

2016
Indiana Family Medicine Residencies
Exit Survey Report

INDIANA MEDICAL EDUCATION BOARD

OCTOBER 2016



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

Office of Educational Affairs

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Produced for:

Indiana Medical Education Board

Produced by:

Office of Educational Research and Data Analysis

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EXECUTIVE SUMMARY

BACKGROUND

It is important to understand the reasons why Indiana family medicine residents choose to practice in specific locations in order to plan effective healthcare workforce development initiatives. Having a better understanding of the factors that influence how residents choose a practice location will help improve the efforts to recruit and retain family medicine physicians in areas of need within the state. Beginning in 2012, data were gathered from residents in all eleven Indiana family medicine residency programs to document their graduates' contribution in meeting the medical care needs of the residents of Indiana and the communities where they will practice. This research has continued into 2016 and the results have been shown in this report.

The *2016 Indiana Family Medicine Residencies Exit Survey*[®] instrument identified what these physicians were planning to do after graduation; where they were planning to practice; why they chose specific locations to work; and, for those leaving Indiana, why they decided not to stay in the state to practice. In addition, the survey also obtained overall feedback on the residents' training and their program's curricula, as well as ideas and suggestions for improvement.

METHODS

A cross-sectional survey of all final-year Indiana family medicine residents was conducted in spring of 2016. The survey used a group-administered questionnaire to obtain respondents' demographic characteristics, reactions to their residency training, and their plans after graduation, including where they intended to practice and why they chose that specific location. In 2016, a total of 96 residents were graduating from the eleven Indiana Family Medicine residency programs. All 96 residents were invited to participate on the *2016 Indiana Family Medicine Residencies Exit Survey*[®]. Of those residents, all 96 responded to the survey, thereby yielding a 100 percent response rate.

The table below shows the response rates to the *Indiana Family Medicine Residencies Exit Survey*[®] from 2012 to 2016. There has been a steady rate (100.0%) over the last 4 years.

Indiana Medical Education Board			
Indiana Family Medicine Residencies Exit Survey Response Rates: 2012-2016			
Year	# of Surveys Distributed	# of Surveys Completed	Response Rate
2012	78	77	98.7%
2013	76	76	100.0%
2014	92	92	100.0%
2015	82	82	100.0%
2016	96	96	100.0%

RESULTS

Demographics: Over three-fifths of the respondents were between the ages of 30 and 34 years. Over two-fifths of the respondents were female. Over four-fifths of the respondents were white. Over one-tenth of the respondents were Asian and about five percent were African American. Three percent of the respondents were of Hispanic or Latino ethnicity. Of the 86 respondents who were from United States, almost one-half had a hometown within Indiana. Over one-third of the respondents reported having graduated from a high school or college in Indiana. One-third of the respondents graduated from Indiana University School of Medicine.

Debt load: About two-thirds of the respondents reported having an individual educational debt of \$200,000 or more. Almost three-fourths of the respondents reported having a total household educational debt of \$200,000 or more. Less than one-tenth of the respondents and their household members indicated having no educational debt.

Program Assessment: Over four-fifths of the respondents “strongly agree” or “agree” that the family medicine residency program was helpful in preparing them for their board exam. Almost all respondents felt “fully” competent in patient care, medical knowledge, interpersonal and communication skills, and professionalism; and about four-fifths of the respondents felt “fully” competent in practice-based learning and systems-based practice. Over three-fourths of the respondents indicated having received training to serve the rural populations. A majority of the respondents indicated having received training to serve the underserved populations. Almost three-fifths of the respondents indicated feeling “fully” competent in providing care to the rural populations. Almost all respondents indicated feeling “fully” competent in providing care to the underserved populations. Almost all respondents rated the quality of their residency program as “excellent” or “above average”. Over four-fifths of the respondents “strongly agree” or “agree” that the faculty in their training program exceeded their expectations. A majority of the respondents “strongly agree” or “agree” that other residents or fellows in their residency program exceeded their expectations.

Patient Care: About four-fifths of the respondents expect to be involved in patient care. Over two-thirds of the respondents planned to practice within Indiana. Almost one-fifth of the respondents reported entering a “private practice” setting (solo or group). Over three-fourths of the respondents (77%) intended to practice in a “hospital or health system owned” setting. A majority of the respondents indicated that they planned to work “full-time” in direct patient-care activities. Over one-half of the respondents expect to see 25 percent or more of the underserved populations in their new practice. A majority of the respondents indicated there were “many jobs” available within their specialty in Indiana. Two-thirds of the respondents expect to earn \$200,000 or more during their first year of practice. Three-fourths of the respondents reported being offered three or more employment or practice positions all together and in Indiana.

Main reasons for choosing a practice location:

- The main reasons given to practice at this location were: met my professional needs or preferences, met my personal needs or preferences, and salary or compensation.
- The main reasons given to practice in Indiana were: cost of practicing is reasonable in Indiana, cost of malpractice, and always intended to practice in Indiana.
- The main reasons given to practice outside Indiana were: proximity to my family, proximity to my spouse's family, and never intended to practice in Indiana.

Chi-square test of association was statistically significant among the male and female respondents:

- Male respondents were more likely to be white.
- Male respondents were more likely to indicate they had received training to serve the rural populations.
- Male respondents were more likely to indicate feeling “fully” competent in providing care to the rural populations.

Increasing trend was noted among respondents who:

- Reported having an individual educational debt load of \$200,000 to \$299,999 from 2013 (32%) to 2016 (37%).
- “Strongly agree” that the training program was helpful in preparing them for their board exams from 2012 (31%) to 2016 (48%).
- Felt “fully” competent in medical knowledge and interpersonal skills from 2012 (84%, 95%) to 2016 (92%, 99%) respectively.
- Rated the overall quality of the program as “excellent” from 2012 (36%) to 2016 (59%).
- “Strongly agree” that faculty in their training program exceeded their expectations from 2012 (29%) to 2016 (48%).
- “Strongly agree” that other residents in their training program exceeded their expectations from 2012 (32%) to 2016 (54%).
- Intended to have a primary practice location within Indiana from 2012 (57%) to 2016 (68%).
- Planned to enter a “hospital or health system owned - outpatient only” setting from 2014 (35%) to 2016 (46%).
- Planned to enter a “hospital or health system owned – inpatient and outpatient” setting from 2014 (21%) to 2016 (28%).
- Expected to see between 25 and 49 percent of the underserved populations in their new practice from 2012 (23%) to 2016 (30%).
- Indicated “salary or compensation” as a main reason to practice in Indiana from 2012 (29%) to 2016 (39%).

Declining trend noted in respondents who:

- Were female respondents from 2012 (46%) to 2016 (43%).
- Indicated having no educational debt from 2012 (17%) to 2016 (6%).
- Reported having an individual educational debt load of \$100,000 to \$199,999 from 2013 (26%) to 2016 (18%).

