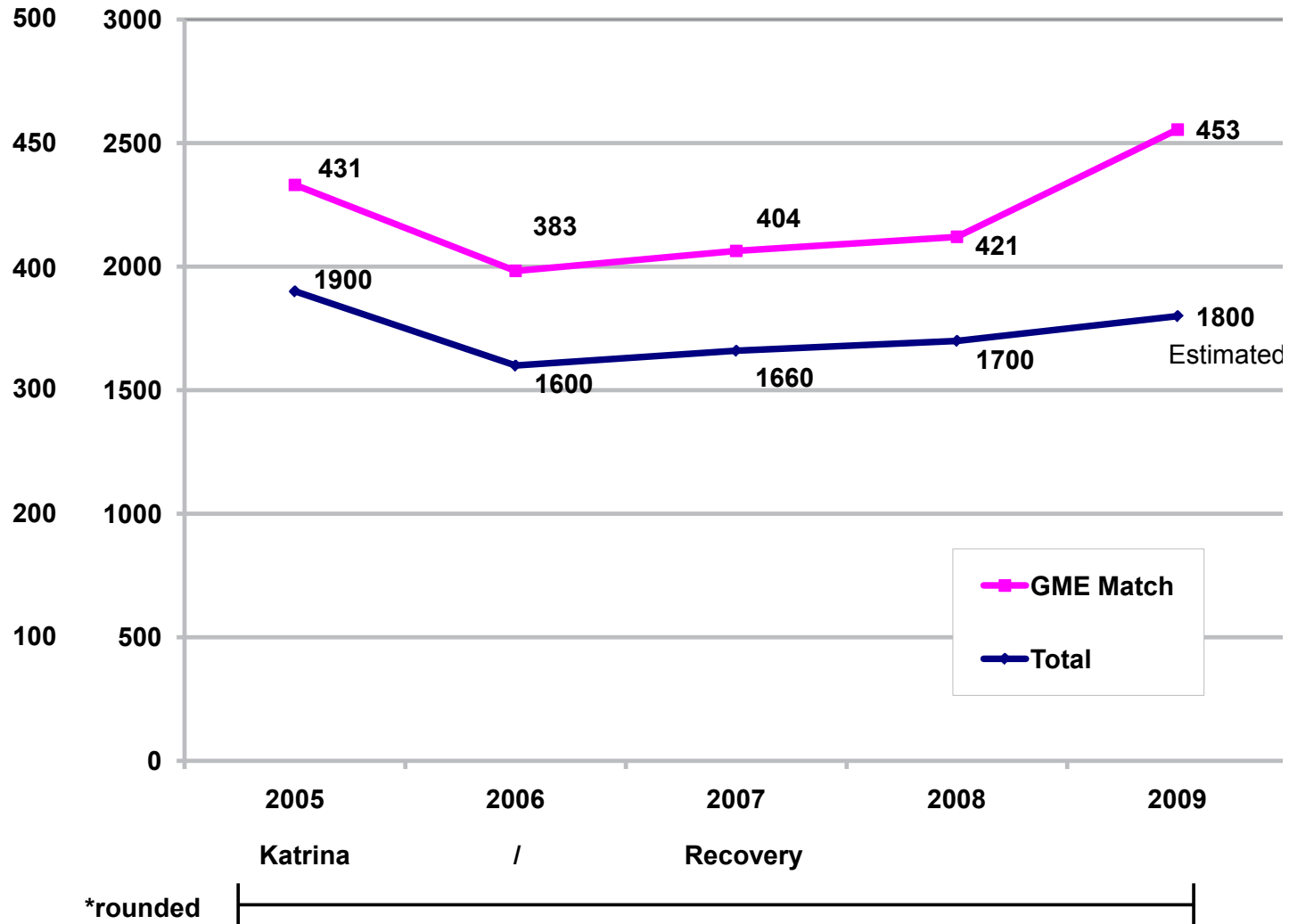
- Medicine preliminary (Med P) is about 2% of total GME in Louisiana (39 in the 2009 Match/1689 total 2008 = 2%)
- Med P is about 9.5% of total PGY-1 main Match 2009 39/410 = 9.5%
- Med P is a separate category in the NRMP Main Match but is included in Internal Medicine in PGY-1 rotations, data in hospital GME, various reports on FTE and stipends, etc.
- Most PGY-1 Med P enter non primary care specialties; some don't; for some it is a holding year to reapply or enter General Internal Medicine
- Pediatrics, where similar to Internal Medicine, with many categories, also has a number enter subspecialties; but has no preliminary category
- Med/Peds is recorded separately, usually, and generally included as a primary care specialty
- There are changes by house officers after the first year both ways, into primary care and out of primary care; similar changes also occur in practicing physicians
- Med P residents are in fact serving as primary care physicians during their PGY-1 experience
- GME in the US, about 106,000 physicians in training are a significant portion of all practicing physicians, 732,234; 14% including all primary care positions
- Senior medical students who seek highly competitive specialty positions may take a Med P position, later applying again not but also ending up in a primary care specialty
- A number of physicians now end up as hospitalists, a growing category especially of Internal Medicine residents. They are not in the match. Often these physicians have 3 years of primary care program training, similar to recognized programs in Internal Medicine, Family Medicine, Pediatrics
- Senior graduates may also enter programs of PGY-1 training, like transitional – leading to more GME; or like preventative medicine; or in combined programs like Family Medicine/Emergency Medicine or Medicine/Preventive Medicine.
- Many of these end up in primary care.

MEDICAL EDUCATION COMMISSION CONSIDERATIONS

(continued)

- OB/GYN was not originally included but later added to the primary care specialty by most groups. This was based on the fact that these physicians were often the first or only physicians seen by many women.
- Specialty matches do not include all specialties or all participants
- The distribution of physicians finishing GME is similar but with a number of differences from PGY-1 entrants; during the mobility and flux the net movement may favor subspecialties, but some go into primary care.
- These bullet points illustrate a complex system, characterized over year by variety, mobility in training, and geographic location.
- Including Med P in primary care (or not) in the match may overestimate or underestimate the sorting of physicians in training training (GME) into primary care or specialization. Over counting or undercounting is inevitable.
- These factors were discussed by the newly appointed Medical Education Committee at the outset (1997), and on the balance. Consensus was to include Med P in the Internal Medicine category, like other such named specialties.

GME AND MATCH



The graphic, GME and NRMP Main Match 2009, (Chart 1) shows the reduction after Katrina and the slow but progressive recovery over 4 years. The match of 453 is above the pre-Katrina number and the average over 10 years. The NRMP Main Match reflects only PGY-1 and PGY-2. The loss of fellows and other specialties was proportionately more than the traditional primary care residencies; and the recovery of fellowships and specialists is also slower. Some programs were lost completely, and these are taking the longest time to get back.

MATCH FILLED POSITIONS PGY-1 AND PGY-2

	2005		2006		2007		2008		2009	
LSUNO	173	40%	156	41%	168	42%	170	41%	183	40%
LSUSH	92	21%	99	26%	101	25%	97	23%	109	24%
L.J. CHAUBERT	5	1%								
TULANE	105	24%	61	16%	71	18%	90	21%	95	21%
OCHSNER	47	11%	52	14%	50	12%	50	12%	51	11%
BRG	8	2%	7	2%	8	2%	8	2%	4	1%
EJ	6	2%	8	2%	6	2%	6	2%	6	1%
	431	100%	383	100%	404	100%	421	100%	453	100%
YEAR'S CHANGE	Katrina Year		Net Loss – 48		Net Gain - +21		Net Gain - +17		Net Gain - +32	

MEDICAL MATCH TRENDS STATE OF LOUISIANA TOTALS

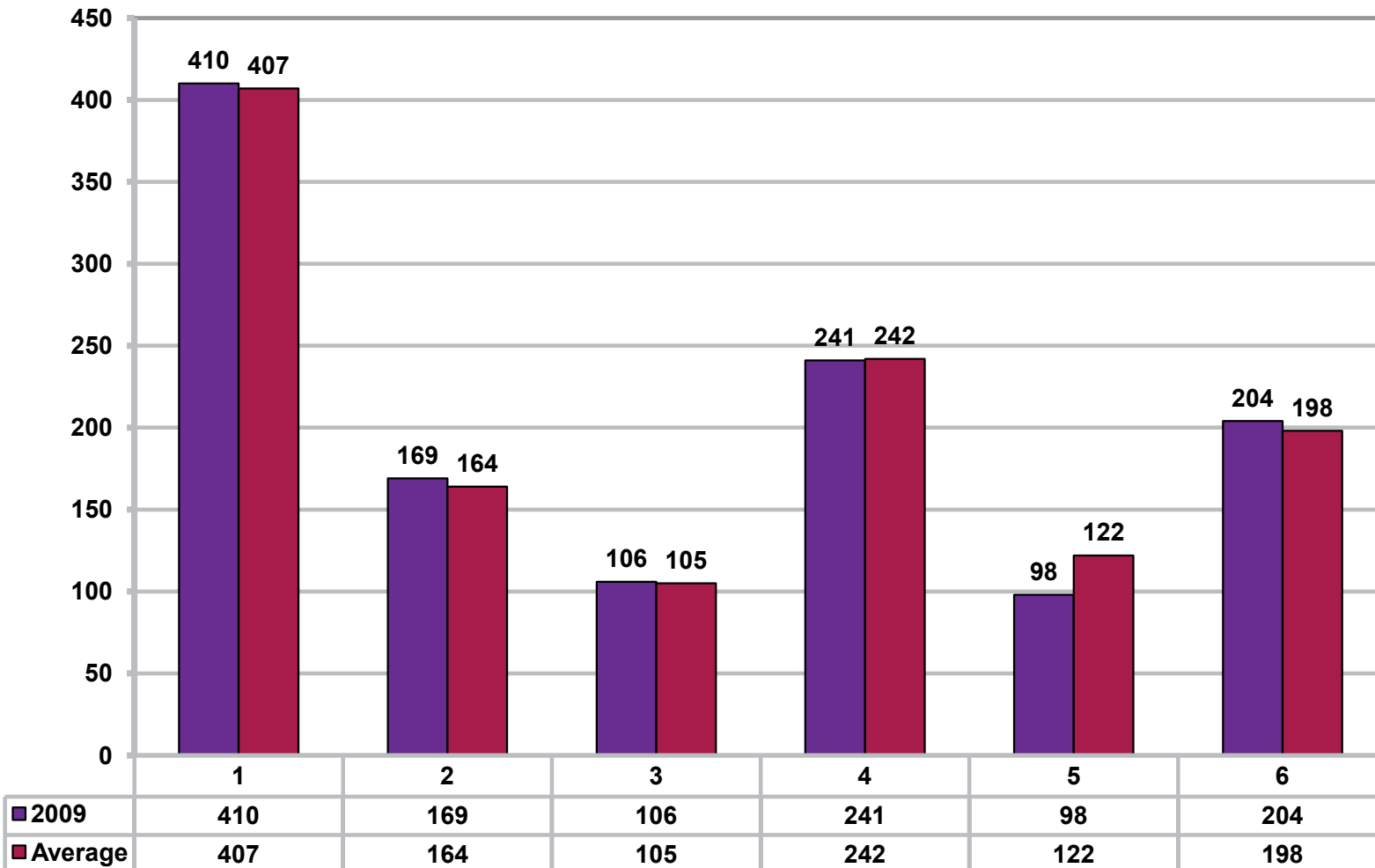
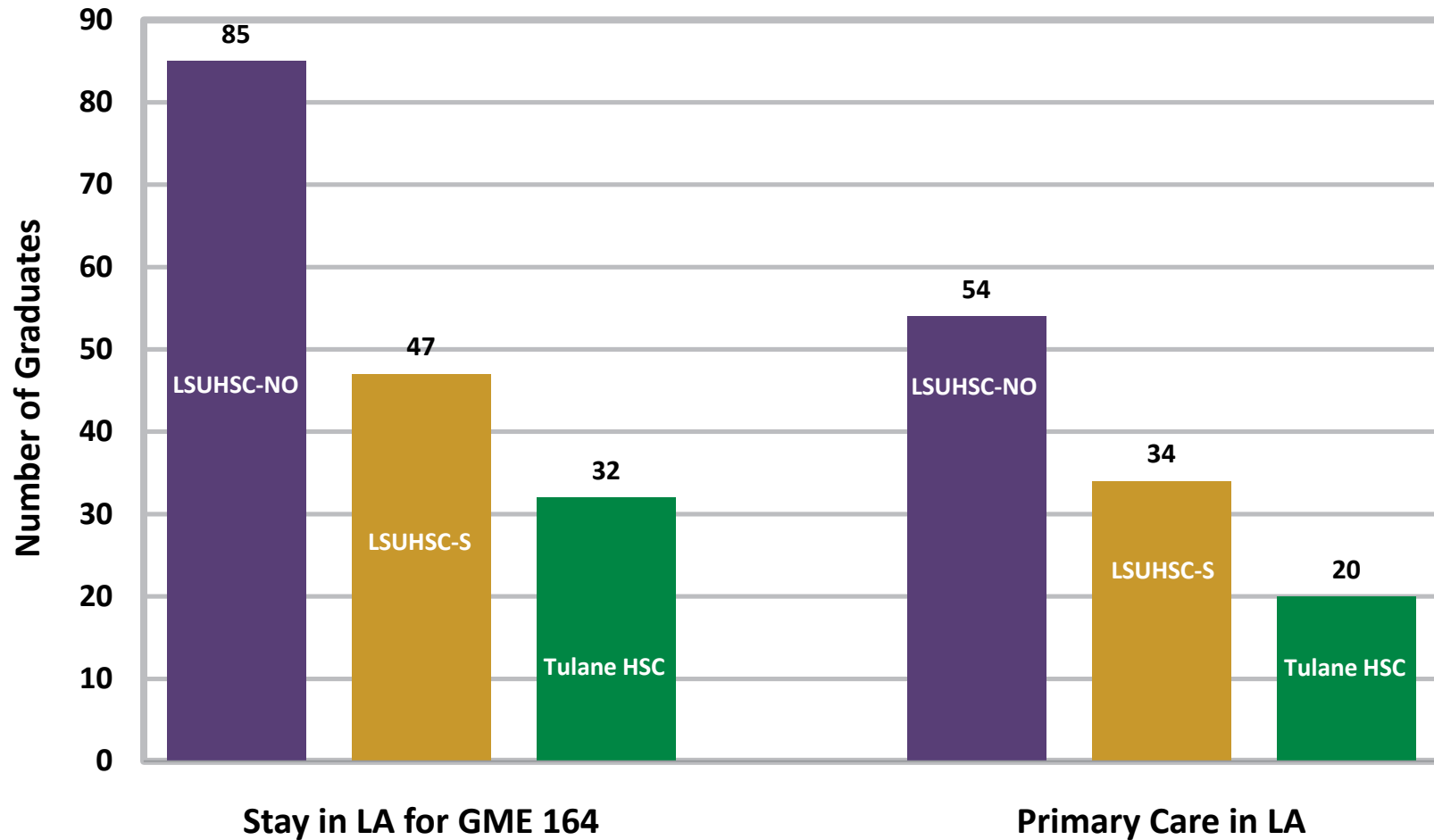


