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Abstract

Background: Hospitalists perform key roles as inpatient educators for family medicine residents. For the past decade, Duke University Family Medicine Residency Program had its inpatient family medicine resident rotation at non-Duke facilities.

Objective: The authors describe the steps taken in 2020 to develop an inpatient Duke family medicine rotation at a North Carolina community hospital, Duke Regional Hospital, and provide outcomes data.

Methods: Duke Family Medicine Residency and Duke Regional Hospital Medicine collaborated in addressing key issues to develop an inpatient rotation for family medicine residents. Performance metrics of patients cared for by both the family medicine inpatient resident team and internal medicine teams were compared. Resident satisfaction survey results were reviewed.

Results: Retrospective cohort evaluation comparing the two inpatient services (internal medicine and family medicine) revealed the family medicine resident inpatient service performed comparatively in length of stay and 30-day readmission rates. Resident evaluation surveys of the family medicine inpatient rotation showed overall satisfaction with learning objectives.

Conclusions: This new family medicine inpatient rotation has benefitted all parties. Key quality performance metrics such as LOS and readmissions are comparable to internal medicine, hospitalists have more teaching opportunities, and Duke family medicine has its residents training in a Duke-affiliated community hospital for their core inpatient rotation.

Keywords: Family practice, Family medicine, Internship and residency, Inpatient rotation, Hospitalists

1. Introduction

The continued shortage of primary care providers, coupled with the growing and aging United States population, has created a healthcare crisis where access is suboptimal to meeting our healthcare needs.¹ The training of family medicine physicians continues to be a key strategy to address this gap. Simultaneous to this healthcare access crisis has been a significant shift over the past decades toward hospitalists as the predominant

provider of general inpatient medicine. The Society of Hospital Medicine estimates 60,000 hospitalists working in the United States in 2020, with this number increasing every year.² As more hospitalists are added to the healthcare system, they are placed in educational roles supervising learners needing a range of inpatient care training.³ Hospitalists are increasingly involved in the inpatient training for family medicine residents, a function they have been shown to perform well.⁴

Effectively training family medicine residents in high-quality inpatient medicine is vital. Trainees

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who plan to practice in an outpatient setting must understand the processes of inpatient hospital-based care and must be able to correctly identify sick outpatients who need urgent help or hospitalization. High-quality inpatient medicine training is particularly important for those trainees who plan to work as hospitalists or maintain inpatient care as part of their practice. Providing such training is a prerequisite for family medicine residency programs and thus, it is imperative to ensure the effectiveness of hospitalists as inpatient educators for family medicine.

A precedent for utilizing hospitalists in this role exists, and data supports their effectiveness. For example, the Council of Academic Family Medicine Educational Research Alliance (CERA) study⁴ revealed that 60% of family medicine residency programs with access to hospital medicine programs incorporate their hospitalists in teaching inpatient medicine to residents. The majority of respondents to the survey had some affiliation to a university, and 20% also had family medicine attendings functioning as hospitalists. Among programs responding to the survey, 63% noted that the hospitalists were “good educators.” While this research highlights successful educational collaborations between family medicine residency programs and hospital medicine programs, little has been published on how to actually develop a hospital medicine educational rotation for family medicine trainees.

We seek to address this gap by outlining the steps we took to develop a novel family medicine inpatient rotation through a partnership between the Duke Family Medicine Residency Program (FMRP) and the Duke Regional Hospital (DRH) Medicine Program. We document the logistical steps, challenges, and benefits of this complex process. We also compare and report our outcomes data between the new family medicine teaching service and our existing internal medicine service, which consists of internal medicine resident-teaching and non-teaching teams.

2. Materials and methods

2.1. Setting

The Duke Family Medicine Residency Program—housed within the Duke Department of Family Medicine and Community Health (FMCH)—has been training residents since 1972 and currently enrolls a total of 18 residents. Over the past decade, the program primarily utilized inpatient medicine rotations at sites not affiliated with Duke. This had several implications, including: limited

oversight and control of the resident educational experience for offsite residents; increased costs to the family medicine training program and Duke health system; limited role modeling of the breadth of family medicine within a single facility; limited opportunities for family medicine residents to work with colleagues on a care team; and lack of opportunities for residents to manage empaneled patients across transitions of care.