- “Agree” that the training program was helpful in preparing them for the board exams from 2012 (50%) to 2016 (38%).
- Felt “fully” competent in practice-based learning competency area from 2012 (87%) to 2016 (79%).
- Rated the overall quality of the program as “above average” from 2012 (45%) to 2016 (32%).
- Planned to enter a “free-standing health center or clinic” setting from 2014 (6%) to 2016 (0%).
- Expected to see less than 10 percent of the underserved populations in their new practice from 2012 (11%) to 2016 (6%).
- Indicated “met my professional needs or preferences” as a main reason to practice at this location from 2012 (66%) to 2016 (59%).
- Indicated “proximity to my spouse’s or significant other’s family” as a main reason to practice in Indiana from 2013 (48%) to 2016 (39%).

Mapping information

In 2016, a majority of the respondents indicated they planned to practice or stay in Indiana, followed by Illinois, Iowa, Kentucky and Ohio. Of the respondents who chose Indiana as their primary location, a majority planned to practice or stay in the central Indiana Metropolitan Statistical Area, followed by St. Joseph, Vanderburgh, and Elkhart counties.

CHAPTER 1: INTRODUCTION

It has become increasingly important to understand how family medicine residents decide where to practice after they complete their training. Nowadays, even more because of the decrease in the number of United States medical school graduates entering primary care specialties.¹ The problem is not only a lack of physicians, but a disparity between rural and urban supplies of physician distribution throughout the state, creating a persistent barrier to health care access in some areas.² Graduating adequate numbers of primary care physicians who will practice in underserved areas has been an ongoing challenge for the last several decades.³ Having a better understanding of the factors that influence how residents choose a practice location will help improve the efforts to recruit and retain family medicine physicians in areas of need within the state.

Not only is it vital for the eleven family medicine residency programs in Indiana to be able to document the contributions their trainees are making to meet the medical care needs of the Indiana community; but also to understand the factors that influence a graduates' decision to practice in a certain location. Because of the shortage and mal-distribution of physicians in Indiana, understanding where the graduates of the residency program go after they complete their training, and understanding the factors that affect those decisions, have become very important. This information may be valuable in improving efforts to recruit and retain physicians in areas of need within our state.

The *2016 Indiana Family Medicine Residencies Exit Survey*[®] marks the 5th consecutive year of determining what these physicians were planning to do after graduation; and, for those planning to primarily provide clinical care, to determine where they were planning to practice. An additional objective was to determine the experiences these individuals had when they were seeking positions in Indiana; why they chose specific locations to work; and, for those leaving Indiana, why they decided not to stay in the state to practice. A final objective was to obtain overall feedback on their training and the residency programs' curricula, specifically suggestions and ideas for improvement.

The next chapter describes the methodology used for this study. Chapter 3 shows responses for the *2016 Indiana Family Medicine Residencies Exit Survey*[®]. Chapter 4 summarizes responses showing gender comparisons. Chapter 5 shows maps that track where the residents are going after completing their training (both within U.S. as well as Indiana). Chapter 6 shows trending patterns from 2012 to 2016. And lastly, Chapter 7 shows the comments made by survey respondents to a couple open-ended questions regarding suggestions to improve the program and new ideas for the residency curriculum. Appendix A includes a copy of the *2016 Indiana Family Medicine Residencies Exit Survey*[®] and Appendix B shows a table with response tally for each family medicine residency program location from 2012 to 2016.

¹ Ferguson, W., Cashman, S., Savageau, J., & Lasser, D. (2009). Family medicine residency characteristics associated with practice in a health professions shortage area. *Family Medicine*, 41(6), 405-410.

² Quinn, K. J., & Hosokawa, M. C. (2010). Factors contributing to the specialty selection, practice location, and retention of physicians in rural practice. *Ann Behav Sci Med Educ*. 16:21-27.

³ Rabinowitz, H., Diamond, J., Markham, F., & Santana, A. (2013). Retention of rural family physicians after 20-25 years: outcomes of a comprehensive medical school rural program. *Journal of The American Board Of Family Medicine*, 26(1), 24-27.

CHAPTER 2: METHODS

SURVEY ADMINISTRATION

The *2016 Indiana Family Medicine Residencies Exit Survey*[®] is a group-administered survey that measures the respondents' plans after graduation, where they intend to practice, and why they chose that location. In addition, the number of employment offers they received all together and within the state, and assessment of their training program. A copy of the *2016 Indiana Family Medicine Residencies Exit Survey*[®] is included in Appendix A.

Prior to data collection, the principal investigator (PI) obtained an exempt approval from the Indiana University Institutional Review Board in March 2016. The PI then administered this cross-sectional survey to all final-year residents in the eleven family medicine residency programs within the state between April and June, 2016.

The PI contacted program directors and/or program coordinators at each family medicine residency site to schedule a visit to administer surveys at each facility in a group setting. In a few cases, where the residents could not attend the group-administered session, the PI left blank surveys and pre-addressed stamped envelopes with the program coordinator(s). The PI made regular follow-ups with those coordinators to ensure that the survey was completed and mailed back to the PI.

Paper survey instruments were used for each of the eleven family medicine residency programs within the state.⁴ The survey was administered to a total of 96 residents graduating from the eleven family medicine programs across the state in the 2016 calendar year (including off-cycle graduates as well). Of those 96 residents, all 96 responded to the surveys, thereby yielding a 100 percent response rate. A table with response tally for each family medicine residency program location from 2012 to 2016 has been shown in Appendix B.

DATA ANALYSIS

Completed paper surveys were scanned into an electronic database. Data analysis was performed using statistical software, *IBM SPSS Statistics, v24* and mapping software, *ArcGIS 10.4*. Chi-square tests were used to compare responses between groups. *P*-values less than 0.05 were considered statistically significant. All data files were kept in a secure and protected database at the Office of Educational Research and Data Analysis.

REPORT GENERATION

At the end of the analysis, this main report was generated for distribution to the Indiana Medical Education Board members as well as to the eleven family medicine residency program directors. In addition to this main report, a "location-specific" report is also being generated specific to each of the eleven family medicine residency programs.

⁴ 1) Community Health Network, Indianapolis; 2) Deaconess Family Medicine Residency, Evansville; 3) Fort Wayne Medical Education Program, Fort Wayne; 4) Indiana University Health Ball Memorial Hospital, Muncie (formerly known as Ball Memorial Hospital); 5) Indiana University Health Methodist Family Medicine Residency, Indianapolis; 6) Memorial Hospital of South Bend; 7) Franciscan St. Francis Health, Beech Grove (formerly known as St. Francis Hospital); 8) St. Joseph Regional Medical Center, South Bend; 9) St. Vincent Family Medicine Residency, Indianapolis; 10) Union Hospital, Terre Haute; 11) Westview Hospital, Indianapolis

CHAPTER 3: RESPONSES TO THE 2016 INDIANA FAMILY MEDICINE RESIDENCIES EXIT SURVEY[©]

This chapter shows responses to questions asked on the 2016 *Indiana Family Medicine Residencies Exit Survey*[©]. The chapter has been further sub-divided into five broad areas: demographic characteristics, medical school rotations, educational debt load, program assessment, and practice characteristics. The data shown in tables 3.1 to 3.17 and figures 3.1 to 3.2 are based on responses from all 96 graduates participating in this survey. The remaining tables and figures show responses from only those survey respondents' who:

- indicated they planned to work in “patient care or clinical practice” after graduation (n=76);
- intended to practice in Indiana (n=49); and,
- intended to practice outside Indiana (n=23).