Chart II presents the 2009 medical school graduates compared to the 11 year average for all GME in Louisiana. The retention of senior graduates in Louisiana GME is right on the Louisiana average overall and in primary care, just now recovering to that level. Louisiana has traditionally had higher retention than other states. The number of outside physician candidates entering GME is increased, especially the last 2 years.

RETENTION OF GRADUATES IN LA FOR GME - 1999-2009 AVERAGE PER YEAR



The number of senior graduates retained by each of the medical schools is shown in Chart III, with total, and the average per year. The multiple over 11 year's times the average (11 x 164) indicates a considerable supply production – 1,804.

MEDICAL MATCH TRENDS LOUISIANA SENIOR GRADUATES

LOUISIANA TOTALS	# Total Graduates	Stay for GME in LA	Primary Care in LA	Leave LA for GME	Primary Care in US	Total Primary Care All
1999	379	183	107	196	82	189
2000	420	181	116	239	150	266
2001	404	154	96	250	139	235
2002	401	169	108	232	131	239
2003	407	159	93	248	132	225
2004	425	174	112	251	119	231
2005	409	177		232		
2006	417	147		267		
2007	394	145		249		
2008	395	143		252		
2009	410	169	106	241	98	204
Average	407	164	105	242	122	198

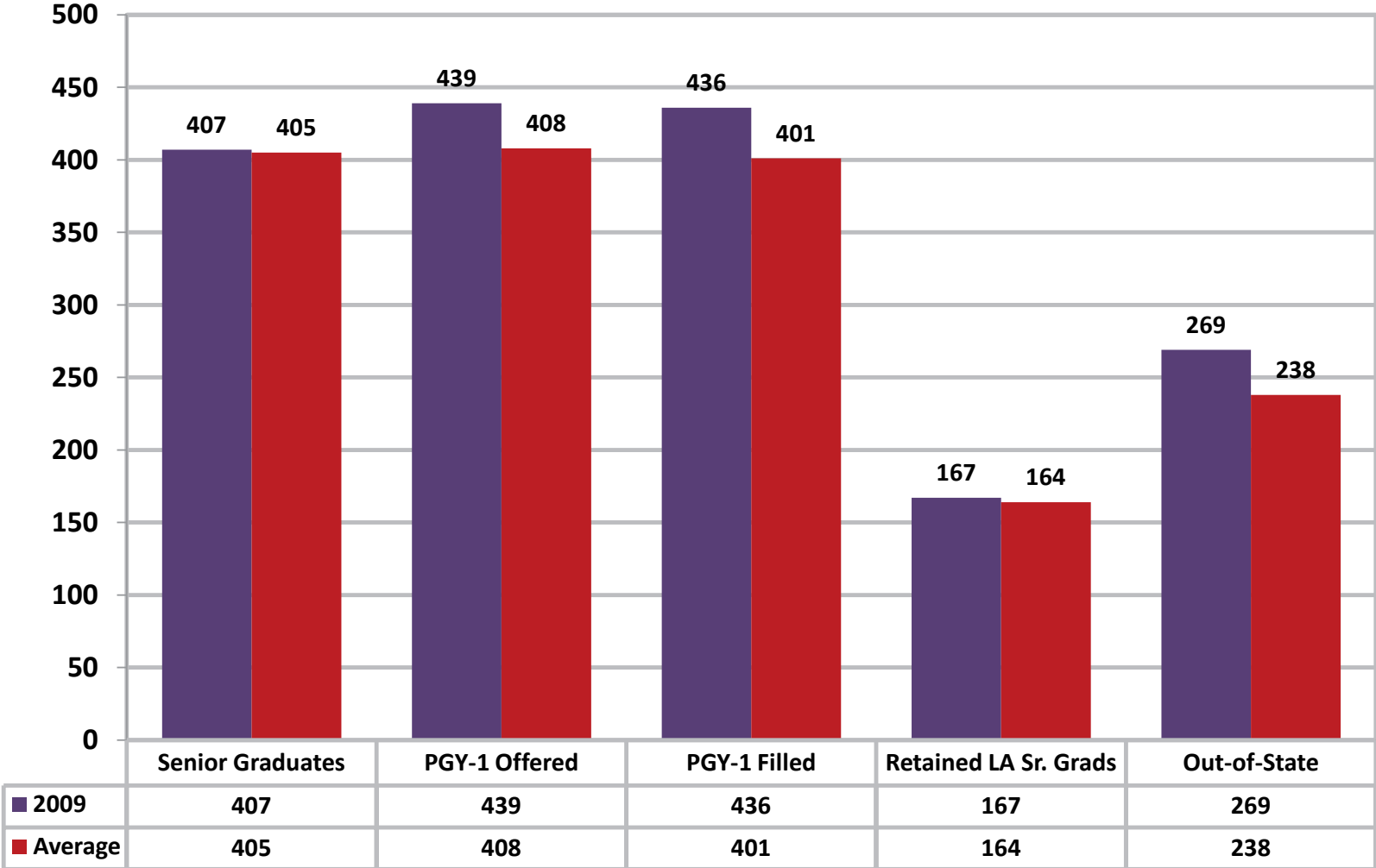
The number of senior graduates retained by each of the medical schools is shown in Chart III, with total, and the average per year. The multiple over 11 year's times the average (11 x 164) indicates a considerable supply production – 1,804.

MEDICAL MATCH TRENDS

(continued)

LOUISIANA TOTALS	# Total Graduates	Stay for GME in LA	Primary Care in LA	Leave LA for GME	Primary Care in US	Total Primary Care All
LSUHSC-NO						
1999	161	97	58	64	34	92
2000	177	100	67	77	52	119
2001	169	78	51	91	53	104
2002	166	93	57	73	42	99
2003	161	86	53	75	43	96
2004	176	94	50	82	37	87
2005	166	85	52	81	45	97
2006	172	76	57	96	51	108
2007	154	69	40	85	33	73
2008	152	75	38	77	42	80
2009	169	86	54	83	32	86
Average	166	85	254	80	42	96
LSUHSC-Shreveport						
1999	83	45	29	38	23	52
2000	97	49	34	48	32	66
2001	86	39	21	47	20	41
2002	90	41	28	49	28	56
2003	94	38	25	56	38	63
2004	98	47	36	51	28	64
2005	100	61	30	39	19	49
2006	92	49	49	43		
2007	92	49	49	43		
2008	93	48		45		
2009	104	52	34	52	21	55
Average	94	47	34	46	26	56
TULANE						
1999	135	41	20	94	25	45
2000	146	32	15	114	66	81
2001	149	37	24	112	66	90
2002	145	35	23	110	61	84
2003	152	35	15	117	51	66
2004	151	33	26	118	54	80
2005	143	31		112		
2006	153	25		128		
2007	148	27		121		
2008	150	20		130		
2009	137	31	18	106	45	63
Average	146	32	20	113	53	73

MATCH TRENDS IN LOUISIANA 2009 SENIOR GRADUATES AND PGY-1



SENIOR GRADUATES AND PGY-1

YEAR	<u>Senior Graduates</u>	<u>PGY-1 Offered</u>	<u>PGY-1 Filled</u>	<u>Louisiana Sr. Graduate</u>	<u>Out-of State</u>
1999	379	427	411	183	228
2000	420	418	404	181	223
2001	404	404	394	154	240
2002	401	396	384	169	215
2003	407	419	414	159	247
2004	425	407	403	174	229
2005	409	407	404	177	227
2006	417	370	368	147	221
2007	394	384	389	145	244
2008	395	413	406	143	270
2009	407	439	436	167	269
Average of 11 years	405	408	401	164	238
Total of 11 years	4458	4484	4413	1799	2613

Table III has been presented previously, now updated in 2009 including averages; and it shows the close correspondence between medical school seniors, PGY-1 offered, and PGY-1 filled. The out-of-state physicians recruited for residency are increasing, as the overall numbers go up.

