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REPORT
ON
THE STATEWIDE MEDICAL EDUCATION
SYSTEM
FOR TRAINING RESIDENT PHYSICIANS
IN
FAMILY PRACTICE

RECEIVED

JAN 21 1975

Office of Lt. Governor

THE UNIVERSITY OF IOWA

IOWA CITY, IOWA 52242



College of Medicine
Office of the Dean
Area 319: 353-4843

January 15, 1975

The Honorable Arthur A. Neu
Lieutenant Governor
State Capitol
Des Moines, Iowa 50319

Dear Lieutenant Governor Neu:

In compliance with Chapter 168, Acts of the 1973 Regular Session of the 65th General Assembly, the second annual report of the Family Practice Advisory Board is respectfully submitted for your information.

The year 1975 was another period of major development in family practice education in Iowa. The statewide medical education system, coordinated with other College of Medicine programs which are directed toward reinstatement of the primary care physician in the health care system, has placed Iowa in the forefront of the nation in attacking the problems of a shortage and maldistribution of physicians. The medical students and community physicians have accepted the challenge to expand rapidly the ranks of family physicians. The reputation of progress of this program can in itself be expected to attract more physicians to the State to practice and to alleviate the primary care deficit ahead of schedule.

The Family Practice Advisory Board recognizes the significance of the contribution of State Government in stimulating this very important health program, and recommend its continued support to keep Iowa out in front.

Sincerely yours,

A handwritten signature in cursive script that reads "Paul M. Seebohm".

Paul M. Seebohm, M.D.
Chairman
Family Practice Advisory Board

PMS/mb

REPORT
ON
THE STATEWIDE MEDICAL EDUCATION SYSTEM
FOR
TRAINING RESIDENT PHYSICIANS
IN
FAMILY PRACTICE

TO

The Honorable Robert D. Ray and the 66th General Assembly

FROM

The Family Practice Advisory Board

ON

January 15, 1975

Paul M. Seebohm, M.D., Chairman
Carl R. Aschoff, M.D.
Kenneth L. Clayton, D.O.
Mr. Charles Ingersoll
Larry W. Lawhorne, M.D.
Mrs. Claudine Mansfield
Donald J. Otilie, M.D.
Mrs. Madge Phillips
Robert E. Rakel, M.D.
R. Keith Simpson, D.O.
Ralph L. Wicks, M.D.

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Introduction

The Statewide Medical Education System for family practice resident training, created by an Act (Chap. 168) of the first regular session of the 65th General Assembly is in the middle of its second year of operation under the 1973-75 biennial appropriation. The purpose of this program is to stimulate the training of more family practice physicians and to encourage them to establish practice in the state of Iowa. In accordance with Section 5 of the Act the advisory board is making this report on the status of the program.

The results to date suggest a major growth in family practice and other primary care specialties. The number of medical students interested in primary care as a career choice has doubled in the past five years. This interest has been manifest by progressive increases in the selection of family practice electives in medical school and in the applications for family practice residencies.

Under the impetus of the statewide system the number of family practice residency programs has doubled in two years with two additional programs to be activated in 1975 for a total of eight in the state. The active programs are in Des Moines (2), Cedar Rapids, Mason City, Iowa City, and Davenport. The programs under development are in Waterloo and Sioux City.

The enrollment of resident physicians in family practice training has grown from three in 1971-72 to 76 in 1975-76. The applicants for first-year positions exceed the number of places by about 500%.

It is evident from these data that medical graduates are becoming increasingly interested in careers in family practice and that the residency programs in Iowa are growing rapidly to provide enough positions to meet this need.

These programs are jointly supported by community hospitals, practicing physicians, and the College of Medicine through the statewide system. The advisory board has recommended the allocation of funds on a formula below the 50% statutory limit per program in order to give financial aid to all existing programs and those under development. The on-going programs have received \$5,000 per resident enrolled plus educational support from the College of Medicine, which represents about 25% of the cost of the program to the community. Start-up grants of \$25,000 per year have been allocated to new programs, and construction grants of \$30,000 to programs needing model office development. The \$925,000 appropriated for the 1973-75 biennium have been budgeted for the entire system using these formulae.

When the enrollment quotas of the existing programs and those under development are filled, there will be from 136 to 156 residents in training by 1976 with a graduation potential of 50-60 family physicians a year in Iowa, a figure calculated to reverse the fall in numbers of primary care physicians by 1976 and progressively correct the shortage by 1986.

To reach these goals continued legislative support commensurate with the growth of the programs and increasing costs to the communities will be essential. It is projected that the number of residents in training in 1975-77 will be double the number in 1973-75. Further, the availability of federal grant support for which all of the active Iowa programs have successfully competed in 1973-75 is uncertain in the years ahead.

The 1975-77 budget for the statewide system is based on the same formula except for an increase in the capitation (per resident) award from \$5,000 to \$10,000. This increase has been deemed necessary to lighten the fiscal burden of these programs on the patient care dollars from the community hospitals and cover the anticipated deficit from federal losses.