For ease of interpretation, percentages in the text have been rounded off to the nearest decimal.

All Respondents [n=96]

I. DEMOGRAPHIC CHARACTERISTICS

Age

Table 3.1	All Respondents	
	2016 (n=96)	
Age	Number	Percent
25-29	18	19.1
30-34	58	61.7
35-39	13	13.8
40-44	3	3.2
>45	2	2.1
Total	94	100.0
Missing	2	

Table 3.1 shows the age distribution of all survey respondents. Over three-fifths (62%) of the respondents were between the ages of 30 and 34 years. The 5-year average was 62 percent.

Gender

Table 3.2	All Respondents	
	2016 (n=96)	
Gender	Number	Percent
Male	55	57.3
Female	41	42.7
Total	96	100.0
Missing	0	

Table 3.2 shows the gender distribution of all survey respondents. Over two-fifths (43%) of the respondents were female. The 5-year average was 44 percent.

Race

Table 3.3	All Respondents	
	2016 (n=96)	
Which of the following describes your race? Please mark ALL that apply.	Number	Percent
American Indian/Alaskan Native	0	0.0
Asian	11	11.7
Black/African American	5	5.3
Native Hawaiian/Pacific Islander	1	1.1
White	77	81.9
Other	0	0.0
Total	94	100.0
Missing	2	

Table 3.3 shows the racial distribution of all survey respondents. Over four-fifths (82%) of the respondents were white, followed by 12 percent of the respondents who indicated they were Asian. The 5-year average was 78 percent and 12 percent for white and Asian respondents, respectively.

Ethnicity

Table 3.4	All Respondents	
	2016 (n=96)	
Do you consider yourself Hispanic or Latino?	Number	Percent
Yes, Hispanic/Latino	3	3.1
No, not Hispanic/Latino	93	96.9
Total	96	100.0
Missing	0	

Table 3.4 shows the ethnicity of all survey respondents. Three percent of the respondents were of Hispanic or Latino ethnicity. The 5-year average was seven percent.

Hometown

Table 3.5	All Respondents	
	2016 (n=96)	
Where do you consider your hometown?	Number	Percent
Outside USA	10	10.4
Within USA	86	89.6
<i>Outside Indiana</i>	46	53.5
<i>Within Indiana</i>	40	46.5
Total	96	100.0
Missing	0	

Table 3.5 shows what the survey respondents' considered to be their hometown. One-tenth (10%) of the respondents indicated they were from another country and over four-fifths (90%) indicated they were from United States. Of the 86 respondents who indicated they were from the United States, almost one-half (47%) had a hometown within Indiana, with a 5-year average of 50 percent.

Respondents from Indiana

Table 3.6	All Respondents	
	2016 (n=96)	
Respondents who have an Indiana...	Number	Percent
High school	33	34.4
College	34	35.4
Medical School	24	25.0

Table 3.6 shows the survey respondents' who graduated from a high school, college, or medical school in Indiana. Over one-third of the respondents indicated they had graduated from a high school (34%), or college (35%) in Indiana. The 5-year average for respondents graduating from a high school or college in Indiana was 38 percent. One-fourth (25%) of the respondents reported graduating from Indiana University School of Medicine (IUSM), with a 5-year average of 26 percent.

II. MEDICAL SCHOOL TRAINING

IUSM First-Year Campus Location

Table 3.7	IUSM Respondents Only	
	2016 (n=24)	
If you attended Indiana University School of Medicine, in which campus did you <u>begin your first year</u> ?*	Number	Percent
Bloomington	0	0.0
Evansville	4	18.2
Fort Wayne	2	9.1
Indianapolis	5	22.7
Lafayette	1	4.5
Muncie	3	13.6
Northwest	1	4.5
South Bend	1	4.5
Terre Haute	5	22.7
Total	22	100.0
Missing	2	

*This includes only those respondents who attended IUSM.

Table 3.7 shows the IUSM campus at which the survey respondents' started their first year. Only those respondents who attended IUSM are included in the analysis for this table.

About one-fourth of the respondents reported beginning their first year of medical school at the Indianapolis (23%) and Terre Haute (23%) campuses.

IUSM Third-Year Family Medicine Rotation Campus Location

Table 3.8 If you attended Indiana University School of Medicine, at which Family Medicine residency program did you complete your 3 rd year required Family Medicine rotation?*	IUSM Respondents Only	
	2016 (n=24)	
	Number	Percent
Community Health Network, Indianapolis	3	13.0
Deaconess Family Medicine Residency, Evansville	0	0.0
Fort Wayne Medical Education Program, Fort Wayne	2	8.7
Indiana University Health Ball Memorial Hospital, Muncie	1	4.3
Indiana University Methodist Family Medicine Residency, Indianapolis	1	4.3
Memorial Hospital of South Bend	1	4.3
Franciscan St. Francis Health, Beech Grove	3	13.0
St. Joseph Community Hospital of Mishawaka	0	0.0
St. Joseph Regional Medical Center, South Bend	1	4.3
St. Mary's Medical Center, Evansville	0	0.0
St. Vincent Family Medicine Residency, Indianapolis	2	8.7
The Methodist Hospitals Inc., Gary	0	0.0
Union Hospital, Terre Haute	4	17.4
Westview Hospital, Indianapolis	0	0.0
Other	5	21.7
Total	23	100.0
Missing	1	

*This includes only those respondents who attended IUSM.

Table 3.8 shows the campus at which the survey respondents' attended their third-year family medicine rotation. Only those respondents who attended IUSM are included in the analysis for this table.

Over one-fifth (22%) of the respondents reported completing their third-year family medicine rotation at "other" locations, followed by less than one-fifth of the respondents at Union Hospital in Terre Haute (17%), Community Health Network in Indianapolis (13%), and Franciscan St. Francis Health in Beech Grove (13%).

IUSM Fourth-Year Elective or Externship Location

Table 3.9	IUSM Respondents Only
	2016 (n=24)
If you attended Indiana University School of Medicine, did you experience a <u>4th year elective or student externship experience</u> at any of the following sites?*	Number
Community Health Network, Indianapolis	5
Deaconess Family Medicine Residency, Evansville	2
Fort Wayne Medical Education Program, Fort Wayne	0
Indiana University Health Ball Memorial Hospital, Muncie	6
Indiana University Methodist Family Medicine Residency, Indianapolis	3
Memorial Hospital of South Bend	3
Franciscan St. Francis Health, Beech Grove	4
St. Joseph Community Hospital of Mishawaka	2
St. Joseph Community Regional Medical Center, South Bend	1
St. Mary's Medical Center, Evansville	0
St. Vincent Family Medicine Residency, Indianapolis	10
The Methodist Hospitals Inc., Gary	0
Union Hospital, Terre Haute	0
Westview Hospital, Indianapolis	0
Other	1

*This includes only those respondents who attended IUSM.