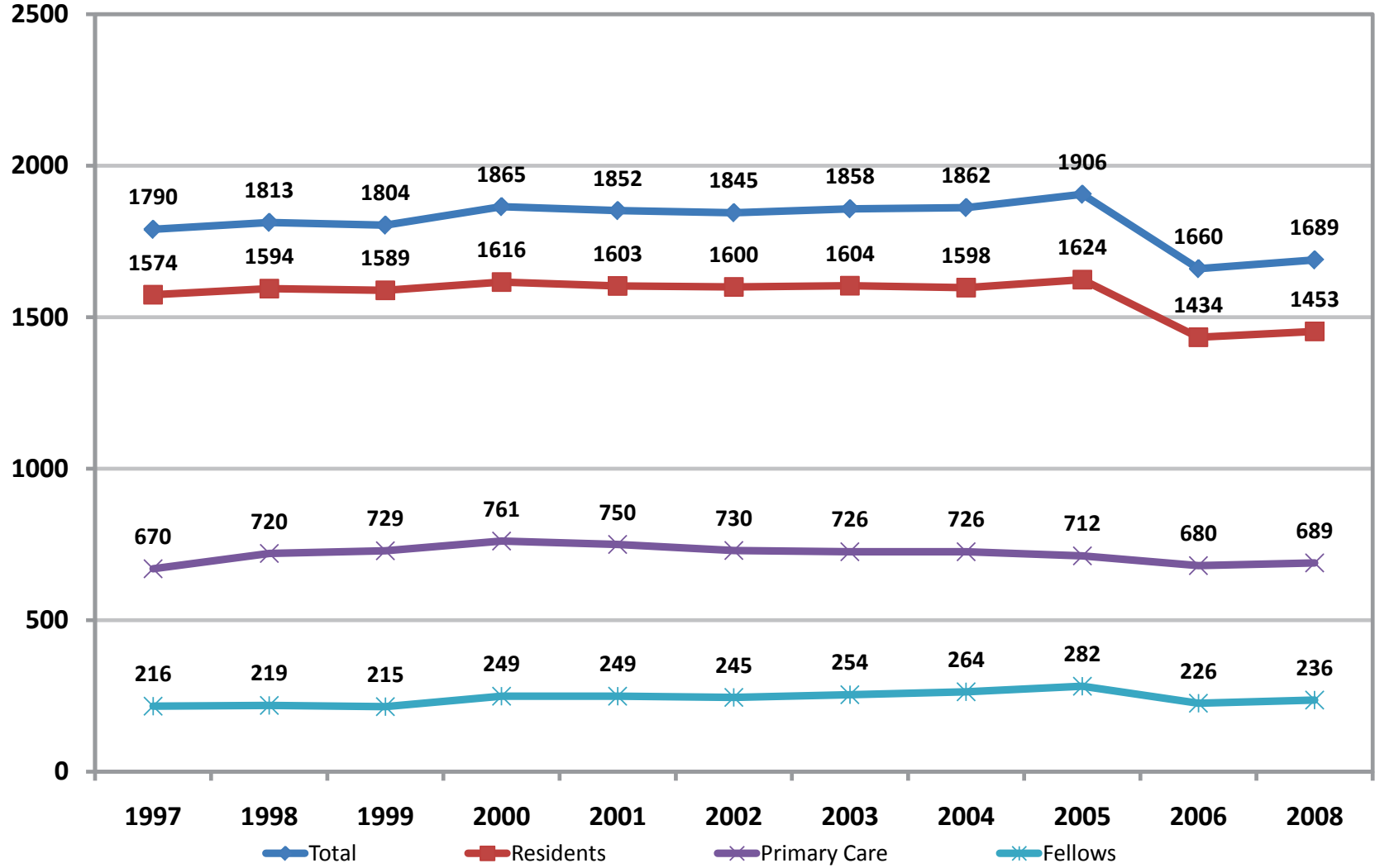
RETENTION AFTER TRAINING

The 70% retention figure is quoted as the proportion of physicians in practice educated in the state either from Louisiana medical schools or GME programs or both. This is confirmed again from data in the AAMC Data Book, 2009, pages 137-140.16 The step wise math is presented as follows:

Proof of Concept: 70% of Physicians in the State of Louisiana were trained either in Medical School or GME or both in Louisiana;

5,566	In state active physicians who graduated from Medical Schools in the State (Column C, pg 137)
+ 5,495	In state active physicians who completed residency in the state (Column C, pg 139)
11,061	Sum
- 9,642	Total active Physicians practicing in the state (Column B, pg 139)
1,419	those with both MD in-state and GME in-state
5,495	Med School
+ 1,419	only Residency
<hr/>	
6,914	Total from within LA of active physicians, Retention of 71%
71%	(6914 of 9642)

LOUISIANA GME TRENDS 1997 TO 2008



PRIMARY CARE

GRADUATE MEDICAL EDUCATION (GME)

The Medical Education Commission (MEC) is concerned about the Graduate Medical Education (GME) component in Primary Care training programs and the special attention in Louisiana on supplying the physician workforce in primary care. The Academic Medical Centers and teaching hospitals have played the key role in expanding Primary Care. As the largest state academic medical center, LSUHSC has strategically emphasized, over the last 10 years the recruitment and retention of primary care physicians. In addition, Tulane School of Medicine has appointed the First Chair in the New Department of Family Medicine. This trend has peaked, and partially receded, and the current efforts lead to a plateau, a new steady state. This effort is sustained, in concert with the academic medical community officials and providers, and with the cooperation of and benefit to the patients we serve.

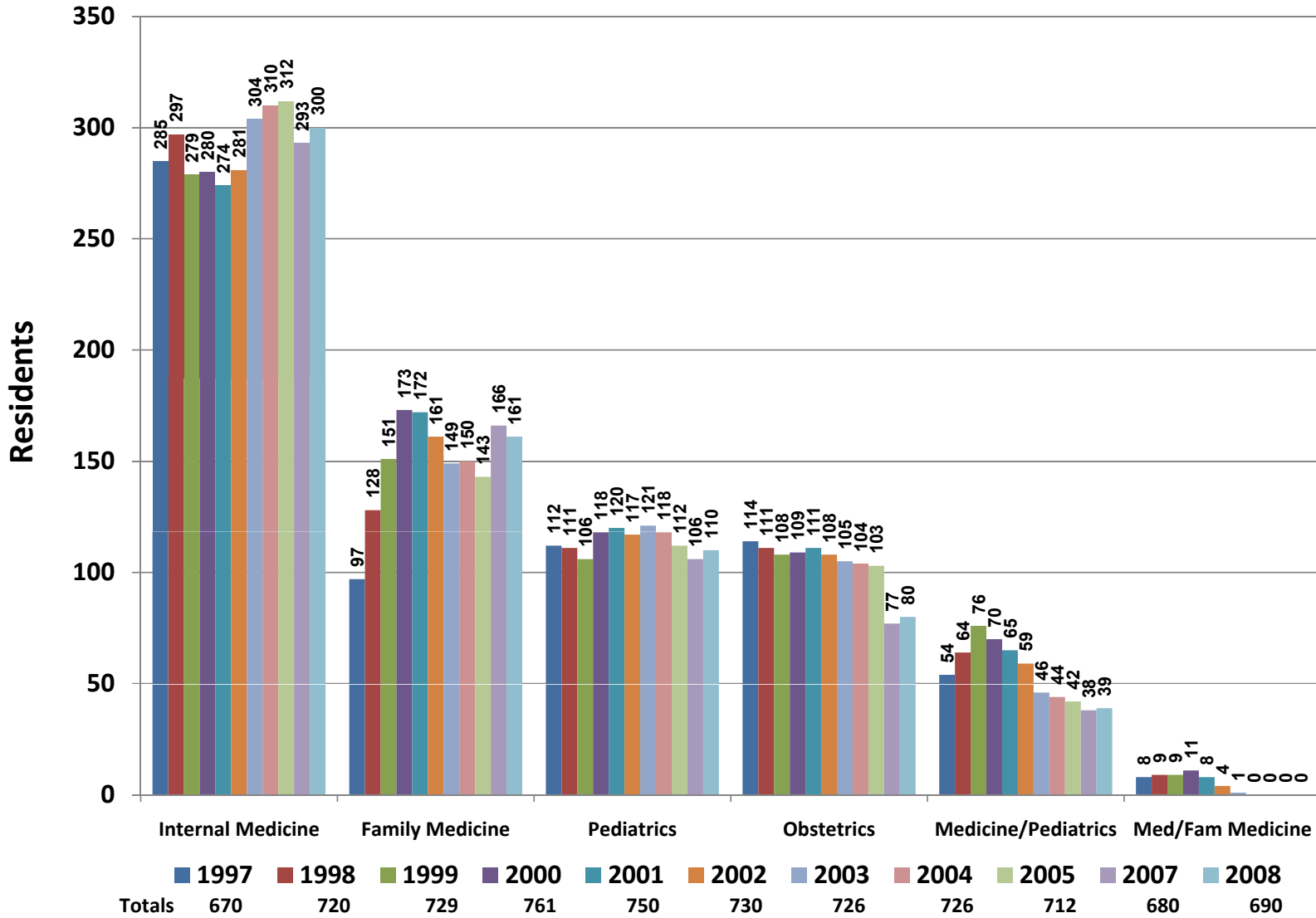
The results are comparatively better than many other states in the development of new GME primary care programs, increased numbers of primary care physician opportunities, retention of both graduating senior medical students and those finishing Primary Care GME programs, applicants by senior medical programs such as telemedicine and the AHEC (Area Health Education Center) initiative. These plans are substantial and appropriate to develop programs in Louisiana to meet the needs for more primary care physicians. Katrina has made this more difficult, and part of the recovery effort is addressed to reinvigorate Primary Care GME.

While General Internal Medicine, Pediatrics and Family Medicine have traditionally been considered to be primary care specialties, the definition of primary care is not simple. The distinctions are mixed in the patient care delivery process. Many specialties also deliver some primary care. The MEC has also included in primary care date the residents in Medicine-Pediatrics, Ob-Gyn and Internal Medicine/Family Practice as have some national databases.

Family Medicine GME is a well defined program, almost all graduates practice primary care, more than 90% go into practice, 75% of those finishing GME are retained in the state, and there has been expansion, leading to a new steady state.

The development of primary care GME in Internal Medicine and Pediatrics has been different, emphasizing improved recruitment to existing programs and career pathways. Med-Peds GME programs have been successfully begun at LSUMS-NO, LSUMS-Shreveport, and TUHSC. Generally now about 27% of trainees in Internal Medicine and 80% in Pediatrics enter a generalist practice, and most in Med-Peds. Physicians in Ob/Gyn usually do both primary and specialty care. The long pipeline for physician workforce production requires opportunity, recruitment, and sustenance. Primary Care GME programs assist recruitment in many ways into practice settings in Louisiana, where the initiative, work and interest is that of the communities.

GME PRIMARY CARE TRENDS 1997 TO 2008



THE NATURE OF KATRINA GME LOSSES, THE NURTURE OF RECOVERY AND RESTORATION

Medical institutions involved in GME education are by nature large, complex, and asymmetric, i.e. Academic Health Centers, Medical Schools and Teaching Hospitals. Asymmetry has many thesauric relatives, i.e. lopsided, imbalanced, irregular, uneven, unsteady, cockeyed, and disproportionate. This characterization is because of the expected and essential variations in the size of components, diverse specialties, each individual's education, experience, personal attributes, locations, environment and almost every difference up and down the line.