The growth of the programs and the proposed increment in capitation award account for the increase in the 1975-77 biennial budget to \$2,824,500.

History

Senate File 598 passed by the 65th General Assembly to establish a statewide medical education system for the purpose of training resident physicians in family practice was implemented in July, 1973. Family practice training programs in the United States are less than five years old. It was not until February 8, 1969, when the standards for training and certification in family practice were approved by the Advisory Board of Medical Specialties, that substantial planning of education programs was started. Since that date, however, continuous progress in program development has occurred both nationally and in Iowa.

On March 25, 1969, the College of Medicine initiated a feasibility study for setting up both undergraduate and graduate training programs in family practice.

In June, 1969, the 63rd General Assembly adopted Senate File 655 which authorized the University of Iowa to study the use of existing facilities in Polk County and elsewhere in the state for the training of students as general medical practitioners.

In January, 1970, the Board of Regents approved a unanimous recommendation of the faculty of the College of Medicine to establish a Department of Family Practice at the University of Iowa. In December, 1970, Dr. Robert E. RakeI was appointed Professor and Head of the Department of Family Practice in the College of Medicine.

In a recent survey of the 110 medical colleges in the country, 49 were found to have family practice programs. Of these, 25 had created full departments but only five of the departments have been operational for four years or more. This places the University of Iowa among the first five colleges of medicine to establish a Department of Family Practice.

In July, 1971, a major affiliation agreement was consummated between the College of Medicine and Broadlawns Hospital. In December, 1971, the family practice residency programs at Broadlawns and St. Luke's-Mercy in Cedar Rapids were accredited by the AMA residency review committee for family practice, the first in the State of Iowa to be authorized to provide residency training in family practice. By July, 1972, three programs (Broadlawns in Des Moines, St. Luke's-Mercy in Cedar Rapids and the Family Practice Department in Iowa City) were accredited and had a small number of residents in training.

Since July, 1973, the family practice movement in Iowa has shown a significant surge in the rate of growth which in most categories of measure has either kept pace or exceeded national trends.

Analysis of the Medical Manpower Shortage

Providing accessibility to high quality medical service for all the citizens of the state is one of the most important public policy issues in Iowa today. The reasons for health care being in the forefront of public interest at this time seemingly are many. In the first place, the people of our time have been conditioned to expect virtual curative miracles from modern medicine, not an unreasonable expectation in light of the scientific advances made against disease in the past two decades. Secondly, in the political arena the provision of health care has been declared to rank among life and liberty as fundamental birthrights of all citizens. Thirdly, the affluence of our times has made available directly or indirectly through government and private insurance the means for most of the population to purchase health care on a self-determined need basis. These factors have had an extraordinary impact on the growth of the demand for medical services at a time when the rate of graduating physicians from medical training programs had remained pegged at the 1950 level. The resulting absolute shortage of medical manpower was further aggravated by the doctors' draft, protracted specialty training and early retirement of practicing physicians.

The effect of these forces has been most vividly demonstrated in small rural communities where the loss of a physician is a conspicuous event, since many were the only doctor in town, and replacements could not be easily recruited.

Most small towns in Iowa are within 10-15 miles of a community of 3,000 population or greater. Such a distance can be traveled in less than 30 minutes, not an unreasonable amount of time to spend in getting to a physician. The problem is that the number of physicians in the larger town has not grown sufficiently to care for the growing population of people from the surrounding communities seeking medical care, nor are the specialists who have replaced many of the general practitioners in the larger communities as available for primary care as were their general practitioner predecessors. With this growing disparity between supply and demand the residents of larger communities also have problems with accessibility to medical care.

Even among those who gain entry into the health care system, there is often dissatisfaction with the services rendered by harried personnel in congested facilities. It is therefore easy to see why availability of quality medical care is a major public policy issue in Iowa and the country as a whole at this time.

In the past thirty to forty years there have been major changes in both the life style of society and the delivery of health care which are inconsistent with the behavioral patterns of patients and physicians of yesteryear.

Society is more mobile. There has been a massive rural to urban shift in population. Small towns are getting smaller and large towns larger. For three decades the military has moved our younger generation of men and women, including physicians and nurses, all over the world. Industry abandons obsolete plants in one state and builds new ones in another. The mobile home industry has equipped millions of families with wheels to change their residence at a moment's notice. Even for those who maintain a stable address, modern transportation can carry them across an Iowa county in half an hour by car and anywhere in the United States in less than half a day by plane.

Medical science too has changed in recent decades. Therapeutic advances have given physicians tools with which to counter disease in a way never dreamed of thirty to forty years ago. Many of these are sophisticated, expensive and require highly specialized training to administer. The physicians and specialized facilities required are limited, and can only be provided to all the patients requiring them if placed in the central focus of a regionalized system of health care. Modern transportation and life support systems now available in Iowa can move most critically ill patients quickly enough to facilities and physicians with the expertise to save them, if the disease or injury is reversible. Geographical isolation can no longer be considered a limiting element in the provision of even the most complicated and scarce forms of medical care to all who need it.