Table 3.9 shows the location at which the survey respondents' attended their fourth-year elective or externship experience. Only those respondents who attended IUSM are included in the analysis for this table. Respondents were provided the option to mark all that apply; thus, no percentages have been shown on this table.

Most of the respondents reported completing their fourth-year elective or an externship experience in St. Vincent Family Medicine Residency in Indianapolis (n=10); Indiana University Health Ball Memorial Hospital in Muncie (n=6), and Community Health Network in Indianapolis (n=5).

III. EDUCATIONAL DEBT LOAD

Current Individual Educational Debt

Figure 3.1: Current Individual Educational Debt (n=96)



Figure 3.1 presents the current level of individual educational debt among the survey respondents. Six percent of the respondents indicated having no educational debt. About two-thirds (65%) of the respondents reported having an educational debt of \$200,000 or more, with a 5-year average of 51 percent.

Current Total Household Educational Debt

Figure 3.2: Current Total Household Educational Debt (n=96)



Figure 3.2 presents the current level of *total* household educational debt among the survey respondents. Five percent of the respondents indicated having no household educational debt. Almost three-fourths (71%) of the respondents reported having a total household educational debt of \$200,000 or more, with a 5-year average of 57 percent.

IV. PROGRAM ASSESSMENT

Training Program

Table 3.10	All Respondents	
	2016 (n=96)	
The Family Medicine residency program was helpful in the preparation for my board exams.	Number	Percent
Strongly Agree	45	47.9
Agree	36	38.3
Neutral	12	12.8
Disagree	1	1.1
Strongly Disagree	0	0.0
Total	94	100.0
Missing/ Board Exam in my field does not exist	2	

Table 3.10 shows the survey respondents' assessment of how helpful the training program was in preparing them for the board exams. Over four-fifths (86%) of the respondents "strongly agree" or "agree" that the family medicine residency program was helpful in preparing them for the board exam. The 5-year average was 88 percent.

ACGME Competency Areas

Table 3.11	All Respondents					
	2016 (n=96)					
	Fully		Partially		Not at all	
How competent do you feel in the following ACGME competencies?	#	%	#	%	#	%
Patient Care	92	96.8	3	3.2	0	0.0
Medical Knowledge	87	91.6	8	8.4	0	0.0
Practice-based learning and improvement	75	78.9	20	21.1	0	0.0
Interpersonal and communication skills	94	98.9	1	1.1	0	0.0
Professionalism	95	100.0	0	0.0	0	0.0
Systems-based practice	79	83.2	16	16.8	0	0.0

Table 3.11 shows the survey respondents' self-rated competency level in the Accredited Council for Graduate Medical Education (ACGME) competency areas. Almost all respondents felt "fully" competent in patient care (97%), medical knowledge (92%), interpersonal/ communication skills (99%)

and professionalism (100%). About four-fifths of the respondents indicated feeling “fully” competent in practice-based learning/improvement (79%) and systems-based practice (83%).

Rural and Underserved Training

Table 3.12	All Respondents			
	2016 (n=96)			
	Yes		No	
In your Family Medicine residency program did you receive training to serve the:	#	%	#	%
Rural Population	73	76.0	23	24.0
Underserved Population	95	99.0	1	1.0

Table 3.12 shows whether the survey respondents’ received training to serve the rural and underserved populations during their training program. Over three-fourths (76%) of the respondents indicated having received training to serve the rural populations. The 5-year average was 73 percent. Almost all (99%) respondents indicated having received training to serve the underserved populations. The 5-year average was 99 percent.

Competency in Providing Care to the Rural and Underserved Populations

Table 3.13	All Respondents					
	2016 (n=96)					
	Fully		Partially		Not at all	
How <u>competent</u> do you feel providing care to the:	#	%	#	%	#	%
Rural Population	56	58.3	36	37.5	4	4.2
Underserved Population	88	91.7	8	8.3	0	0.0

Table 3.13 shows the survey respondents’ self-rated competency levels in providing care to the rural and underserved populations. Almost three-fifths (58%) of the respondents indicated feeling “fully” competent in providing care to the rural populations. The 5-year average was 64 percent. Almost all (92%) respondents indicated feeling “fully” competent in providing care to the underserved populations. The 5-year average was 93 percent.

Quality of Program

Table 3.14	All Respondents	
	2016 (n=96)	
I would rate the overall <u>quality</u> of my Family Medicine residency program as:	Number	Percent
Excellent	57	59.4
Above Average	31	32.3
Average	6	6.3
Below Average	2	2.1
Extremely Poor	0	0.0
Total	96	100.0
Missing	0	

Table 3.14 shows the survey respondents' overall rating of the quality of their family medicine residency program. Almost all (92%) respondents rated the quality of their residency program as “excellent” or “above average”. The 5-year average was 89 percent.

Faculty Assessment

Table 3.15	All Respondents	
	2016 (n=96)	
I would rate the overall performance of the <u>faculty</u> in my Family Medicine residency program to have exceeded my expectations.	Number	Percent
Strongly Agree	46	47.9
Agree	33	34.4
Neutral	12	12.5
Disagree	5	5.2
Strongly Disagree	0	0.0
Total	96	100.0
Missing	0	

Table 3.15 shows the survey respondents' overall performance rating of faculty in their family medicine residency program. Over four-fifths (82%) of the respondents “strongly agree” or “agree” that the faculty in their training program exceeded their expectations. The 5-year average was 84 percent.

Assessment of Peer Residents and Fellows

Table 3.16	All Respondents	
	2016 (n=96)	
I would rate the overall performance of the <u>other residents</u> in my Family Medicine residency program to have exceeded my expectations.	Number	Percent
Strongly Agree	52	54.2
Agree	40	41.7
Neutral	3	3.1
Disagree	1	1.0
Strongly Disagree	0	0.0
Total	96	100.0
Missing	0	

Table 3.16 shows the survey respondents' overall performance rating of other residents and fellows in their family medicine residency program. A majority (96%) of the respondents “strongly agree” or “agree” that other residents or fellows in their residency program exceeded their expectations. The 5-year average was 93 percent.