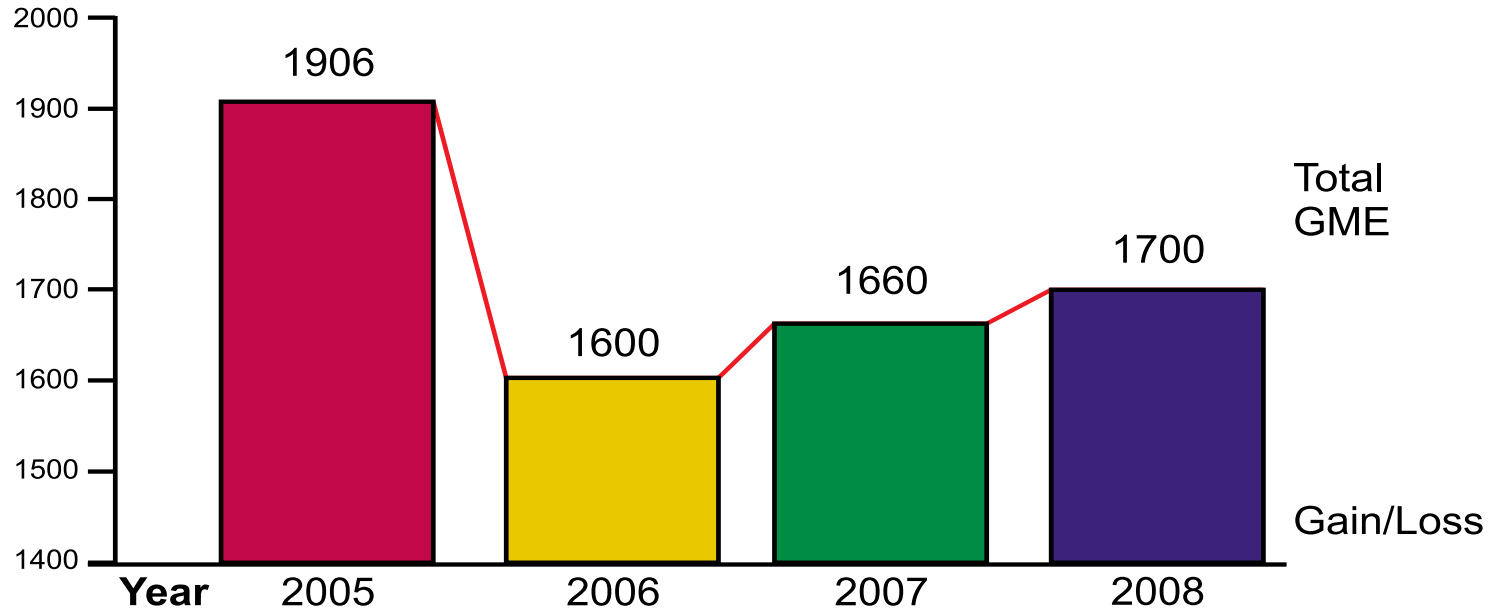
These institutions in overall, macro terms appear relatively stable, performing and adding tasks and service contributions, and are important for workforce production and community service and interaction. But inside, in micro terms, the institutions are seething with activity and change, discovery and transmission, endless varieties in complex arrays and patterns.

Katrina happened. The losses in GME, physicians, hospital beds, population from location, etc., are inevitable in its destructive path. The losses are asymmetric, unpredictable, related to the storm path and intensity and the nature of the institutions and locations affected. So the gross numbers of categorical losses represent the surface of deep variability. The asymmetric losses result in some whole programs lost, while others survive; some specialties depleted some less so.

The GME programs and institutions in Louisiana did a remarkable job; exhibiting leadership and tenacity in first responses, minimizing losses, shifting locations and priorities as needed; and posited a beginning recovery from what could have been a far worse collapse. The ongoing, now, progressing restoration of GME will have the difficult problem of the asymmetry in the nature of the institutions, the varieties in the losses, and the planning and implementation required to gain both macro and micro GME components.

The asymmetric nature of this complex arrangement, a system of education in Louisiana was not fully appreciated before Katrina, and the nature of growth in GME after Katrina needs to be recognized in its complexity. It will continue to take committed leaders and institutions, and informed and supportive advocates, to grow GME, with recovery and restoration.

STATE OF LOUISIANA GME KATRINA KINETICS 2005-2008



Hospitals

Hospital Type	2005	2006	2007	2008
Public Teaching	1120	700	750	800
Private Teaching	626	760	830	820
Veterans Admin.	160	140	80	80

*rounded

AMA** DATA PC&D

KATRINA CATEGORICAL LOSSES

AMA Category	2003	2004	2005	2006	2007
Total Physicians	12,878	<u>12,999</u>	12,650	12,643	<u>12,741</u>
*Total Patient Care	10,643	<u>10,809</u>	10,509	10,393	<u>10,410</u>
Office Based	8,046	<u>8,270</u>	8,266	8,087	<u>8,004</u>
*Resident /Fellows	1,852	<u>1,826</u>	1,554	1,540	<u>1,579</u>
Physician Staff	745	<u>713</u>	689	766	<u>827</u>
Administration	176	<u>158</u>	142	130	<u>129</u>
Medical Teaching	190	<u>189</u>	193	196	<u>189</u>
Research	114	<u>106</u>	107	97	<u>88</u>
Other	45	<u>40</u>	38	36	<u>37</u>
Not Classified	<u>736</u>	<u>596</u>	492	577	<u>634</u>
Inactive	<u>974</u>	<u>1,104</u>	1,169	1,214	<u>1,254</u>
*TPC - *GME					
GP/FM Prac	1,291	<u>1,313</u>	1,288	1,292	<u>1,302</u>
Res/Fel	151	<u>157</u>	143	160	<u>161</u>
Med Prac	3,841	<u>3,900</u>	3,805	3,788	<u>3,803</u>
Res/Fel	739	<u>733</u>	617	622	<u>644</u>
Surg. Specialty	2,798	<u>2,799</u>	2,687	2,629	<u>2,609</u>
Res/Fel	493	<u>454</u>	374	367	<u>378</u>
Other Specialty	2,713	<u>2,797</u>	2,729	2,684	<u>2,696</u>
Res/Fel	469	<u>482</u>	420	391	<u>396</u>

* Note: Resident/Fellows number is within Total Patient Care numbers

** Physician Characteristics and Distribution10-14

The collection of five consecutive years of AMA data depicts the pre and post Katrina changes in GME, and in physician numbers and types; these downs and ups reveal interesting trends and conclusions about the size of change and speed of restoration. (Table 1 Total GME is up slightly from the prior year as recover proceeds.

PARTNERSHIP IN LOUISIANA

The future of medical education in Louisiana is tied directly to that in the United States. The statistical comparisons of Louisiana to US physician education, before Katrina in both undergraduate and graduate medical education (GME), and physicians entering practice are closely aligned in most respects. These are the GME percent of physicians (14%), physicians per 100,000 (295), primary care proportion (34%), and other parameters. There is now an acute and growing scarcity of physicians in Louisiana. These parameters are changing constantly, and currently some restoration back-up to prior levels is beginning, although detailed objective data is scarce.

Seventy-nine percent (79%) of all residents and fellows are trained in the US Academic Health Center teaching hospitals, where 44% of all indigent care in the US is provided (safety net hospitals). In Louisiana in 2008, three medical schools (LSUHSC New Orleans, LSUHSC Shreveport, and Tulane) in three of the 125 US Academic Health Centers (AHC's) produce about 400 graduates per year. These three large AHC's entered about 352 of the 412 house officers (first year Interns) in Louisiana into their teaching hospitals, and the Alton Ochsner Clinic Foundation teaching hospital enters 47, for a total of 399, or 97% of the State GME.

In Louisiana compared to the US, virtually all of the AHC residents and fellows, as well as undergraduate students, have been trained in the public hospitals, 60% at any one time. This high proportion of total GME in public hospitals is not as prominent in other states. Thus, the closely linked and interwoven medical education while providing patient care model in the public hospitals, combined with rotation in private hospitals and the VA has worked well in producing physicians in the renewal of the workforce in Louisiana.

The private hospitals in New Orleans and Baton Rouge have responded post Katrina to increase their numbers in GME. Several have revised, increased and/or preserved GME programs for LSU School of Medicine in New Orleans and Tulane Medical School. Both private and public hospitals have come through to help those severely affected by Katrina, and have in fact increased as a group the types and numbers of GME as a cooperative venture.

PUBLIC/PRIVATE PARTNERSHIP

Consider the total Graduate Medical Education (GME) in the State (LA) as a system of education; necessary for each medical school graduate and the pipeline for recruitment of practicing physicians. As we in the Medical Education Commission (MEC) have previously reported and now wish to emphasize, this is a public/private partnership. The MEC has published the data on GME for 12 years, and this data has shown stability with very gradual increase; and then changed by – Katrina in 2005.

The graphs show what happened, insult, response, and recovery in the years '05 to '09. Although losses in GME were sustained by all programs in the New Orleans area, partially compensated by others, the public/private partnership survived, thrived, and was in fact demonstrably enhanced. All of the institutions with GME programs made crucial decisions in the aftermath of Katrina, and they cooperated with each other to preserve most of GME in the State. It was a four-way cooperation, asymmetric, complex, but balanced to result in some more GME in private hospitals, even though private institutions had their own program losses as well as did public institutions. The acute responses by all cooperating parties are very much appreciated, leading to ongoing prospects for continued systematic restoration of GME in Louisiana.

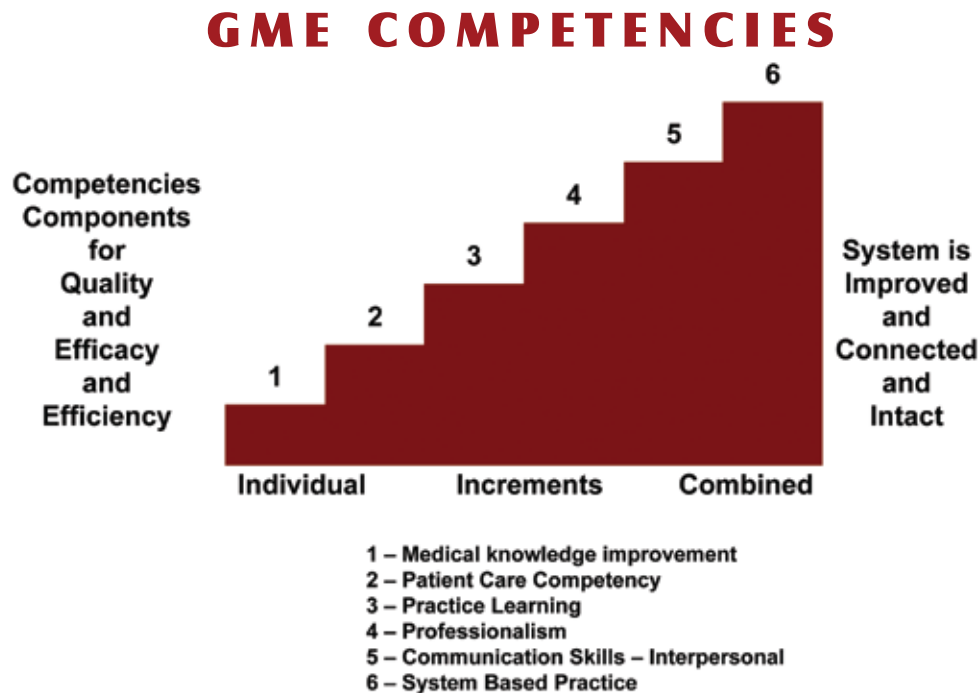
	Public	Private
Public	Yes	Yes
Private	Yes	Yes

Cooperation between Institutions and Hospitals

WHAT IS THE ROLE OF GME IN THE US HEALTH CARE SYSTEM?

GME is central in the supply of physicians, advanced education after medical school and before practice, a required accredited experience, and the chronologic place of specialty choices and mobility. This movement is a triple opportunity at the junction of (1) medical school senior: intern, (2) resident: fellow; and (3) finish GME: practice, with change in program or location of about 50% at each interface.