Today's physicians knowing of the growing capacity of medical science to conquer disease are not content to practice in professional isolation. When they meet a medical problem beyond their expertise, they want to have access to consultation whether it be from colleagues in the same community or from physicians in secondary or tertiary care centers located a distance sufficiently far away to require the transfer of the patient from the community. This is not to say the modern primary physician is relegated to a role of a triage officer, who simply directs his patients to the appropriate specialists. On the contrary, he must be trained to treat definitively the majority of the patients' ills who come to him. It is estimated that 80% of the conditions for which a patient visits his doctor are treatable by a physician trained in primary care medicine; however, to do this accurately one not only needs the skills to treat this group but must have sufficient knowledge to appraise the nature of the problems of the remaining 20% in order to request an appropriate consultation. To meet these requirements the primary physician of today needs more training than that provided by four years in medical school and an internship.

The primary care specialties of Family Practice, Internal Medicine and Pediatrics all require at least three years of residency training. It is generally agreed this educational period is needed to establish the professional self-confidence so important in making decisions in patient management at the primary care level.

Almost as important to the quality of health care delivery as the training of the physician is the setting in which the physician practices. The services of the best trained doctor soon deteriorate if he must see 70 patients a day, respond to emergencies day and night and curtail breaks for post-graduate education and vacation because of practice demands. The prevention of such a situation requires not only more physicians but the grouping of three or more physicians per community. This ratio suggests that the population of communities needed to support grouped physicians will need to exceed at least 3,000 people. The practical importance of this arrangement is that communities below the 3-5,000 population are likely to be without physicians in residence. For some of these people improved transportation will permit easy travel to the physician in the larger center; for others less mobile some provision for primary care in the community will be needed.

In recent years considerable attention has been given to the partitioning of the tasks of physicians to determine those functions that might be delegated to allied health personnel. The Physician's Assistant is a category of health professional now being trained to perform as a physician extender. Through the use of Physician's Assistants the physician group in moderate sized towns will have the capacity to sustain satellite offices in the community too small to support full time physicians.

One of the most important factors associated with the maldistribution of physicians had been the decline of the primary care physician. Specialists need large population bases to generate the kinds of medical conditions they are trained to treat. They therefore logically gravitate to large population centers to practice. Most of the depopulation of rural communities of physicians was not due to a migration of doctors to larger centers, but to an inadequate supply of new physicians entering primary care specialties. Since 1969 considerable progress has been made in re-establishing the role of the general practitioner under a new label of Family Physician.

Status of Family Practice Education in Iowa

a. Undergraduate Education in Family Practice

Both the University of Iowa and the College of Osteopathic Medicine and Surgery have increased enrollments over the past several years, so it could be expected that student interest in the various specialties might increase proportionately. In actual fact, surveys of student interest made at the University of Iowa College of Medicine show both a percentage and an absolute increase in interest in family practice.

The Medical Education-Community Orientation (MECO) program is an elective assignment offered by community hospitals and physicians to freshman medical students wishing to have a real-life medical experience early in their academic career. Interest in this program shown by both the communities and the students reached an all-time high in 1974.

	<u>MECO Program</u>				
	1970	1971	1972	1973	1974
Number of students	18	48	64	81	81
Number of hospitals	10	32	35	45	47

The sophomore course "Introduction to Family and Community Medicine" was elected by 29 students in 1972, 35 students in 1973, and 33 students in 1974. The senior electives in family practice, the majority (75%) of which are community-based, were selected by 47 students in 1972, 70 in 1973, and 103 in 1974.

Along with the development of new opportunities for training in Family Practice has been a growing interest in this specialty among medical students. The biographical inventory of incoming students at the University of Iowa College of Medicine has shown an increasing interest in Family Practice as a career choice.

	Freshman Medical Student Career Choice of Family Practice								
	1966	1967	1968	1969	1970	1971	1972	1973	1974
Number of students	33	28	44	32	52	72	87	85	92
Percentage of class	27	22	34	25	36	49	52	51	53

These data show an increased interest in family practice developing in 1970. This coincides with the clarification of the role of the family practitioner in the health care delivery system and the greater visibility given the specialty in the medical college curricula and hospital residency programs.

b. Residency Training in Family Practice

The increased interest of medical students in family practice as a career requires provision for an adequate number of residency training programs in this specialty. One of the most misunderstood concepts in medical

education is the depth of training required to develop a high quality professional for the practice of family medicine. The teaching of the tremendously expanded body of medical knowledge developed in the past two decades can no longer be compressed into the medical college curriculum and one year of a hospital internship, which was the standard of training for general practice forty years ago. A recent College of Medicine evaluation of physicians under fifty years of age who left rural practice in Iowa indicated most returned to hospital residencies for further professional training.

The residency training requirements of family practice absorb the internship year into the first year of residency and require two additional years of residency training; that is, a total of three years after graduation from medical college.