Plans after Graduation

Table 3.17	All Respondents	
	2016 (n=96)	
What do you expect to be doing after completion of your current Family Medicine residency program? Please mark only ONE option.	Number	Percent
Patient Care or Clinical Practice (in Non-Training Position)	76	79.2
Fellowship or Additional Subspecialty Training	19	19.8
Academic position (Teaching and/or Research)	1	1.0
Temporarily Out of Medicine	0	0.0
Military	0	0.0
Industry	0	0.0
Other	0	0.0
Undecided or Don't know yet	0	0.0
Total	96	100.0
Missing	0	

Table 3.17 shows what the survey respondents' expect to do after completing their current family medicine residency program. About four-fifths (79%) of the respondents expect to be involved in "patient care or clinical practice" followed by one-fifth (20%) of the respondents who plan to enter a fellowship. The 5-year average for respondents going into "patient care or clinical practice" was 79 percent.

NOTE: The following section is only for those survey respondents' who indicated they were going into "patient care or clinical practice" (n=76).

V. PRACTICE CHARACTERISTICS

This section includes only those going into "patient care or clinical practice"

Primary Practice Location

Table 3.18	Clinical Care Respondents	
	2016 (n=76)	
Where is the location of your primary activity after completing your current Family Medicine residency program?	Number	Percent
Same city of country as current training	22	30.6
Same region in Indiana, but different city or county	20	27.8
Other area in Indiana	7	9.7
Other U.S. state (not Indiana)	21	29.2
Outside of U.S.	2	2.8
Total	72	100.0
Missing/Undecided	4	

Table 3.18 shows the location of the survey respondents' primary activity after completing their current family medicine residency program. Over two-thirds (68%) of the respondents planned to practice within Indiana and over one-fourth (29%) intended to relocate to another state in the United States after completing their current family medicine residency program. Four respondents were undecided at the time the survey was administered. The 5-year average for respondents planning to practice within Indiana was 64 percent.

Type of Practice

Table 3.19 Which best describes the principal type of Patient Care Practice you will be entering?	Clinical Care Respondents	
	2016 (n=76)	
	Number	Percent
Private practice-Solo	2	3.1
Private Practice-Group or Partnership (2 or more persons)	10	15.4
Hospital or health system owned- inpatient only	2	3.1
Hospital or health system owned- outpatient only	30	46.2
Hospital or health system owned- inpatient and outpatient	18	27.7
Urgent care facility	2	3.1
Managed care organization or insurance company	0	0.0
Free-standing health center or clinic	0	0.0
Nursing home or institutional residential facility	0	0.0
Other	1	1.5
Total	65	100.0
Missing	11	

Table 3.19 shows the principal type of patient care practice setting the survey respondents' will be entering after completing their training. Almost one-fifth (18%) of the respondents indicated they will be entering a private practice: solo (3%) or group (15%). Over three-fourths (77%) of the respondents reported entering a "hospital or health system owned" setting: inpatient only (3%), outpatient only (46%), and inpatient + outpatient (28%).

Amount of Direct Patient-Care Activities

Table 3.20 In your upcoming position, what amount of direct patient-care activities will you do?	Clinical Care Respondents	
	2016 (n=76)	
	Number	Percent
No patient-care activities	1	1.3
Part-time patient-care activities	4	5.3
Full-time patient-care activities	70	93.3
Total	75	100.0
Missing	1	

Table 3.20 shows the survey respondents' expected amount of time spent in direct-patient-care activities in their upcoming position. Almost all (93%) respondents indicated they will be working "full-time" in direct-patient-care activities. The 5-year average was 95 percent.

In addition, a majority (85%) of respondents indicated they had no obligation or visa requirement. The 5-year average was 84 percent.

Percentage of Patients Expected to be seen from Underserved Populations

Table 3.21	Clinical Care Respondents	
	2016 (n=76)	
In your new practice, what percentage of the patients do you expect to see from underserved populations?	Number	Percent
Less than 10 percent	4	6.1
10-24 percent	26	39.4
25-49 percent	20	30.3
50-74 percent	11	16.7
More than 75 percent	5	7.6
Total	66	100.0
Missing	10	

Table 3.21 shows the percentage of patients that the survey respondents' expect to see from underserved populations (Medicaid or self-pay, educationally or economically disadvantaged) in their new practice. Over one-half (55%) of the respondents expect to see 25 percent or more of the underserved populations in their new practice. The 5-year average was 51 percent.

Opportunities in Indiana

Figure 3.3: Overall Assessment of Practice Opportunities in Indiana (n=76)

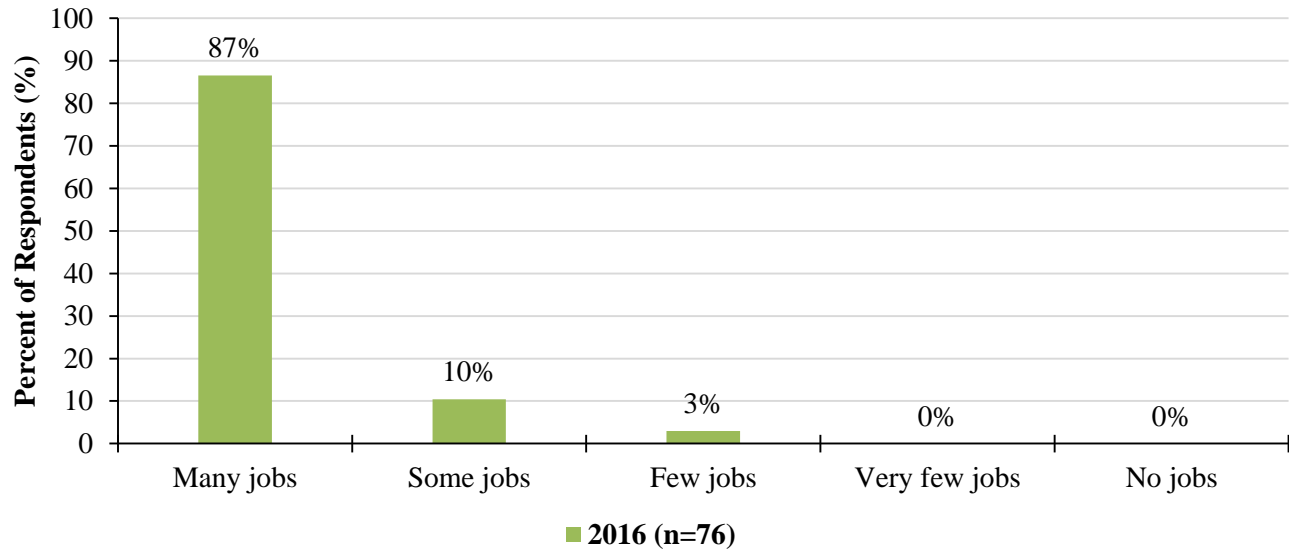


Figure 3.3 presents the overall assessment of practice opportunities for survey respondents' within their specialty in Indiana. A majority (87%) of the respondents indicated that there were "many jobs" available within their specialty in Indiana. The 5-year average was 83 percent.