Duke Regional Hospital was established in 1976 and is a community hospital located in Durham, North Carolina, and is part of Duke University Health System (DUHS). The DRH Hospital Medicine Program was started in 1998. DRH hospitalists have been involved in teaching internal medicine residents, medical students, physician assistant students, and other learners since 2006. Leaders in the DRH Hospital Medicine Program recognized that a family medicine inpatient service would provide more teaching opportunities for hospitalists at DRH as well as enhance the academic reputation of the program. This new service could result in improving recruitment for the program by attracting family medicine hospitalists. In 2018, with support and advocacy from both departments, DUHS committed resources to prioritize the development of an inpatient residency rotation for Duke family medicine residents at DRH.

2.2. Collaboration

With these advantages, however, were barriers to overcome. Both groups were concerned about the ability to obtain adequate funding support to ensure success. Family medicine residency leaders were concerned about the timing of bringing residents back to a Duke facility because of the required significant advance notice to the outside hospital where they were training in inpatient medicine. Duke hospital medicine leadership was concerned about developing a coverage model that required close nighttime supervision. Detailed interdepartmental collaboration was necessary to address these issues proactively and work through the significant logistics that were involved in the development of this rotation.

At the onset of the collaboration in 2018, stakeholders met at least monthly to establish the vision, goals, and strategy for the project and to explore logistics and barriers to successful implementation. Stakeholders at the meetings included clinical hospitalists, family medicine residency program and departmental leadership, family medicine Chief Residents, finance and administrative representatives, as well as periodic attendance by DRH Chief

Medical Officer. Stakeholders identified several key issues needing collaborative solutions during the preparatory meetings and these issues and their solutions are detailed in [Table 1](#).

2.2.1. *Schedule and rotation*

Currently, the structure of the resident rotation consists of a daytime rounding and admitting team and a separate night coverage resident ([Table 2](#)). The daytime team consists of a PGY-2 or PGY-3 resident, intern, and attending. This team rounds on a service of 10–12 patients and admits one patient in the afternoon. The night resident is a PGY-2 or PGY-3 resident who admits 3 patients per 12-h night shift, cross-covers the family medicine inpatients, manages laboring or triaging obstetric patients, and covers home call for the Duke Family Medicine practice. Nighttime admissions are supervised by hospital medicine's nocturnist physicians, who also supervise resident involvement in overnight rapid responses and emergencies. Additionally, if the resident is busy with an obstetrics patient or cross-cover issues, the nocturnist fills in to temporarily cover patient care responsibilities.

Attending supervision follows a model developed on the DRH internal medicine service. Residents generally rotate on the service in four-week blocks, during which two attendings alternate in a week-on and week-off model. This approach allows attendings to gain increased familiarity with the residents

and increased awareness of their longitudinal development.

Patient selection on the family medicine service also follows the model established on the DRH internal medicine service. The family medicine resident receives notification pages from the emergency department on new admissions. The resident then decides to accept the patient based on needs of the learners on the team or if it is a patient empaneled to Duke Family Medicine, allowing for continuity of care.

2.2.2. *Curriculum and teaching*

We are fortunate to have an existing robust faculty development program with many DRH faculty already involved in interprofessional education, quality improvement projects, research, and leadership. The ability to tap into this outstanding faculty group to support the family medicine residents and create a quality rotation is vital.

Resident teaching topics covered by the attendings throughout the year are selected from Clinical Conditions in the Society of Hospital Medicine Core Competencies.⁶ In addition to teams-specific teaching, family medicine residents participate in daily virtual conferences offered by the internal medicine residency. They also participate in morbidity and mortality conferences and journal club offered by the hospitalist medicine service. Alongside daily bedside teaching, daily didactic sessions, pertinent

Table 1. Challenges faced with developing family medicine inpatient rotation at DRH and solutions implemented.

Challenge	Solution
Inpatient Rotation Leadership	Hiring of a Family Medicine physician with significant hospital medicine and teaching experience to serve as director
Family Medicine hospitalist recruitment	Dedicated recruitment efforts for family medicine “core faculty” hospitalists to meet ACGME requirements ⁵
Employment mechanism	Family medicine hospitalists hired under health system employment
Credentialing of family medicine hospitalists	Collaboration with DRH Medical staff leadership and committees
Financing	Reallocation of GME funded positions to DRH; DRH commitment to staffing costs
Night coverage	Hospital medicine nocturnist coverage agreement
Space	Allocated workroom adjacent to other resident programs as well as night call rooms
Obstetrics and clinic call coverage	Collaboration with OB services

Abbreviations: ACGME - Accreditation Council for Graduate Medical Education, DRH – Duke Regional Hospital, OB - obstetrics.