The Statewide Medical Education System for training resident physicians in Family Practice, which was established effective July, 1973, by the 65th General Assembly with a biennial appropriation of \$925,000 is well underway. There are now six accredited training programs in the state:

Mercy Hospital, Iowa City
St. Luke's Mercy Hospital, Cedar Rapids
Iowa Lutheran Hospital, Des Moines
Broadlawns, Des Moines
St. Joseph Mercy, Mason City
Mercy/St. Luke's Hospitals, Davenport

These have been developed on the following schedule:

	Accredited Residency Programs in Family Practice in Iowa					
	1969	1970	1971	1972	1973	1974
Number	0	0	1	3	5	6

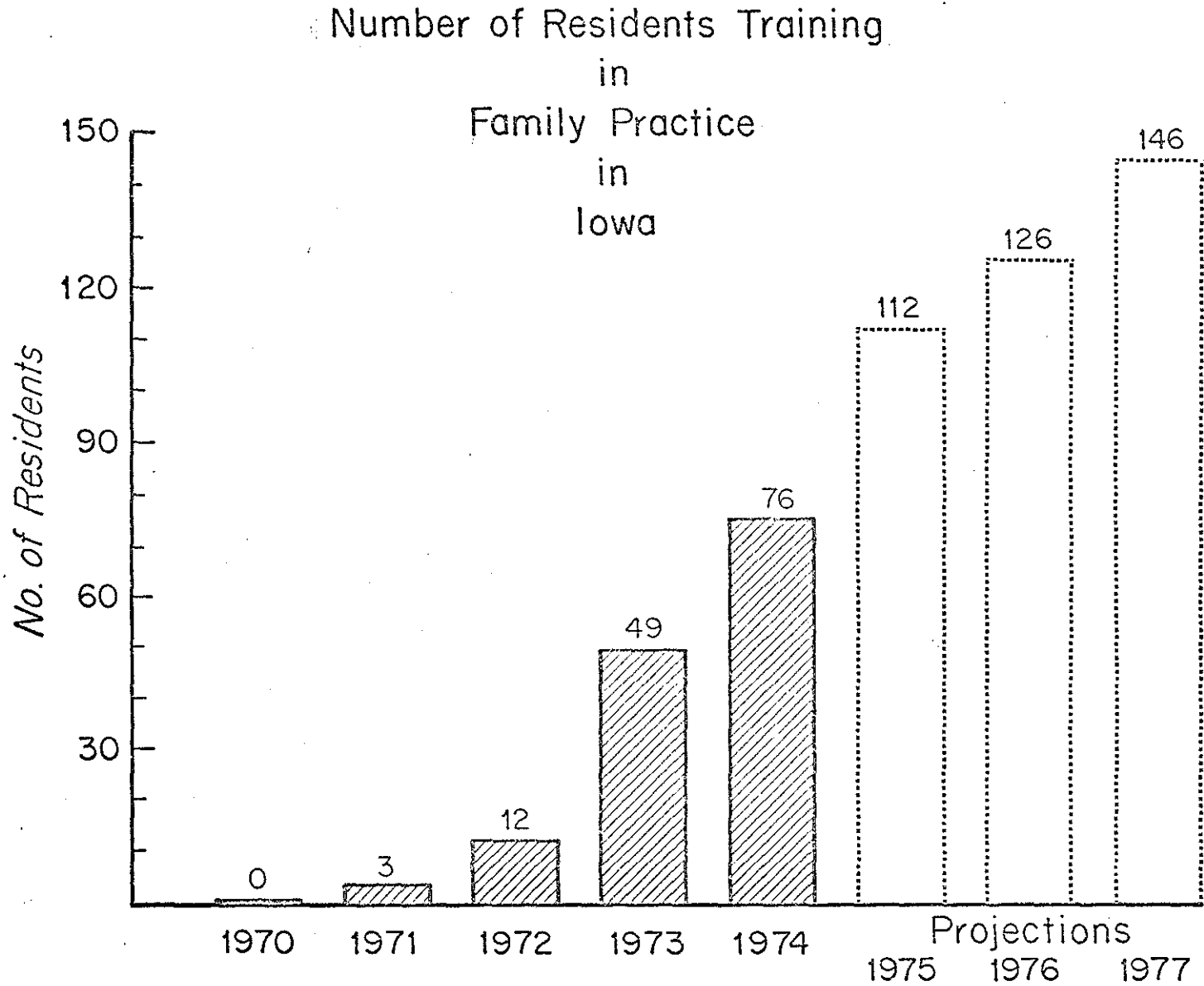
Additional programs are now under development in:

Sioux City
Waterloo

During this same period there has been a similar growth in the number of approved Family Practice programs nationally.

	1969	1970	1971	1972	1973	1974
Number	26	50	75	130	180	219

Coincident with the increase in the number of programs there has been a growth in the enrollment of residents in training, a trend that is projected to further increase with the filling of positions in existing programs and the opening of new programs now under development (see Exhibit I).