The total GME number in training in 2008 had increased to 108,176, from 99,964 in 2003, a gain of 8,212 over 5 years including all specialties in multi-array. This elevates the number per year by about 1,692, and rising. The ACGME has placed increasing emphasis on program accreditation details and educational compliance and evaluation; the introduction of the six competencies and their interrelationships are illustrated by Figure I. They are each presented in educational scenarios multiple times, in all years of GME training, and documented by various evaluation techniques. There is also an emphasis on evidence based medicine, when and where such evidence exists and can be assessed. While later outcomes are as yet untested, the crossover into practice of these educational pieces is a hope and anticipation.



What is the Role of GME in the US.doc

SUPPLY HAS STARTED UP

United States Medical Schools, encouraged by the AAMC and others to address the physician shortage, have collectively increased the number of medical students. Many schools have added students, and there are several new medical schools. There has been concern that Graduate Medical Education (GME) and especially Postgraduate Graduate Year One (PGY-1) slots will not be enough to accommodate the increase.

The number of International Medicine Graduates (IMG's) should remain the same if the medical school increases are to be effective.

The data published in JAMA, September 2009, the Medical Education issue, provides an insight as to how this is proceeded (See Table)

1. The total medical school increase so far (last 5 years) is about 791/year average, or 1.2% per year. (C)
2. The total GME increase so far (last 5 years) is about 1,642/year, or 1.6% per year. (G)
3. The PGY-1 increases are about 423 per year (last 5 years) or about 1.9% per year. (J)
4. The gap, or difference between PGY-1 slots and the average medical school class is steady – about 6,180 per year; these slots are filled by IMG's and others each year. (D)
 - 1a. Most of the increase is recent, and class size grows progressively; eventually the goal (AAMC) is that at least 5,000 more seniors will graduate per year and seek PGY-1 positions, a 30% increase.
 - 2a. The total GME now looks large, but includes all specialties, and there is steady but uneven increase last 5 years.
 - 3a. The PGY-1 increases are lower than needed in the long run – and are uneven over the last 3 years. The all PGY-1, '08 open slots are 25,987; so subtracting 23,759, the yearly filled number, indicates 2,228 left over. If filled, these would accommodate some of the proposed increases, mostly in primary care.

SUPPLY HAS STARTED UP
(continued)

The conclusion is that:

The number of medical students and first year residents are increasing, but the trends show that PGY-1 positions, and more total GME, are needed to accommodate the increasing medical student classes and maintain IMG's to successfully increase the supply of physicians in the US according to plan.

The present remaining open positions after the annual NRMP match are mostly in primary care, i.e. Family Medicine, Internal Medicine, Pediatrics, Ob-Gyn, and Med-Peds. The new positions being created i.e., by and expanding new medical schools also include a preponderance of primary care GME. The graduates will face increasing competition for the available specialty positions. Some will move into primary care, not necessarily their first choice. Since the physician shortage is and will be in both primary and specialty care, more GME positions in specialties will be necessary. As the number of PGY-1 open positions draws closer to the number of acceptable applicants, the spread of filled positions geographically will occur even more than now. More GME in the home state will help ameliorate some losses to other states at the GME level.

RECENT INCREASE IN MEDICAL STUDENTS IN US MEDICAL SCHOOLS AND IN GME THE GAIN, THE CAP, AND THE GAP*

Line	Name	2003-'04	'04-'05	'05-'06	'06-'07	'07-'08	'08-'09	Increase	Increase	Comment
A	Total # Medical Students	67,166	67,296	68,280	69,028	70,349	71,119	3,953	5.9%	Steady <u>Gain*</u>
B	# Added each year	-----	130	984	748	1,321	770	3,953		Start small
C	Avg. increment/yr		791/year 5 years =						1.2%/yr	About 20% of goal
D	**Total ÷ 4 (#/class)	16,791	16,824	17,070	17,257	17,587	17,780	989	5.9%	Formula is similar

E	GME total	99,964	101,291	103,106	104,897	106,012	108,176	8,212	8.1%	
F	# Added each yr	-----	1,327	1,815	1,773	1,333	2,164	8,212		Each year up but uneven
G	Avg. increment/yr		1,642/year for 5 years =						1.6%/yr	Remove <u>Cap*</u>
H	**GME total ÷ 4	24,991	25,323	25,777	26,220	26,503	27,044	2,053	8.2%	Approximation is close
I	PGY-1 No prior GME	22,444	22,788	23,325	23,587	23,759	24,560	2,116	3.6%	Filled positions
J	# Added each year		344	537	262	172	801	2,116		Need more
			+423/year for 5 years =						1.9%/yr	About 10% of goal

K	Gap for IMG's and others/yr	5,653	5,964	6,255	6,330	6,172				Must continue if full increase goal is met
			Average <u>Gap*</u> 6180 = steady/year							

* JAMA September 23, 2009, Vol. 302, No. 10

** JLSMS - The Yearly Cycle of Physician Supply: Use of a Simple Formula for Renewal – IN PRESS

The Medical Education Commission Report 2008-2009: Louisiana GME Plan is Tracking U.S. Averages - Submitted

THE GAIN, THE CAP, AND THE GAP* *(continued)*

The current picture, a snapshot of GME in Louisiana, can be superimposed on similar findings and averages of the United States. These pictures are in motion, always changing, creeping incrementally ahead. So Louisiana is like no other state, but tracks and trends with the nation; evolving, planning, and incorporating goals and implementation relating closely to the U.S.

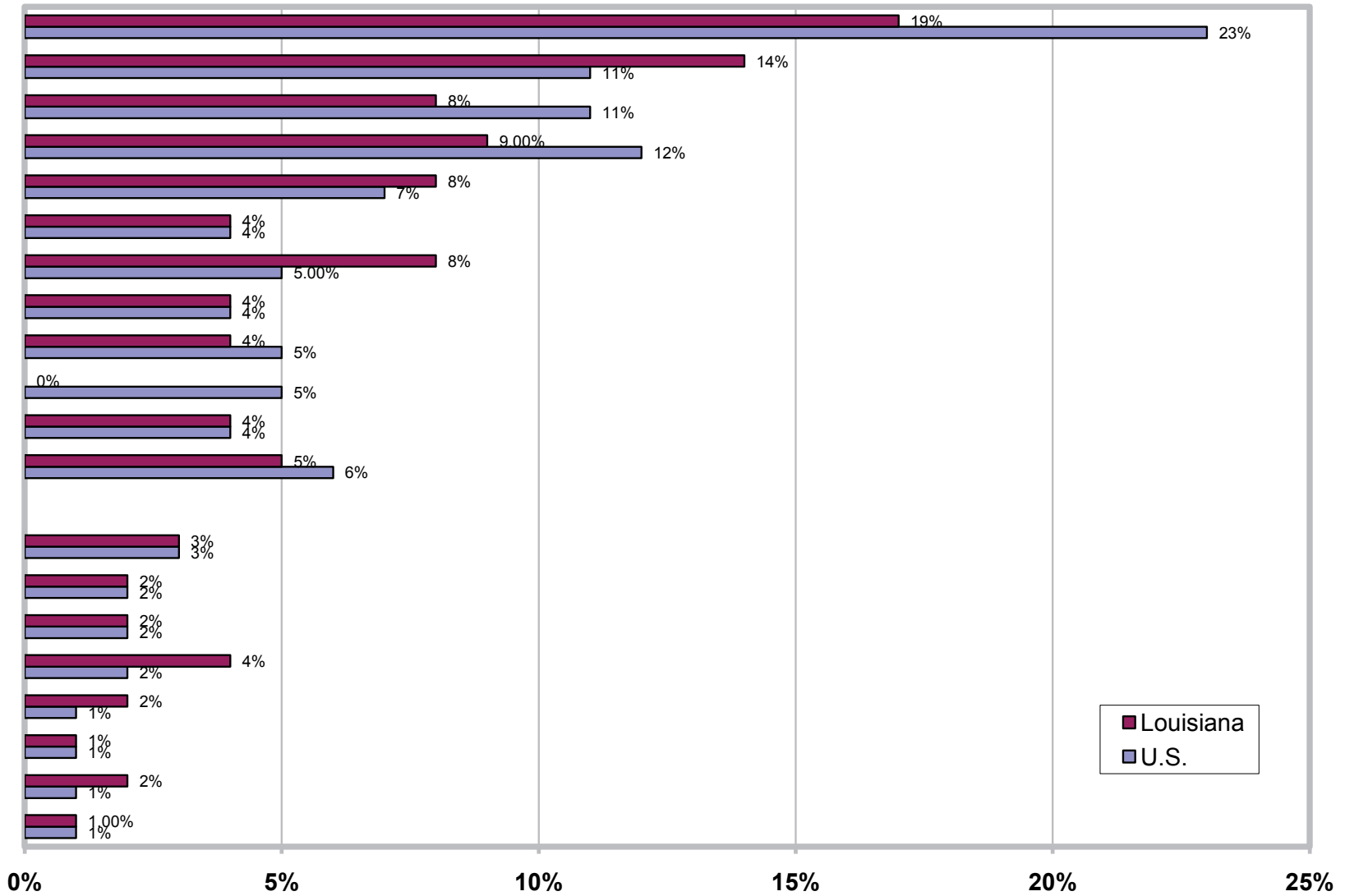
Why is this? There are many reasons; a few are that GME and Medical Education are national enterprises, moved in planned directions by strong institutions using accreditation, meetings and interaction, consensus, literature, and advocacy. The participants are quite mobile, and spread among institutions, bringing both change and similarity. This system works woven together in the private/public sector with authority and the responsibilities of American medical institutions.

Louisiana GME and physician numbers compare closely and proportionately to the United States numbers and averages. There is no set definition or agreed formula for physician supply; but it is meaningful to compare a state (LA) to the averages and proportions in the U.S. Louisiana has a similar supply of GME compared to the US, per population and per total physicians. The '08 NMRP National Main Match is published (latest graph available, similar in distribution to '09), and is compared to the '09 Louisiana match which is showing recovery after Katrina. LA numbers are after the scramble, percents are very close in all specialties. The number and the value to Louisiana of GME is proportionally the same as in the US, better since Louisiana retains more graduates proportionately than other states. LA has the same types of shortages in the same specialties as does the U.S., aggravated by Katrina.

Overall, in primary care, specialists, and other compartments, Louisiana matches up across the spectrum of GME; this pattern has evolved over considerable time with lots of input, evaluation and accreditation. Institutions change incrementally over time.

More specialists are needed as well as more in primary care, based on all the matches, and increasing shortages in the U.S.19-20 These patterns are consistent over time, and changes of magnitude take a long time frame period. (years – 5 to 10 or more) All programs across the country must be accredited and repeatedly evaluated, and must be competitive in recruiting and retaining residents and fellows.

DATA FROM THE MAIN NRMP MATCH COMPARING FILLED POSITIONS IN THE US (2008) AND LOUISIANA (2009)



KATRINA FOLLOW-UP

The effect of Katrina on Louisiana and especially New Orleans has been documented in the last several Medical Education Commission (MEC) reports. The basic GME and practice numbers are published and tracked in the MEC reports; an update to these findings is added. The recovery continues in the trend to return to prior levels in GME, faculty and physicians, but the restoration is not yet back or complete. The recovery should continue to “get back on track” so that the future shortages of physicians in LA and the US can be addressed from a stable base.

The shortage of physicians has been well documented, as previously reported and confirmed by national organizations; even more so for reform and awareness coverage. The AAMC has championed the proposal that US Medical Schools increase the class size by 5000 per year, as a major response to future supply requirements. This increase has begun, is about two thirds implemented in the beginning stages, and expected to be fully implemented by 2017. There must be a corresponding availability and/or expansion of GME to have a net gain of practicing physicians. The GME piece is very important, i.e. that is where specialty choices by graduating seniors and IMG's (International Medical Graduates) set the numbers and variety of specialists. The IMG's must be recruited in at least the same numbers and fill the various empty slots available to appreciate the overall increase in GME.