Table 2. Day and night shift team members and responsibilities.

	Day team	Night team
Team Members	PGY2/3 Resident & PGY1 intern	Night float PGY2/3 resident
Supervising attendings	HM Daytime attending	HM nocturnist
# of patients covered (census)	Average = 10 Cap = 12	Average = 10 Cap = 12
# of patients admitted/shift	1	3
Other duties	Weekends - Cross cover laboring OB patients of FM clinic, answer/triage patient night calls	Nightly - Cross cover laboring OB patients of FM clinic, answer/triage patient night calls

Abbreviations: PGY – post-graduate year, HM – hospital medicine, Cap – maximum patient census, OB – obstetrics, FM – family medicine.

to the current patients, are coordinated by the attending physician covering the team.

To augment daytime educational activities, the nocturnist team is developing a family medicine nighttime curriculum to specifically target care of the decompensating patient with a focus on cross-cover emergencies.

2.3. Data

Outcomes data were obtained from the DRH electronic medical record using a retrospective cohort evaluation period of 9 months from July 1, 2020 (coinciding with the start of the family medicine rotation) to March 31, 2021. Patients were categorized into two cohorts; family medicine inpatient teaching service or internal medicine service (which included internal medicine inpatient teaching service and hospital medicine service). Primary variables reviewed were length of stay and 30-day readmission rates. For readmissions, the index hospitalization was at DRH and readmissions were at any of the three hospitals within Duke University Health System. Patients included were inpatient adults ages 18 and older. Similar to CMS algorithm we excluded patients whose index admissions or readmissions were based on psychiatric diagnoses, rehabilitation care, non-surgical cancer MSDRGs (Medicare Severity Diagnosis Related Groups), or admitted for inpatient hospice. Patients who were transferred to other acute facilities, died during index hospitalization, or left against medical advice were also excluded. Baseline patient characteristics examined were age, sex, race, ethnicity (Hispanic), main diagnostic related group (DRG) classification, and numerical DRG weight.

Length of stay was also adjusted by DRG weight to create case mix adjusted LOS (LOS/DRG weight for each patient) to allow comparison for differences in case mix. Readmissions were not case mix adjusted as that typically involves a more complex process using risk model-based expected values, which we did not have access to.

Resident satisfaction surveys were obtained from our family medicine residency MedHub© system which is the platform for obtaining feedback on family medicine rotations. We examined the number of residents that either agreed or strongly agreed with the learning objective statement “The rotation adequately addressed the learning objectives”. The questions utilized a Likert scale from “strongly disagree” to “strongly agree” (see Appendix - FMIS

Evaluations). Learning objectives and goals of the rotation were conveyed to the residents at the beginning of every rotation by the Family Medicine Residency Program Director as well as each time a new attending physician joined the team. The surveys were sent to the residents in the final week of their rotation. On average, residents completed the evaluations within 2–4 weeks after receipt.

We report these retrospective cohort evaluation study findings following defined methods in the “STrengthening the Reporting of OBservational studies in Epidemiology” STROBE guidelines.⁷

2.4. Statistical analysis

All data comparing the outcomes for the two teams were analyzed using JMP Pro 15. We used Chi-square test to evaluate for the difference in readmissions as a dichotomous variable. We used Wilcoxon rank sum test (non-parametric) to evaluate for differences in length of stay and DRG weights as continuous variables not normally distributed (analysis by normal quantile plot distribution and Anderson-Darling statistic). We used multiple logistic regression to evaluate for differences in baseline characteristics. We defined P values < 0.05 as statistically significant.

3. Results

During the 9 month period after the start of the family medicine inpatient rotation, there were 366 patient discharges from the family medicine service and 4025 discharges from the internal medicine service. Baseline characteristics of patients discharged by both inpatient services were similar except for DRG weight, with a lower DRG weight or case mix index in family medicine (Table 3). Mean length of stay (Table 4) was significantly shorter in patients discharged from family medicine service, however, when adjusted for case mix, this difference became non-significant. Unadjusted readmission rates (Table 4) to a Duke-affiliated hospital within 30 days were significantly lower for the family medicine service. DRG classifications between the two services are listed in Table 5. Review of the resident evaluation surveys (MedHub©) of the family medicine inpatient rotation showed overall satisfaction with 100% of resident responders (n = 11 out of 18 survey recipients) agreeing (strongly agree or agree) with the statement “The rotation adequately addressed the learning objectives”.

Table 3. Patient baseline characteristics by inpatient provider team.