Family Practice Residents in Training

	70-71	71-72	72-73	73-74	74-75	Projected		
						75-76	76-77	77-78
*Iowa	0	3	12	49	76	112	126	144
U.S.A.	165	632	1041	1680	2671	--	--	--

*Includes University of Iowa residency program.

The number of applicants for residency appointments has also increased substantially.

Number of Applications Received
For Family Practice Residency Positions
(Iowa City, Broadlawns, Cedar Rapids, Iowa Lutheran and St. Joseph Mercy - Davenport)

1973-74	1974-75
111	215

c. Retention of Medical Graduates in Iowa

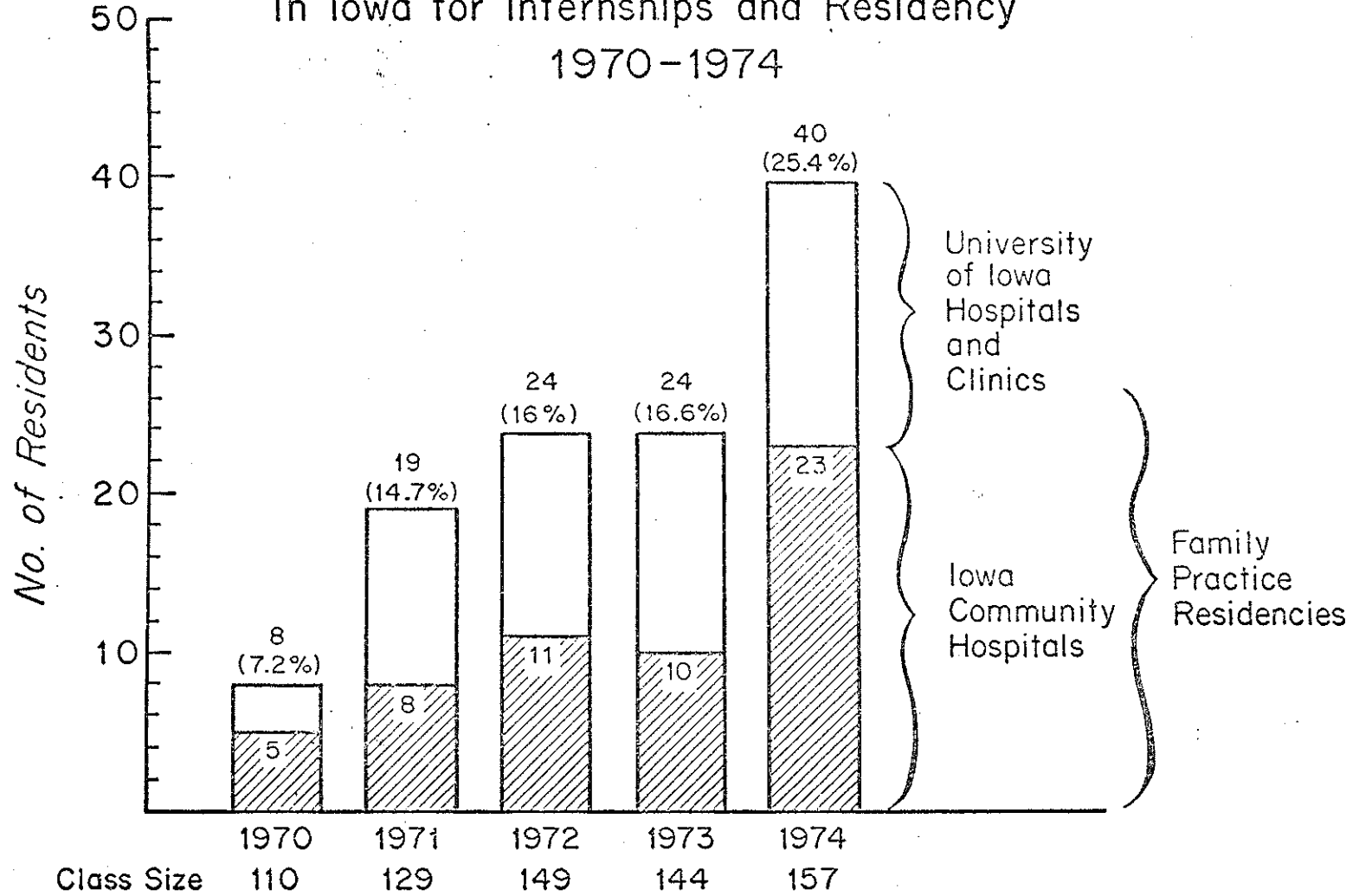
Since 1970 the number of graduates of the University of Iowa College of Medicine who have remained in Iowa for internships and residencies has increased progressively. The growth has been in both the University Hospital and the community hospital programs, and more than half have selected family practice. Exhibit II shows the trend in the absolute and percentage increase over the past five years. Since the location of the residency is the most important factor in determining where a young physician will practice, this data is a very significant indicator that true progress in combating the doctor shortage in Iowa is being made.

d. Services of Model Offices

The model offices of the family practice programs are the primary training base for the residents. Exhibit III shows the number of visits made to the model offices in the statewide system. The care provided is equivalent to that required of a community of 20,000 people.