The two major events are perturbing and changing GME in LA and the US, interrupting the movement as well as the quantitative aspects of the system. The damage from Katrina was like a leak in the pipe, with patching and attempted restoration. The movement in medical school and GME expansion is a widening of the pipeline to enlarge the supply.

THE PLAN IS UNDERWAY

The plan for Louisiana GME, discovered by finding the numbers and trends on the same time and proportional scale as the United States averages, projects a parallel increase in physician supply related to the path of the United States. This direction and focus is planned and projected nationwide by the Association of American Medical Colleges (AAMC) to address the present and growing physician shortages of all types. It has begun, and is underway by medical institutions in many states.

The national increase in GME is 20,000 from 100,000 to 120,000, an increase of 20%. The national increase in PGY-1, adding 5,000 to current level is 27,000, 19%. This is now underway in both the U.S. and in Louisiana. These increases will be the sum of the plans of the institutions in the state that produce medical students and have GME. National legislation will be required to lift the GME cap.

Louisiana should restore the GME total to pre-Katrina levels, (1906) and increase to meet the expected and planned U.S. increase. The graph base data shows the Louisiana GME plan to recovery and the U.S. track, adding 400 GME to 2100.

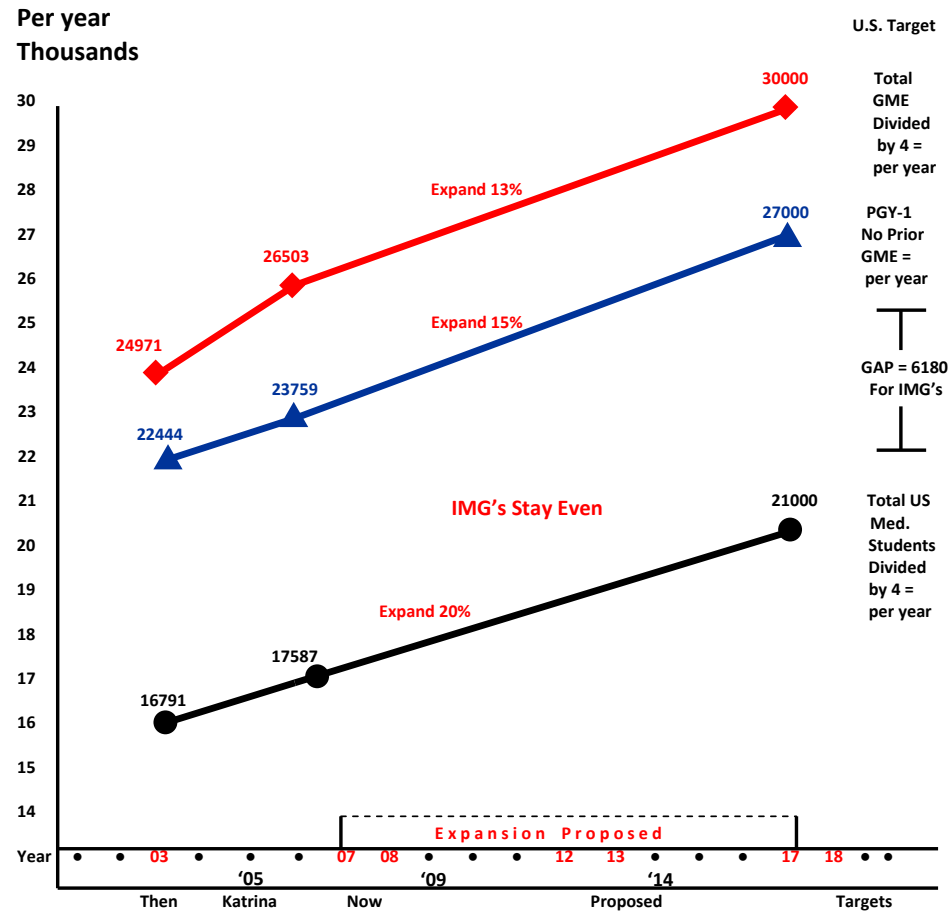
The early results are encouraging, if the agreed goal is more physicians for the State of Louisiana (LA). The medical schools in LA, all three, have expanded the number of students per class. LSU in New Orleans has added a rural track in medical school, above the usual 170 per year, based in Lafayette after basic sciences in New Orleans. Eventually this offers 20 to 30 additional per year, with an obligation to practice in LA. Tulane has increased class size after Katrina, to a new high of 185, an increase of about 35. LSU in Shreveport has enlarged to 118, a 10% increase. Ochsner is starting a Medical School in Australia, basic science 2 years in Brisbane, and the students taught their last 2 years in New Orleans. New Residency programs have begun in Bogalusa in Family Medicine and at Chaubert in Internal Medicine.

This will help meet the AAMC objective of 5000 additional graduating US senior applicants per year to GME. GME must go up accordingly. GME in Louisiana is recovering from Katrina; the line graphic depicts the actual and projected growth of medical students and GME in the U.S., and data at the base show how it corresponds with Louisiana's track. This plan has begun; it correlates and supports efforts by institutions, programs, agencies, commissions, governments and national organizations. The plan is to address the issues likely in reform approaches as well as post-K recovery.

THE LOUISIANA MEDICAL SCHOOLS INCREASES PER YEAR

	2005	2008	2011
LSU-NO	170	190	200
LSU-SH	100	110	118
TULANE	150	178	185
OCHSNER	0	0	120
SUM	420	478	623

THE PARALLEL RISE IN GME AND MEDICAL STUDENTS IN U.S. MEDICAL SCHOOLS PROJECTED LOUISIANA TRACK NUMBERS PROPOSED



U.S. Totals			<u>Totals</u>	<u>Expand in 10 yrs</u>
Med. Stud.	67,000	70,000	84,000	30% from 64,000
GME.	100,000	107,000	120,000	19% from 100,000
LA Total				
Med. Stud.	1,600	1,600	2,400	50% from 1,600
Seniors		400/yr	600/yr	
GME.	1,860	1,700	2,100	24% from 1700
PGY-1		435/yr	525/yr	

STRATEGIC PLAN FOR PHYSICIAN SUPPLY IN LOUISIANA

- 1985-2009: The planning and decisions for medical education were institutionally based (medical schools and teaching hospitals) progressing incrementally just as in the same ways, proportions and norms as the United States.
- 1997-2005: The supply of physicians and the total number was increasing in the same proportions and at the same rate as the averages and norms of the United States.
- 2005-2009: Katrina and Rita hit hard at the medical education institutions, and they just now have proceeded to return to the former average numbers of graduating senior medical students and PGY-1 match filled slots in GME.
- 2009: Shortages in all physician specialties and categories are present and are predicted to get worse.
- 2009-2014: To increase the supply on track with the United States (AAMC plans). The number of medical students in Louisiana per class will climb to 600 graduates per year from 400 currently.
- 2009-2017: To increase the supply in graduate medical education (GME) the number of slots should be increased to 1900 to match the 2005 pre-K level, and add 200 more to track the United States path expected by 2017.
- This strategy based on institutional initiatives will bring Louisiana back on track with the United States in State Physician Supply, for the variety of physician categories and coverage's needed, as much as possible in this time frame. The state number in practice has started back up again after Katrina and Rita.

LSU SCHOOL OF DENTISTRY (LSUSD)

ORAL AND MAXILLOFACIAL SURGERY (OMFS) RESIDENT AND GENERAL PRACTICE RESIDENT (GPR) ACTIVITIES FALL 2009

ORAL AND MAXILLOFACIAL SURGERY RESIDENCY

There are currently 21 residents in the 6 year Oral and Maxillofacial Surgery (OMFS) – MD residency which accepts 4 dentists each year, **there is 1 resident in the 4 year, non-MD track** and there are 6 non-categorical interns in a one year OMS program. They are funded by MCLANO (University Hospital) in New Orleans, Earl K. Long Memorial Hospital in Baton Rouge, and the University OMS at Charlotte North Carolina. Education/surgery experience for the residents occurs at LSU School of Dentistry, LSU School of Medicine, and East Jefferson Hospital in Metairie, Children's Hospital in New Orleans, and the Williamson Clinic in Baton Rouge. The OMFS patient care provides experiences in Facial Trauma, Temporomandibular Joint Reconstruction (TMJ), Orthognathic and Cranial Facial Surgery, Oral and Maxillofacial Pathology and Reconstruction, and Dental Implants is at or exceeding the Commission on Dental Accreditation (CODA) requirements.

GENERAL PRACTICE RESIDENCY

The General Practice Residency (GPR) program consists of 11 one year residents, 2 residents in the optional second year and 1 fellow that receive funding from MCLANO in New Orleans; Earl K. Long Medical Center, Baton Rouge; Leonard J. Chabert Medical Center, Houma; Northlake Supports and Services Center, Hammond; Pinecrest Supports and Services Center, Pineville; Greater New Orleans Supports and Services Center, Gretna. The primary clinics are at LSU Interim Hospital (University Hospital) and LSUHSC School of Dentistry's Baton Rouge's LSU South Campus (affiliated with Earl K. Long Medical Center). Our patients consist largely of medically compromised patients referred by medical/surgical residencies for dental clearance prior to treatment; alveolar trauma patients in conjunction with OMFS (implants, TMJ Disorders patients, cancer/pathology and trauma patients). In addition, our fellows work in outpatient clinics for Neurodevelopmental/Intellectually Disabled patients at the state developmental centers with support from our other residents. Numbers at MCLANO are increasing but limited due to limited chairs; however, we are reaching more patients at our new clinics in Baton Rouge, Houma, Hammond and Pineville.

MCLANO CLINIC – The OMFS/GPR Dental Clinic at MCLANO in New Orleans is currently housed in the East wing on the fourth floor. There are 8 chairs: 2 sedation rooms shared by both services; 2 have portable delivery systems for GPR and hygiene; 4 OMFS rooms and 1 shared by both services depending on schedule. There is also a functioning lab for basic work, a digital panorex, and two education rooms. Construction has begun on a much larger (5000 sq ft) interim clinic with projected opening in the spring of 2010.

2009: The clinic will have 14 rooms: 5 plumbed and wired for GPR/hygiene; 7 for OMFS and 2 surgical rooms with attached recovery area. In addition, there will be a fully functional lab for our Certified Dental Technician (CDT), conference room with distant learning capabilities; residents and faculty rooms wired for IT and lockers; and lounge, storage, etc. This clinic will be located outside the University Hospital on the Perdido Street entrance and will be connected to the hospital with internal access. Clinic numbers for both services are improving daily but are hampered by lack of clinical space.

EARL K. LONG CLINIC - In Baton Rouge, Earl K. Long Hospital OMFS Clinic has been transferred to an ambulatory clinic at the Vista Surgery Center for OMFS/GPR to support residency programs with outpatient surgeries, consults and ambulatory procedures such as facial deformities and dental implants and other “elective” surgeries. Resident support in Baton Rouge is gained and monitored by LSU Faculty through the offices of OMFS Hornsby, Regan, Casadaban, and Towns. Dr. Jack Kent assumed the direction of the OMFS residents in Baton Rouge in September 2009.

THE LOUISIANA STATE UNIVERSITY – HEALTH CARE SERVICES DIVISION

The LSU-Health Care Services Division (LSU-HCSD) operates seven of Louisiana’s state public hospitals. It serves as the medical home for over 600,000 Louisianians, providing inpatient, outpatient, and emergency services to the un- and under-insured.