	Family Medicine	Internal Medicine ^a	P value
Discharges (“n”)	n = 366	n = 4025	
Sex			
Male n (%)	189 (51.6)	1999 (49.7)	0.47
Female n (%)	177 (48.4)	2026 (50.3)	0.47
Age mean (± SD)	63.6 (± 16.7)	64.4 (± 16.6)	0.38
Race			
White n (%)	177 (48.4)	1913 (47.5)	0.34
Black n (%)	174 (47.5)	1871 (46.5)	0.34
Other n (%)	15 (4.1)	241 (6.0)	0.34
Ethnicity			
Hispanic n (%)	14 (3.8)	200 (5.0)	0.33
DRG weight (CMI) mean (± SD)	1.35 (±0.9)	1.56 (±1.0)	<.0001

Abbreviations: DRG = Diagnosis related group, CMI = Case Mix Index.

^a Internal medicine reflects both internal medicine resident teaching teams and hospitalist teams.

Table 4. Inpatient team association with LOS and readmissions.

	Family Medicine	Internal Medicine ^a	P value
Mean LOS, days (±SD)	4.8 (±6.9)	5.8 (±7.2)	<.0001
Median LOS, days (IQR)	3.0 (1.9,5.0)	3.9 (2.2,6.8)	
Mean DRG (CMI) adjusted LOS, days (±SD)	3.7 (±4.0)	3.9 (±4.8)	0.051
Median DRG (CMI) adjusted LOS, days (IQR)	2.7 (1.8,4.3)	3.0 (1.9,4.8)	
Readmissions ^b in 30 days n (%), Odds ratio (95% CI)	33 (10.2), 0.6 (0.4–0.9)	577 (15.6), 1.6 (1.1–2.4)	0.01

Abbreviations: LOS = Length of Stay, IQR = Interquartile range.

^a Internal medicine reflects both internal medicine resident teaching teams and hospitalist teams.

^b Readmission rates are unadjusted for severity given lack of access to models creating expected readmission rates.

4. Discussion

With over two years of significant planning, Duke family medicine residents have finally returned to a Duke-affiliated hospital as their inpatient rotation site as of July 1, 2020. Analysis of outcomes data including

length of stay and 30-day readmissions show that this new service performs very well compared to the larger, more established internal medicine service. The CMI of patients discharged by the family medicine service was less than the internal medicine services. Resident evaluation surveys of the family

Table 5. Most common DRGs for family medicine and internal medicine.

	Count	Frequency
Family medicine top 10 common DRGs		
Heart failure and shock with MCC	21	0.057
Renal failure with CC	17	0.046
Septicemia or severe sepsis without mv > 96 h with MCC	15	0.041
Diabetes with CC	14	0.038
Esophagitis, gastroenteritis, and miscellaneous digestive disorders without MCC	13	0.036
Septicemia or severe sepsis without mv > 96 h without MCC	11	0.030
Respiratory infections and inflammations with MCC	9	0.025
Cellulitis without MCC	9	0.025
Intracranial hemorrhage or cerebral infarction with CC or TPA in 24 h	7	0.019
Circulatory disorders except AMI, with cardiac catheterization without MCC	7	0.019
Internal Medicine top 10 common DRGs		
Septicemia or severe sepsis without mv > 96 h with MCC	342	0.085
Respiratory infections and inflammations with MCC	317	0.079
Heart failure and shock with MCC	214	0.053
Septicemia or severe sepsis without mv > 96 h without MCC	102	0.025
Diabetes with CC	80	0.020
Gastrointestinal hemorrhage with CC	75	0.019
Intracranial hemorrhage or cerebral infarction with CC or TPA in 24 h	68	0.017
Renal failure with CC	66	0.016
Esophagitis, gastroenteritis, and miscellaneous digestive disorders without MCC	64	0.016
Chronic obstructive pulmonary disease with MCC	59	0.015

Abbreviations: AMI = Acute Myocardial Infarction, CC = Complication or comorbidity, MCC = Major complication or comorbidity, MV = Mechanical Ventilation.

medicine inpatient rotation showed overall satisfaction with learning objectives, confirming that the educational objectives were being met.