Retention of University of Iowa College of Medicine Graduates

In Iowa for Internships and Residency
1970-1974



NUMBER
OF
PATIENT VISITS TO FAMILY PRACTICE RESIDENCY
MODEL OFFICES

(FISCAL 1974-75 BASED ON OCTOBER, 1974)

<u>Location</u>	<u>Program</u>	<u>Office Visits</u>
Oakdale	University of Iowa	5,964
Williamsburg	University of Iowa	9,168
Mason City	St. Joseph Mercy Hospital	4,608
East Des Moines Family Care Center	Iowa Lutheran	19,368
Family Health Center	Broadlawns	7,764
Cedar Rapids	St. Luke's-Mercy Hospital	20,436
Mechanicsville	St. Luke's-Mercy Hospital	<u>5,784</u>
	Total	73,092

e. Family Practice Advisory Board

The eleven-member Family Practice Board was constituted in the fall of 1973. Its membership, geographic distribution and terms of appointment are shown in Exhibit IV.

The Board in cooperation with the administration of the College of Medicine has surveyed hospitals and communities with residency programs in the planning or operational stage and recommended to the College of Medicine that the above on-going programs be budgeted and supported in 1973-74; and that the new sites of Davenport, Sioux City and Waterloo be designated for the development of programs with support being budgeted in 1974-75.

The Board further advised that on-going program support be based on the number of full time equivalent residents in training in the program, and established for 1973-74 the capitation rate to be \$5,000 per resident enrollee. Developing programs with less than five residents were approved for base support after a director was acquired. The Board also budgeted funds for model office construction or renovation for developing programs.

f. Community Participation

The progress to date in the development of these programs would not have been possible without substantial support from the communities in which they are located. The physicians, generalists and specialists alike, have donated many hours to instruction for these resident trainees, principally by inviting them to participate in the care of their patients. Likewise hospital administrators and members of hospital boards have sponsored and financially supported the development of facilities and the major costs of education. The Statewide Educational System then continues to be a cooperative venture between the medical community, the College of Medicine, HEW, and the State of Iowa. The magnitude of the community investment in these programs is reflected in the one year (1974-75) budget of \$2,314,960 shown in Exhibit V.

Physician Placement

Second only in importance to producing more family physicians is the organization of the setting in which they are to practice. It is expected that primary medical care coverage of the rural areas will be centered in communities of 4-5,000 population, with service areas of 10,000 to 20,000. Smaller towns in the service area can be expected to be the sites of satellite centers, which will be branch units of the primary care center.

Recognizing that the primary care center with satellite functions may need some direction, the University of Iowa College of Medicine, in conjunction with the Regional Medical Program has inaugurated a study of the medical communities of Southwest Iowa with the intent of supporting the planning

Family Practice Education Advisory Board
Membership

Paul M. Seebohm, M.D., Chairman
Executive Associate Dean, University of Iowa College of Medicine
Iowa City, Iowa

Robert E. Rakel, M.D.
Head, Department of Family Practice, University of Iowa
College of Medicine, Iowa City, Iowa

Larry Lawhorne, M.D. (1974)
Family Practice Resident, University Hospitals, Iowa City, Iowa

Carl R. Aschoff, M.D. (1975)
Program Director, Cedar Rapids, Iowa

R. Keith Simpson, D.O. (1974)
College of Osteopathic Medicine and Surgery, Des Moines, Iowa

Charles Ingersoll (1975)
Administrator, Des Moines, Iowa

Ralph L. Wicks, M.D. (1976)
Iowa Medical Society, Boone, Iowa

Kenneth L. Clayton, D.O. (1976)
Iowa Society of Osteopathic Physicians and Surgeons, Spirit Lake, Iowa

Donald J. Otilie, M.D. (1974)
Iowa Academy of Family Physicians, Oelwein, Iowa

Mrs. Madge Phillips (1977)
Public Member, Cedar Rapids, Iowa

Mrs. Claudine Mansfield (1977)
Public Member, Humboldt, Iowa

OPERATING
1974-75 BUDGETS
OF
FAMILY PRACTICE RESIDENCY PROGRAMS IN IOWA

Community-based

Mason City	\$ 200,059
Cedar Rapids	641,736
Broadlawns, Des Moines	617,371
Iowa Lutheran, Des Moines	500,000
Mercy Hospital, Iowa City	92,044
St. Luke's-Mercy Hospital, Davenport (projected)	163,750
Waterloo (projected)	50,000
Sioux City (projected)	<u>50,000</u>

\$2,314,960

required to develop a Model Regional Primary Care Center and satellite in a rural setting. Site selection criteria included regional service patterns, community interest, local financial support, medical community support and availability of local facilities to house the center's operation. The site selected was Red Oak and now a local task force and a University-based educational committee will oversee the planning activities and seek Foundation and Federal support to cover start-up costs and some operating costs for an initial three-year period, after which it is anticipated its revenues from patient service should make it fiscally self-sufficient.