Expected Gross Income

Figure 3.4: Expected Gross Income (n=76)

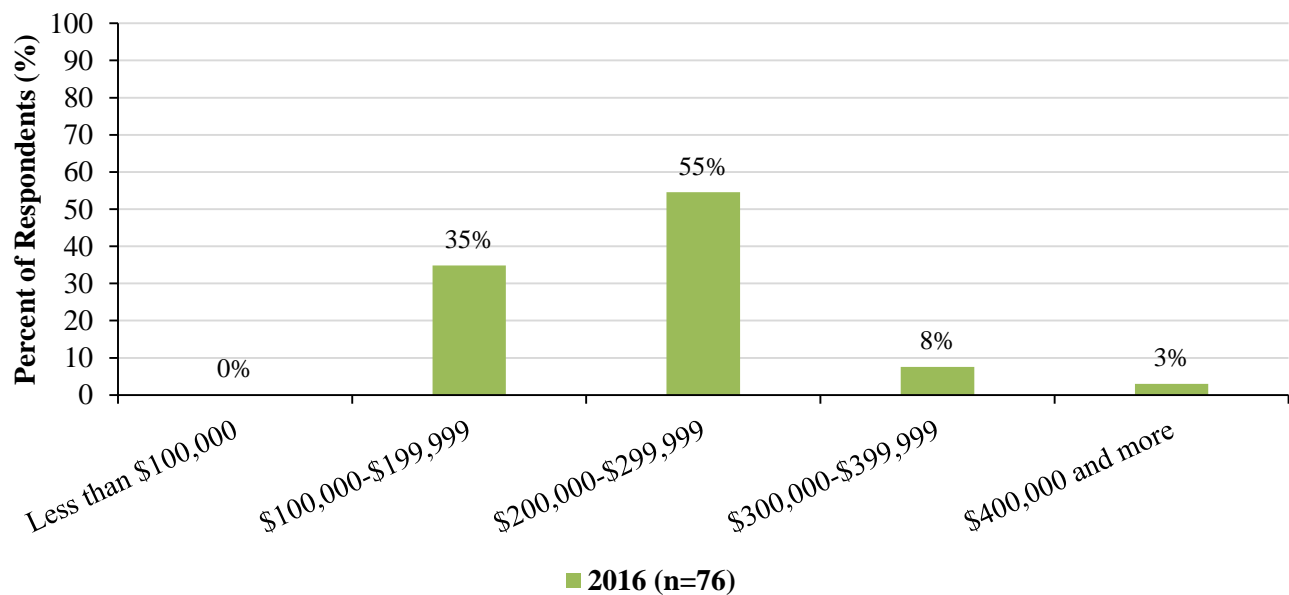


Figure 3.4 presents the gross income (salary plus incentives) that survey respondents' expect to earn during their first year of practice. Two-thirds (66%) of the respondents expect to earn \$200,000 or more during their first year of practice. The 5-year average was 66 percent.

Job Offers All Together

Table 3.22	Clinical Care Respondents	
	2016 (n=76)	
How many offers for employment/practice positions did you receive <u>all together</u> ?	Number	Percent
0	0	0.0
1	6	9.5
2	10	15.9
3	17	27.0
4	6	9.5
5 or more	24	38.1
Total	63	100.0
Missing/Did not seek employment position at the time	13	

Table 3.22 shows the *total* number of offers the survey respondents' received for employment or practice positions. Three-fourths (75%) of the respondents reported being offered three or more offers for employment or practice positions all together. The 5-year average was 72 percent.

Main Reasons to Practice at this Location

Figure 3.5: Main Reasons to Practice at this Location (n=76)

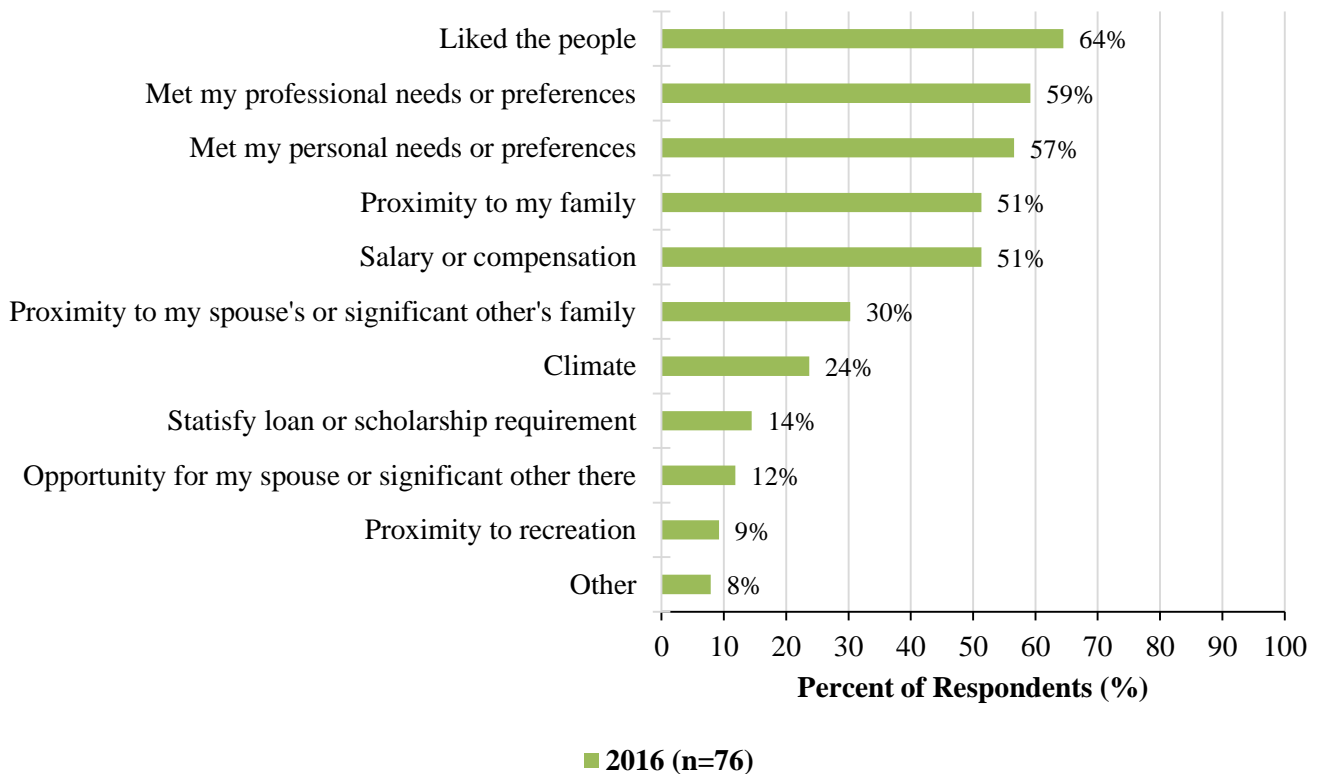


Figure 3.5 presents the main reasons the survey respondents’ chose to practice at this location. The main reasons given by the respondents for choosing to practice at this location were: “liked the people” (64%), “met my professional needs or preferences” (59%), “met my personal needs or preferences” (57%), “proximity to my family” (51%) and “salary or compensation” (51%).