We have identified significant benefits achieved from this transition. Patients benefit from improved continuity of care when they are discharged by the service and receive post-hospital care in the Duke Family Medicine clinic, often by the resident who discharged them. Residents benefit by being able to serve alongside resident colleagues at their “home” institution and within an interprofessional team. A significant amount of attending oversight is provided by board-certified family medicine attendings. The hospital benefits from the integration of family medicine physicians in the inpatient setting who provide valuable contributions such as a focus on value-based care and a unique understanding of the importance of transitions of care, as well as the knowledge they bring of the impact of family dynamics and overall health of the patient.⁸ Our results are consistent with the literature which has shown that family medicine teaching services can perform very favorably to hospitalist services in metrics such as length of stay or costs,^{9,10} and beneficial educational outcomes occur when hospitalists work collaboratively with a family medicine residency program to provide faculty coverage for the family medicine inpatient service.¹¹

Limitations to this study and applicability to other sites are noted. First, we were unable to adjust readmission rates for comparison between internal medicine and family medicine services because we lacked access to models creating expected readmission rates. We focused our analysis on two performance metrics, LOS and readmissions, and did not evaluate for mortality, patient experience, or other parameters which may have shown differences between the two inpatient services. In addition, because of the academic resources available for us at DUHS, clinical education initiatives like this project may not be possible at other sites without similar educational training resources. Lastly, the limited number of family resident surveys of the inpatient rotation precludes any formal statistical comparison of them to other control groups.

Challenges to this rotation have included: communication obstacles between day and night teams; lack of experience of interns working nights; daily admissions interfering with “synthesis time” to incorporate didactic teaching on the care that they are giving.

To address these challenges and prepare for next steps, we hold bi-monthly meetings of stakeholders to address any concerns and to initiate real-time improvements to the service as needed. We are also developing survey tools to get

feedback from house staff and attendings to improve the overall learning and experience. We believe this inpatient rotation has been a critical next step in the potential future growth of the family medicine residency program.

Ethics approval and consent to participate

This study was carried out with methods that are in accordance with the Duke Health/Duke University Health System Institutional Review Board (IRB) clinical trial guidelines and regulations. The Duke Health/Duke University Health System Institutional Review Board (IRB) reviewed and approved the study and the protocols. Because we did not conduct human subjects research or experiments but rather used existing programmatic evaluation data, the Duke Health/Duke University Health System Institutional Review Board (IRB) determined that this study satisfies the Privacy Rule (as described in 45CFR164.514), was low-risk, and therefore exempt from the need for individual participant-level consent. Duke Health/Duke University Health System Institutional Review Board IRB Protocol Review # Pro00108890.

Consent for publication

Not applicable since no personal data are included in the manuscript.

Previous presentations or publications of this work

None.

Authors’ contributions

We followed the ICMJE authorship guidelines in that all authors contributed substantially to the design of the work and this publication.

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Conflict of interest

The authors declare that they have no competing or conflicts of interests.

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We dedicate this manuscript to the memory of our dear, departed colleague, Danielle Richardson MD, DRH nocturnist medical director, whose support helped development of this project.

Appendix

Resident Rotation Evaluation Form(s)

Printed on date:

Family Medicine Inpatient Service - Resident Evaluation of Rotation

Evaluator:

Service: Family Medicine Inpatient Service

Please rate your level of agreement with each statement.

1. The rotation adequately addressed the learning objectives.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
2. The rotation adequately addressed my personal learning goals/expectations.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
3. Residents/fellows were treated as respected members of the care team	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
4. I felt safe asking questions, expressing concerns, and taking learning risks (ie - the environment was psychologically safe).	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5. I felt mistreated at any time over the course of this rotation. If yes, please provide any additional information in the space provided:	Yes	No			
6. Attendings and fellows were readily available for supervision.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
7. Patient care demands allowed sufficient time for education, including self-directed learning and formal teaching opportunities.	Yes	No			
8. The level of responsibility and patient care placed on me was appropriate for my level of training.	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
9. Did you struggle to stay within required duty hours?	Yes	No			
10. If yes, please provide any additional information in the space provided below.					
11. On a scale of 0 to 4, rate the average level of your 'Wellness Fuel Tank' over the course of this rotation (0 = empty, 4 = completely full)					
12. Please use this space to provide any contributing factors to your wellness score above. (Optional)					
13. Please list any positive experiences or interactions with supervising attendings/fellows/residents during this rotation that you would like to describe here. (Optional)					
14. Please list any negative experiences or interactions with supervising attendings/fellows/residents during this rotation that you would like to describe here. (Optional) (Note: any feedback provided here will be addressed anonymously)					
15. What suggestions do you have on ways to improve this rotation? (Optional)					
16. If you selected YES, DISAGREE, or STRONGLY DISAGREE, to any of the questions above, please use this space to include any additional details/information. (Optional)					

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