A feature of this program will be the rotation of fourth-year medical students and third-year family practice residents through the center and satellite. This experience is expected to demonstrate the positive values associated with this type of practice and help the student physician organize similar practice programs in communities of comparable size that are short of medical manpower.

Projected Increase in Family Practice Physicians

The number of general practitioners in Iowa has been falling for several decades; however, with the new emphasis in medical education on primary care the decline is reaching a turning point. The rate of attrition of practicing physicians based on retirement because of age is a constant factor for the next decade. The growing number of family physicians graduating from training programs should by 1976 exceed the rate of retirement.

The statewide system should soon have an impact on the upward trend. A ratio of one primary care physician for 2,500 population is a desired optimum. This could be reached by 1986 if all graduates of the residency programs remain in Iowa to practice. Exhibit VI portrays the annual rate of change projected in this analysis. In addition to primary care physicians, an equal number of other specialists are required in the health care system. These are being produced in adequate numbers both in and out of Iowa. These projections do not include physicians who train in other states and come to Iowa to practice. A fringe benefit of an active medical educational program at the community level is the creation of a practice environment attractive to physicians in all specialties. It is therefore not unlikely that with the headstart Iowa has in medical education in the primary care field the physician shortage could be over within the decade.

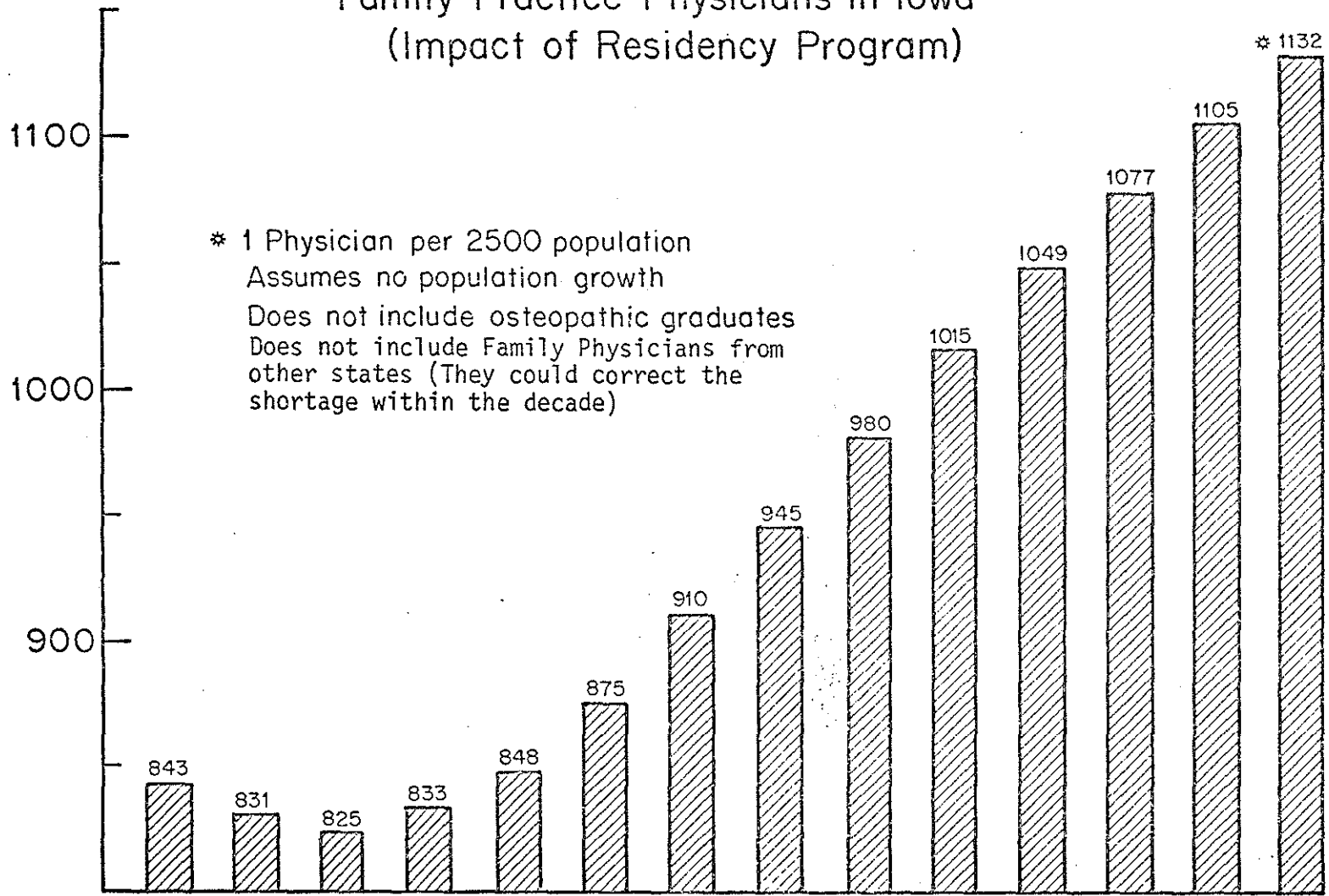
Budgets

The 1973-75 appropriation (\$925,000) was allocated to developing programs through base operation grants of \$25,000 plus construction grants of \$30,000.