In accordance with LA Revised Statutes 17:1519.4 B, the mission of the LSU-HCSD is: (1) To provide access to high quality medical care for patients; (2) Develop medical and clinical manpower through accredited residency and other health education programs; (3) Operate efficiently and cost effectively; and (4) Work cooperatively with other health care providers and agencies to improve health outcomes.

The goals of LSU-HCSD reflect the acronym “TRRAQSS”: Teaching, Research, Revenue, Access, Quality, Service, and Stakeholders. Relative to Teaching, LSU-HCSD provides an adequate infrastructure and supportive environment for teaching and learning. Relative to Research, LSU-HCSD continues generating new knowledge and technology through research and scholarly activities to enhance the well-being of the state’s population and economic status. Relative to Revenue, LSU-HCSD maintains an efficient and effective administrative structure necessary to accomplish its mission. Relative to Access to Patient Care, LSU-HCSD continues the implementation of appropriate, effective, and compassionate care that is accessible, affordable, and culturally sensitive and that will serve as a model for others in Louisiana and across the country. Relative to Quality, LSU-HCSD continues to serve as a valued partner in providing clinical care of the highest quality outcomes conforming to evidence-based standards, in settings that support the mission. Relative to Service, LSU-HCSD meets and exceeds the standards of customer service with internal and external partners and constituencies to advance excellence in healthcare. Relative to Stakeholders, LSUHCSD provides opportunities and resources for continuous improvement of workforce and fosters cooperation and communication among stakeholders.

Prior to Hurricane Katrina in August 2005, in State Fiscal Year 2005 the LSU-HCSD hospital system with its 350 clinics and 1,000 staffed beds provided 40,000 medical/surgical admissions, 6,000 psychiatric admissions, 850,000 clinic visits, and 400,000 emergency visits. Within its facilities the LSU-HCSD trained 1,200 medical residents and fellows and 4,000 nurses and allied health professionals. All of these accomplishments were made possible with 8,000 employees and an approximate budget of \$850 million, with 74 percent of this amount federal funding through the Medicaid and Medicaid-Disproportionate Share Program.

After Hurricane Katrina the LSU-HCSD medical centers completed State Fiscal Year 2006 with 175 clinics and 600 staffed beds, and provided 25,000 medical/surgical admissions, 4,000 psychiatric admissions, 684,000 clinic visits, and 287,000 emergency visits—all with a budget of \$711 million (76% of this amount being Medicaid and Medicaid-DSH) and 5,700 employees. With Katrina rendering the Medical Center of Louisiana

LSU – HEALTH CARE SERVICES DIVISION
(continued)

at New Orleans vastly destroyed, the LSU-HCSD trained fewer health professionals -- approximately 700 medical residents and fellows and 2,000 nurses and allied health professionals.

Although the Reverend Avery C. Alexander Charity Hospital campus remains permanently closed, the LSU-HCSD medical centers continue their rebirth post-Katrina. In November 2006, the LSU Interim Hospital (LSU IH) in New Orleans, formerly known as the University Hospital campus, opened after extensive restoration and repair to hurricane wind and flood damage. On June 30, 2008, the LSU IH had been restored to 213 acute care staffed beds and 39 psychiatric beds, the psych beds off-campus at DePaul Hospital. In addition to its usual array of ambulatory services -- women's services, general medicine, HIV services, and sub-specialty services-- the LSU IH now operates 6 neighborhood primary care clinics.

The following table portrays the pre- and post-Katrina statistics for the LSU-HCSD:

PORTRAYS THE PRE- AND POST-KATRINA STATISTICS FOR THE HCSD

	FY Pre-K 2005	FY Post-K 2006	FY Post-K 2007	FY Post-K 2008
Hospitals	8	7	8	7
Staffed Beds	964	600	600	707
Med/Surg Admissions	40,000	25,000	26,000	31,947
Psych Admissions	5,500	4,000	3,500	3,556
Clinic Visits	850,000	684,000	603,000	658,656
Emergency Visits	365,000	287,000	270,000	303,655
Education Med				
Residents & Fellows	775	Not Available	380	
Employees	8,000	5,236	5,375	6,342
Budget	\$ 850,544,672 82% Medicaid & DSH	\$ 723,617,126 75% Medicaid & DSH	\$ 765,813,001 73% Medicaid & DSH	\$ 856,531,363 70% Medicaid & DSH

The following are the LSU HCSD hospitals for this reporting period:

Leonard J. Chabert Medical Center, Houma
 University Medical Center, Lafayette
 W. O. Moss Medical Center, Lake Charles
 Interim LSU Public Hospital, New Orleans

Earl K. Long Medical Center, Baton Rouge
 Lallie Kemp Medical Center, Independence
 Bogalusa Medical Center, Bogalusa

Notes: Huey P. Long Medical Center, Pineville, previously part of LSU-HCSD, was transferred to LSUHSC-Shreveport, effective July 1, 2008. "DSH" means Medicaid-Disproportionate Share funding

TABLE NOTES

Louisiana State University, Tulane University, Alton Ochsner Clinic Foundation, Baton Rouge General, and East Jefferson hospital were the five institutions providing graduate medical education. The data in the following tables are from these five institutions and cover the period of fiscal 2008 (July 1, 2007 through June 30, 2008).

TERMINOLOGY

RESIDENT is used in this document to refer to a participant in a formal program of graduate medical education leading to initial certification in a specialty or to a participant in a program of postgraduate medical education which is prerequisite for entry into a program leading to initial certification (transitional year programs). Intern refers to a first year resident.

FELLOW is used to refer to a physician who has completed the requirements of a program leading to initial certification in a specialty and who is participating in a program of graduate medical education in a subspecialty of the discipline. Most of these programs lead to certification in a subspecialty of a discipline (e.g. cardiology, maternal and fetal medicine) but in some instances the primary certifying body has not yet developed programs of certification in the sub-discipline (e.g. retinal disease, cutaneous micrographic surgery). Specialties considered primary care are in italics; see separate section on Primary Care GME regarding definitions.

METHOD

The MEC method on data collection annually is to begin with submission of GME filled positions for the last full year by the academic medical institution. The number of filled positions is identified by institution, program (e.g. LSUHSC/EKL, LSUHSC/UMC) PGY level, specialty and/or subspecialty and assignment (hospital). The numbers are rolled up into summaries for additional presentation to indicate totals and percentages.

These tables are cycled to each institution for correction and the MEC group to finally agree on the presentations. The institutions, hospitals and totals in columns as designated on each page can be cross-referenced.

INSTITUTION ABBREVIATIONS

AOMC	—————	ALTON OCHSNER MEDICAL FOUNDATION, NEW ORLEANS
AOMC	—————	ALTON OCHSNER MEDICAL FOUNDATION, NEW ORLEANS
BRG	—————	BATON ROUGE GENERAL MEDICAL CENTER, BATON ROUGE
CHILD	—————	CHILDREN’S HOSPITAL, NEW ORLEANS, LA
EAC	—————	E.A. CONWAY MEDICAL CENTER, MONROE, LA
EJEFF	—————	EAST JEFFERSON GENERAL HOSPITAL, METAIRIE, LA
EKL	—————	EARL K. LONG MEDICAL CENTER, BATON ROUGE, LA
HPL	—————	HUEY P. LONG MEDICAL CENTER, PINEVILLE, LA
LC	—————	LAKE CHARLES MEMORIAL HOSPITAL, LAKE CHARLES, LA
LSUSHR	—————	LSU HEALTH SCIENCES CENTER-UNIVERSITY HOSPITAL, SHREVEPORT, LA
RAPIDES	—————	RAPIDES REGIONAL MEDICAL CENTER, ALEXANDRIA, LA
OBVA	—————	OVERTON BROOKS VETERANS AFFAIRS MEDICAL CENTER, SHREVEPORT, LA
OLOL	—————	OUR LADY OF THE LAKE REGIONAL MEDICAL CENTER, SHREVEPORT, LA
MCLANO	—————	MEDICAL CENTER OF LOUISIANA AT NEW ORLEANS, LA
NO	—————	NORTH OAKS MEDICAL CENTER, HAMMOND, LA
TOURO	—————	TOURO INFIRMARY, NEW ORLEANS, LA
TUHSC	—————	TULANE UNIVERSITY HEALTH SCIENCES CENTER, NEW ORLEANS, LA
VAB	—————	VETERANS AFFAIRS MEDICAL CENTER, BILOXI, MS
VANO	—————	VETERANS AFFAIRS MEDICAL CENTER, NEW ORLEANS, LA
WK	—————	WILLIS-KNIGHTON MEDICAL CENTER, SHREVEPORT, LA

MEC STIPEND STRATEGY

The Medical Education Commission has established as a major financial priority, ongoing and each year, the recommendation to increase GME stipends. This principle is to stay current and meet or exceed the COTH Southern Regional Average. The purpose is for the continuing recruitment and retention of the best and brightest current applications for the institutions and HCSD GME programs to fulfill the workforce and workload requirements as the lifeblood of future commitments for GME in Louisiana.

The data sheet, comparing Resident Pay Scales to COTH Survey Data, depicts the history, current, and potential proposed stipend increase to 2009-2010. The parallel and sequential columns show the PGY 1-6 data from prior years.

The average % change is compared by inspection for the MEC scale and the COTH Southern Regional Average. The proposed 3% increase per year is obviously conservative.

The timing should be emphasized. The target amounts for PGY-1-6 are an appropriate starting point for calculations and adjustments. The funds to be recommended and to be established for budget proposals will be calculated after July 1, 2009, when this years GME numbers and schedules are available.

Since the stipend increases are proposed for the year following, 2009-2010, this continuity depends on the usual, now reasonably established, conservative assumptions on recruitment, matching, appointments, and finance.

COMPARING RESIDENT PAY SCALES TO AAMC SURVEY DATA UPDATED 9/5/07

Medical Education Commission Scale											\$	%
<u>PGY</u>	<u>2003-04</u>	<u>2004-05</u>	<u>2005-06</u>	<u>2006-07</u>	<u>2007-08</u>	<u>2008-09</u>	<u>2003-04 to</u>	<u>2003-04 to</u>	<u>Average</u>	<u>Proposed</u>	<u>Over/Under</u>	<u>Over/Under</u>
							<u>2008-09</u>	<u>2007-08</u>	<u>Annual</u>		<u>2009-10</u>	<u>Estimated</u>
							<u>\$ Change</u>	<u>% Change</u>	<u>% Change</u>		<u>2009-10</u>	<u>2009-10</u>
											<u>AAMC</u>	<u>AAMC</u>
1	\$ 36,413	\$ 36,413	\$ 38,598	\$40,528	\$42,757	\$44,168	\$7,755	21.30%	4.26%	\$ 45,802	\$110	0.25%
2	\$ 37,484	\$ 37,484	\$ 39,733	\$41,720	\$44,015	\$45,467	\$7,983	21.30%	4.26%	\$ 47,149	\$47	0.10%
3	\$ 38,852	\$ 38,852	\$ 41,183	\$43,242	\$45,620	\$47,125	\$8,273	21.29%	4.26%	\$ 48,869	\$200	0.42%
4	\$ 40,422	\$ 40,422	\$ 42,847	\$44,989	\$47,463	\$49,029	\$8,607	21.29%	4.26%	\$ 50,843	\$374	0.77%
5	\$ 41,815	\$ 41,815	\$ 44,324	\$46,540	\$49,100	\$50,720	\$8,905	21.30%	4.26%	\$ 52,597	\$84	0.17%
6	\$ 43,643	\$ 43,643	\$ 46,262	\$48,575	\$51,247	\$52,938	\$9,295	21.30%	4.26%	\$ 54,897	\$321	0.61%