Job Offers in Indiana

Table 3.23	Clinical Care Respondents	
	2016 (n=49)	
How many offers for employment/practice positions did you receive <u>in Indiana</u> ?*	Number	Percent
0	0	0.0
1	4	9.1
2	6	13.6
3	17	38.6
4	4	9.1
5 or more	13	29.5
Total	44	100.0
Missing/Did not seek employment position at the time	5	

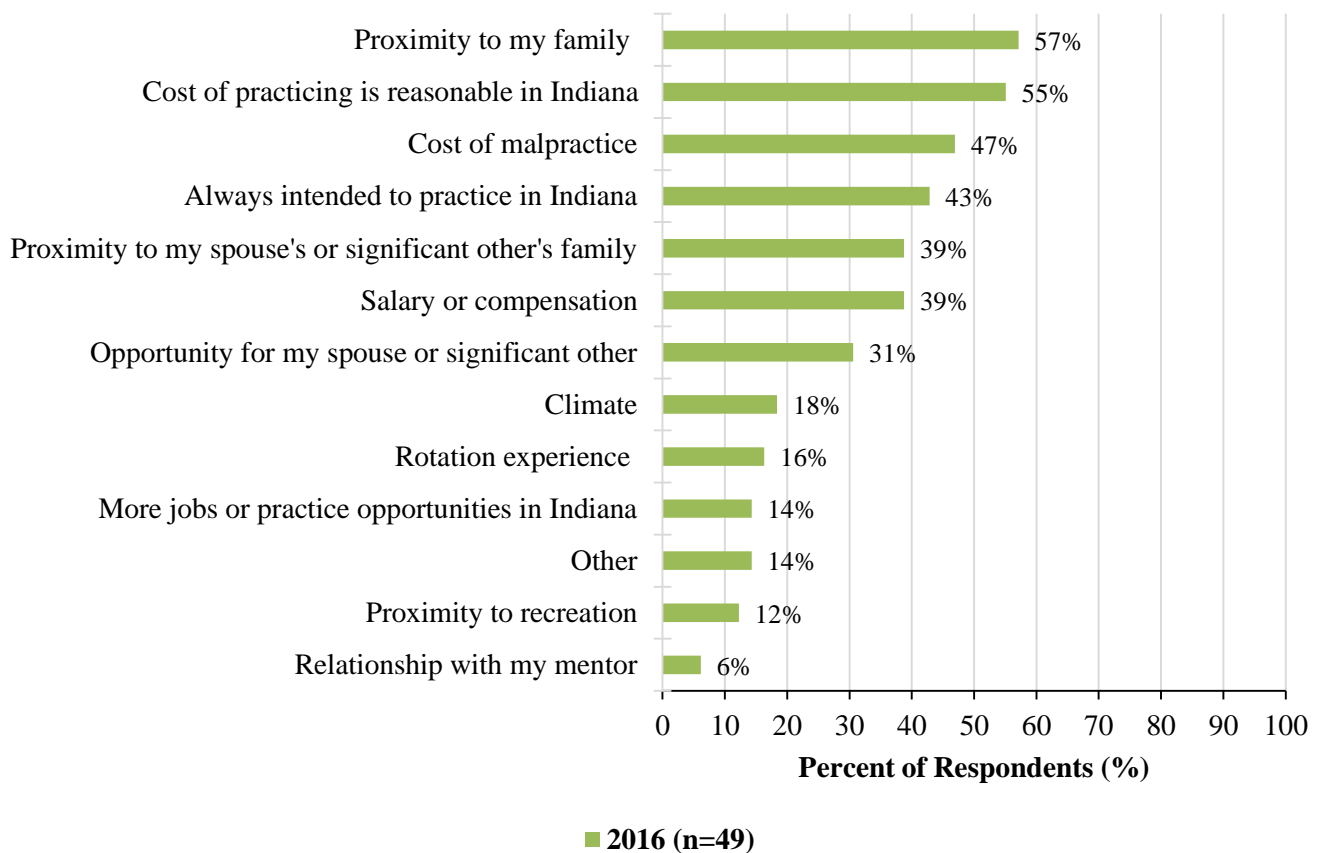
*Reflects responses from only those respondents who indicated their primary practice location was in Indiana.

Table 3.23 shows the number of offers the survey respondents’ received for employment or practice positions in Indiana. Only the respondents who indicated their primary practice location was in Indiana were included in the analysis for this table.

Of those intending to practice in Indiana, over three-fourths (77%) of the respondents indicated they had received three or more offers for employment or practice positions in Indiana. The 5-year average was 64 percent.

Main Reasons to Practice in Indiana

Figure 3.6: Main Reasons to Practice in Indiana(n=49)*



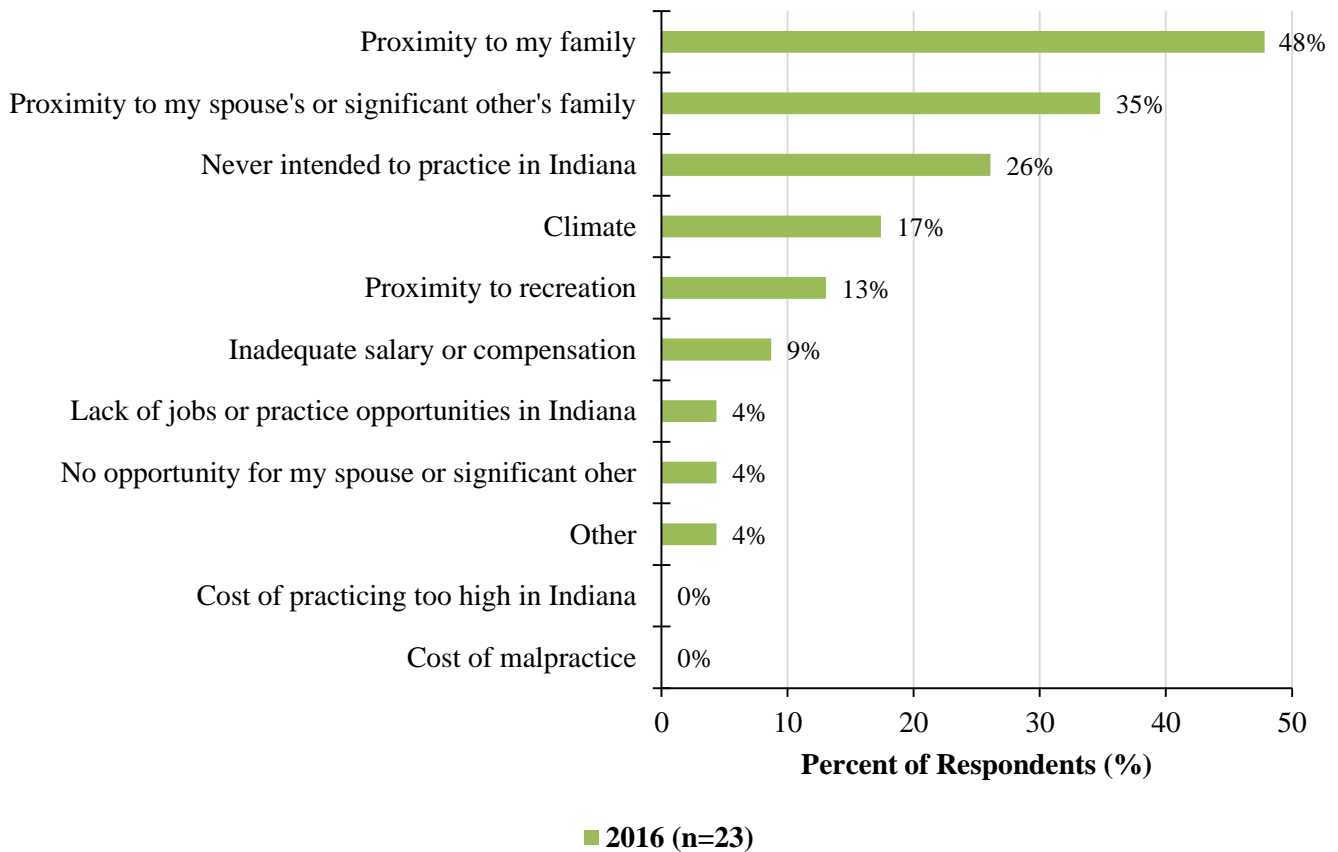
**Reflects responses from only those respondents who indicated their primary practice location was in Indiana.*