The operational programs were awarded \$5,000 per year for each full time equivalent resident in training.

Projected Increase in Numbers of Family Practice Physicians in Iowa (Impact of Residency Program)

Exhibit VI



- 16 -

Family Practice Resident Graduates	11	17	31	38	50	58	58	58	58	58	58	58	58	
Attrition of MD's (over 65)	-23	-23	-23	-23	-23	-23	-23	-23	-23	-23	-24	-30	-31	
Net change	-12	-6	+8	+15	+27	+35	+35	+35	+35	+35	+34	+28	+27	
Year	73	74	75	76	77	78	79	80	81	82	83	84	85	86

The College of Medicine was allocated 20% of the appropriation for educational support of the programs.

The 1975-77 budget is based on the same formula except for an increase in the capitation award from \$5,000 to \$10,000. This increase has been deemed necessary to lighten the fiscal burden of these programs on the patient care dollars from the community hospitals, and will still fall below the statutory 50% support level provided for in the Act.

The growth of the programs and the proposed increment in capitation award account for the increase in the 1975-77 biennial budget to \$2,284,500.

STATEWIDE FAMILY PRACTICE EDUCATION SYSTEM
BUDGET
1973-75 BIENNIUM

	<u>Capitation</u>	<u>Base Operation</u>	<u>College of Medicine Educational Support</u>	<u>Construction*</u>	<u>Total</u>
1973-74	\$194,000	\$ 50,000	\$ 64,500	\$ 30,000	\$338,500
1974-75	<u>275,000</u>	<u>100,000</u>	<u>121,500</u>	<u>90,000</u>	<u>586,500</u>
Total	\$469,000	\$150,000	\$186,000	\$120,000	\$925,000

1975-77 BIENNIUM

	<u>Capitation</u>	<u>Base Operation</u>	<u>College of Medicine Educational Support</u>	<u>Construction*</u>	<u>Total</u>
1975-76	\$ 970,000	\$25,000	\$257,000	\$35,000	\$1,287,000
1976-77	<u>1,230,000</u>	<u>-0-</u>	<u>307,500</u>	<u>-0-</u>	<u>1,537,500</u>
Total	\$2,200,000 ^a	\$25,000 ^b	\$564,500 ^c	\$35,000 ^d	\$2,824,500

*Model Office Development

See Attachments a
b
c
d

*Capitation Operational Support

1975-77 Biennium

<u>Program</u>	<u>1975-76</u>		<u>1976-77</u>		<u>Total</u>
	<u>FTE</u>	<u>Allocation</u>	<u>FTE</u>	<u>Allocation</u>	
Broadlawns (Des Moines)	28	\$280,000	28	\$ 280,000	\$ 560,000
Cedar Rapids	24	240,000	24	240,000	480,000
Iowa Lutheran (Des Moines)	12	120,000	16	160,000	280,000
Mason City	10	100,000	12	120,000	220,000
Davenport	8	80,000	14	140,000	220,000
Sioux City	8	80,000	14	140,000	220,000
Mercy Hospital (Iowa City)	7	70,000	7	70,000	140,000
Waterloo	0	<u>-0-</u>	8	<u>80,000</u>	<u>80,000</u>
Total		\$970,000		\$1,230,000	\$2,200,000

*Based on a \$10,000 per full time equivalent (FTE) resident in training rate.

*Base Operation Support

1975-77 Biennium

	<u>1975-76</u>	<u>1976-77</u>	<u>Total</u>
Waterloo	\$25,000	-0-*	\$25,000
	<hr/>	<hr/>	<hr/>
Total	\$25,000	-0-	\$25,000

*Awarded to programs in development phase and with less than 5 residents.

College of Medicine Educational Support

1975-77 Biennium

	<u>1975-76</u>	<u>1976-77</u>
Faculty Coordinator	\$ 45,000	\$ 45,000
Administrative Coordinator	28,000	28,000
Clerical (2)	16,000	16,000
Advisory Board	3,000	3,000
Visiting Professor Program (Faculty to Community)	12,000	15,000
Receiving Professor Program (Community Faculty to Iowa City)	6,000	8,000
Educational Equivalent to Non-Affiliated Program	2,000	2,000
Travel (Administrative)	2,500	3,000
Supplies	1,000	1,500
Stipends for Community-Based Residents on University Hospital Electives (14-18 FTEs)	<u>141,500</u>	<u>186,000</u>
Total	\$257,000	\$307,500

*Construction

1975-77 Biennium

	<u>1975-76</u>	<u>1976-77</u>
Waterloo	\$35,000	-0-

*Model Office Development