AAMC Southern Regional Average												
<u>PGY</u>	<u>2002-03</u>	<u>2003-04</u>	<u>2004-05</u>	<u>2005-06</u>	<u>2006-07</u>	<u>2007-08</u>	<u>2002-03 to</u>	<u>2002-03 to</u>	<u>Average</u>	<u>Estimated</u>	<u>Estimated</u>	
							<u>2006-07</u>	<u>2006-07</u>	<u>Annual</u>			
							<u>\$ Change</u>	<u>% Change</u>	<u>% Change</u>	<u>2008-09</u>	<u>2009-10</u>	
1	\$ 36,387	\$ 36,405	\$ 38,341	\$ 39,707	\$ 41,468	\$ 42,687	\$ 6,300	17.31%	3.46%	\$ 44,164	\$ 45,692	
2	\$ 37,559	\$ 37,626	\$ 39,541	\$ 40,945	\$ 42,825	\$ 44,022	\$ 6,463	17.21%	3.44%	\$ 45,536	\$ 47,102	
3	\$ 38,905	\$ 39,069	\$ 41,024	\$ 42,522	\$ 44,473	\$ 45,521	\$ 6,616	17.01%	3.40%	\$ 47,069	\$ 48,669	
4	\$ 40,421	\$ 40,570	\$ 42,463	\$ 43,857	\$ 45,981	\$ 47,232	\$ 6,811	16.85%	3.37%	\$ 48,824	\$ 50,469	
5	\$ 42,132	\$ 42,359	\$ 44,076	\$ 45,382	\$ 47,521	\$ 49,174	\$ 7,042	16.71%	3.34%	\$ 50,816	\$ 52,513	
6	\$ 43,881	\$ 44,242	\$ 45,787	\$ 47,223	\$ 49,422	\$ 51,134	\$ 7,253	16.53%	3.31%	\$ 52,827	\$ 54,576	

1. The AAMC regional averages are available through 2007-08. Table 4, Weighted Mean Housestaff Stipends by Region is used from the AAMC Survey of Housestaff Stipends, Benefits and Funding, Autumn 2007.

2. The AAMC averages for 2008-09 and 2009-10 are estimated by adding the average increase from 2002-03 to 2007-08 to the 2007-08 regional average.

3. We are proposing an increase of 3.7% to keep pace with the projected weighted mean housestaff stipend for the Southern Region in FY 2009-10.

PROPOSED 2009-2010 HOUSE OFFICER STIPEND

Title	Count	2008-09		2009-10		\$ Difference	% Difference	Annual Cost	Fringe	Total Cost
		Current LSUHSC Stipend Level	2008-09 AAMC Southern Region Medical School Median	Proposed LSUHSC Stipend Level	2009-10 Proposed LSUHSC Stipend Level					
House Officer 1	198	\$ 44,168	\$ 44,168	\$ 44,168	\$ 44,168	\$ -	0.00%	\$ -	\$ -	\$ -
House Officer 2	173	\$ 45,467	\$ 45,500	\$ 45,500	\$ 45,500	\$ 33	0.07%	\$ 5,709	\$ 902	\$ 6,611
House Officer 3	156	\$ 47,125	\$ 47,179	\$ 47,179	\$ 47,179	\$ 54	0.11%	\$ 8,424	\$ 1,331	\$ 9,755
House Officer 4	97	\$ 49,029	\$ 48,950	\$ 49,029	\$ 49,029	\$ -	0.00%	\$ -	\$ -	\$ -
House Officer 5	47	\$ 50,720	\$ 50,636	\$ 50,720	\$ 50,720	\$ -	0.00%	\$ -	\$ -	\$ -
House Officer 6	26	\$ 52,938	\$ 52,547	\$ 52,938	\$ 52,938	\$ -	0.00%	\$ -	\$ -	\$ -
House Officer 7	2	\$ 52,938	n/a	\$ 52,938	\$ 52,938	\$ -	0.00%	\$ -	\$ -	\$ -
	699							\$ 14,133	\$ 2,233	\$ 16,366

1. Where our current stipend level is the same or higher than the AAMC Southern Region Median Stipend for Medical School affiliated residency programs, no change is proposed in the stipend amount, (House Officer levels 1, 4, 5, 6 and 7).

2. Only our current stipend amounts for House Officer levels 2 and 3 are below the AAMC Southern Region Median Stipend for Medical School affiliated residency programs.

3. Specific AAMC data is not available for fellows at various levels, (Fellow 1, 2 and 3). However, we currently pay fellows at levels that approximate the house officer pay scale. Most House Officer 8/Fellow 1's are paid at the House Officer 4 level, most House Officer 9/Fellow 2 are paid at the House Officer 5 level and all House Officer 10/Fellow 3's are paid at the House Officer 6 level.

4. The AAMC Southern Regional Median for Residency Programs affiliated with Medical Schools was used by LSUHSC Shreveport as a benchmark in their recent increase in stipends.

Small increases were approved for House Officer 2's and 3's. The intent was to bring their stipend levels up to the AAMC Southern Regional Median for Residency Programs Affiliated with a Medical School. This addresses a concern related to House Officers on an H1-B visa. All other levels are at or above the AAMC Southern Regional Median for Residency Programs Affiliated with a Medical School. A broader increase was not possible due to budget reductions.

HISTORICAL MEC STIPEND LEVELS

	HO I	HO II	HO III	HO IV	HO V	HO VI
1979-80	\$13,193	\$13,941	\$14,680	\$15,433	\$16,106	\$ -
1980-81	\$14,097	\$14,891	\$15,716	\$16,593	\$17,273	\$ -
1981-82	\$15,024	\$15,804	\$16,695	\$17,520	\$18,475	\$ -
1982-83	\$16,866	\$17,807	\$18,716	\$19,656	\$20,457	\$20,932
1983-84	\$16,866	\$17,807	\$18,716	\$19,656	\$20,457	\$20,932
1984-85	\$16,866	\$17,807	\$18,716	\$19,656	\$20,457	\$20,932
1985-86	\$16,866	\$17,807	\$18,716	\$19,656	\$20,457	\$20,932
1986-87	\$17,709	\$18,697	\$19,652	\$20,639	\$21,480	\$21,979
1987-88	\$17,709	\$18,697	\$19,652	\$20,639	\$21,480	\$21,979
1988-89	\$20,507	\$21,651	\$22,757	\$23,900	\$24,874	\$25,452
1989-90	\$21,327	\$22,517	\$23,667	\$24,856	\$25,869	\$26,470
1990-91	\$21,385	\$22,579	\$23,732	\$24,926	\$25,941	\$26,543
1991-92	\$28,070	\$27,240	\$28,427	\$29,598	\$30,833	\$31,693
1992-93	\$28,000	\$29,000	\$30,000	\$31,000	\$32,000	\$33,000
1993-94	\$29,120	\$30,160	\$31,220	\$32,240	\$33,280	\$34,320
1994-95	\$29,877	\$30,944	\$32,032	\$33,078	\$34,145	\$35,212
1995-96	\$29,877	\$30,944	\$32,032	\$33,078	\$34,145	\$35,212
1996-97	\$29,877	\$30,944	\$32,032	\$33,078	\$34,145	\$35,212
1997-98	\$31,045	\$32,133	\$33,379	\$34,803	\$36,092	\$37,614
1998-99	\$33,132	\$34,107	\$35,352	\$36,781	\$38,048	\$39,712
1999-00	\$33,351	\$34,332	\$35,585	\$37,024	\$38,299	\$39,974
2000-01	\$35,352	\$36,392	\$37,720	\$39,245	\$40,597	\$42,372
2001-02	\$36,413	\$37,484	\$38,852	\$40,422	\$41,815	\$43,643
2002-03	\$36,413	\$37,484	\$38,852	\$40,422	\$41,815	\$43,643
2003-04	\$36,413	\$37,484	\$38,852	\$40,422	\$41,815	\$43,643
2004-05	\$36,413	\$37,484	\$38,852	\$40,422	\$41,815	\$43,643
2005-06	\$38,598	\$39,733	\$41,183	\$42,847	\$44,324	\$46,262
2006-07	\$40,528	\$41,720	\$43,242	\$44,989	\$46,540	\$48,575
2007-08	\$42,757	\$44,015	\$45,620	\$47,463	\$49,100	\$51,247
2008-09	\$44,168	\$45,467	\$47,125	\$49,029	\$50,720	\$52,938
2009-10	\$44,168	\$45,500	\$47,179	\$49,029	\$50,720	\$52,938

*Does not reflect fellow stipends

MEDICAL EDUCATION COMMISSION RECOMMENDATIONS

The Medical Education Commission has been formed to make reports and recommendations on Graduate Medical Education (GME), the post M.D. residents and fellows in training in Louisiana. These recommendations are both short and long-term so that yearly and multi-year cycles for GME are programmed. An initial and yearly database is required to develop accurate, recurring information on the numbers, locations, specialties, dependable funds, and distributions for GME in the HCSD. This is significant and strategic opportunity to serve the health needs in the care and education of the citizens of Louisiana and in the education of health professionals.

I. The repair and rejuvenation of Katrina damaged institutions is the number one recommendation: A ten year plan, underway to insure the number of medical students and GME is recommended, to increase the supply of physicians in the State. Flexibility in management, resources provided for specific purposes, and support by all parties across the State is key in coming back and moving forward.

II. Long-term: Institutional Commitment:

- 1) The success of the arrangements between sponsoring institutions and the affiliated state public hospitals and clinics require continuity, stability, and commitment. Continued reciprocal support among academic institutions and the Health Care Services Division (HCSD) must be ongoing. State fund reductions in some years for the public hospitals have made serious difficulties, including making stable plans.
- 2) The number of patients in the hospitals is large and diverse, and provides a significant opportunity for the number of physicians currently participating in GME within present accreditation standards. The importance of flexibility in institutional planning and in medical school and management of GME programs at teaching hospitals is emphasized, and has become profoundly important after Katrina. Decreasing numbers in GME programs occurred. Major geographic and public/private hospital shifts saved the day. Incremental changes will occur as reconstruction takes place, and will require attention to accreditation regulations.

Workforce Planning:

- 3) The total numbers in GME in Louisiana were relatively stable and include a strong emphasis on primary care. The increase in primary care GME programs has been a substantial gain, presently a plateau designed to fulfill this specific need; more GME slots are needed again to recruit on increased supply of senior medical students.
- 4) The physician workforce production for Louisiana requires multi-year planning for competitive recruitment and program improvements and adjustments. The manpower planning process must be cognizant and responsive to changes in concerns of the public and policies of governmental bodies in a timely fashion. Institutions hit by Katrina will need resources and time to become competitive again.
- 5) Faculty supervision and suitable administrative supports should be provided and coordinated in the context of the GME programs.

MEDICAL EDUCATION COMMISSION RECOMMENDATIONS

(continued)

III. Annual:

- 1) An annual GME stipend increase each fiscal year, indexed to the COTH Southern Regional Average, is essential. A documented request is made for next year 2010-2011. The incorporation of these requests into the budget cycle of the State Public Hospitals is necessary.
- 2) Assurances for the resident match program filled positions is important in timing and continuity of funding, and in rebuilding after the storm.
- 3) Adequate funds to support the State teaching hospitals in their educational mission is essential. This takes on new significance after Katrina, because of such devastating damage.
- 4) Present contracts and current working arrangements are in place but may require revisions.

IV. Recruitment:

It is essential to emphasize continually the recruitment of trainees of high quality into Louisiana's programs. Retention of the Physicians who complete them from within the state is important and should have renewed emphasis.

V. Communication:

Dissemination of information on GME is important and desirable in order to continue the success of the partnership between the State Public Hospitals, the Private Teaching Hospitals, and the academic institutions.