Figure 3.6 presents the main reasons influencing the survey respondents’ choice of practice location in Indiana. Only those respondents who indicated their primary practice location was in Indiana were included in the analysis for this table.

The main reasons given by the respondents for practicing in Indiana were: “proximity to my family” (57%), “cost of practicing is reasonable in Indiana” (55%), “cost of malpractice” (47%), and “always intended to practice in Indiana” (43%).

Main Reasons not to Practice in Indiana

Figure 3.7: Main Reasons Not to Practice in Indiana (n=23)*



**Reflects responses from only those respondents who indicated their primary practice location was outside Indiana.*

Figure 3.7 presents the main reasons influencing survey respondents' choice of practice location outside Indiana. Only those respondents who indicated their primary practice location was outside Indiana were included in the analysis for this graph.

The top three reasons given by the respondents were: “proximity to my family” (48%), “proximity to my spouse’s or significant other’s family” (35%), and “never intended to practice in Indiana” (26%).

CHAPTER 4: COMPARISON OF RESPONSES BY GENDER, 2016

Based on the responses to Question 2 on the *2016 Indiana Family Medicine Residencies Exit Survey*[®], the survey respondents were stratified by gender into a male and female category. Of the 96 respondents, 55 reported their gender as male and 41 as female. Tables 4.1 to 4.16 and figures 4.1 to 4.2 show gender comparisons between all respondents. The remaining tables and figures show gender comparisons between only those respondents who:

- indicated that they planned to work in “patient care or clinical practice” after graduation: male (n=42) and female (n=34);
- intended to practice in Indiana male (n=25) and female (n=24); and,
- intended to practice outside Indiana: male (n=17) and female (n=6).

Data analysis was performed using statistical software, *IBM SPSS Statistics, v22*. Chi-square tests were used to compare responses between groups. *P*-values less than 0.05 were considered statistically significant and denoted with a symbol (¥). For ease of interpretation, percentage values have been rounded off to the nearest decimal in the text.

All Respondents [n=96]

I. DEMOGRAPHIC CHARACTERISTICS

Age by Gender

Table 4.1	All Respondents			
	Male (n=55)		Female (n=41)	
Age	#	%	#	%
25-29	8	14.8	10	25.0
30-34	35	64.8	23	57.5
35-39	9	16.7	4	10.0
40-44	1	1.9	2	5.0
>45	1	1.9	1	2.5
Total	54	100.0	40	100.0
Missing	1		1	

Chi-square *p*-value= 0.741

Table 4.1 shows the age distribution of all male and female respondents to the survey. About two-thirds (65%) of the male respondents were between the ages of 30 and 34 years, compared to 58 percent of the female respondents. There was no statistically significant difference between groups.

Race by Gender

Table 4.2	All Respondents			
	Male (n=55)		Female (n=41)	
Which of the following describes your race? Please mark ALL that apply.	#	%	#	%
American Indian/Alaskan Native	0	0.0	0	0.0
Asian	3	5.6	8	20.0
Black/African American	1	1.9	4	10.0
Native Hawaiian/Pacific Islander	0	0.0	1	2.5
White	50	92.6	27	67.5
Other	0	0.0	0	0.0
Total	54	100.0	40	100.0
Missing	1		1	

Chi-square p -value= 0.002^y

Table 4.2 shows the racial distribution of all male and female respondents to the survey. A majority (93%) of the male respondents were white, compared to 68 percent of the female respondents. The chi-square test of association between the two groups was statistically significant. Male respondents were more likely to be white.

Ethnicity by Gender

Table 4.3	All Respondents			
	Male (n=55)		Female (n=41)	
Do you consider yourself Hispanic or Latino?	#	%	#	%
Yes, Hispanic/Latino	1	1.8	2	4.9
No, not Hispanic/Latino	54	98.2	39	95.1
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value= 0.394

Table 4.3 shows the ethnicity of all male and female respondents to the survey. A majority of the male (98%) and female (95%) respondents indicated having a non-Hispanic or Latino ethnicity. There was no statistically significant difference between groups.

Hometown by Gender

Table 4.4	All Respondents			
	Male (n=55)		Female (n=41)	
Where do you consider your hometown?	#	%	#	%
Outside USA	7	12.7	3	7.3
Within USA	48	87.3	38	92.7
<i>Outside Indiana</i>	<i>30</i>	<i>62.5</i>	<i>16</i>	<i>42.1</i>
<i>Within Indiana</i>	<i>18</i>	<i>37.5</i>	<i>22</i>	<i>57.9</i>
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value= 0.304

Table 4.4 shows the location that the male and female survey respondents' considered to be their hometown. About one-tenth of the male (13%) and female (7%) respondents were from another country. Of the respondents who indicated they were from United States, over one-third of the male (38%) respondents indicated having a hometown within Indiana, compared to 58 percent of the female respondents. There was no statistically significant difference between groups.

Connections to Indiana by Gender

Table 4.5	All Respondents			
	Male (n=55)		Female (n=41)	
Respondents who have an Indiana...	#	%	#	%
High school	16	29.1	17	41.5
College	18	32.7	16	39.0
Medical School	10	18.2	14	34.1

Table 4.5 shows the male and female survey respondents who reported graduating from a high school, college, or medical school in Indiana. About one-third of the male respondents indicated graduating from a high school (29%) or college (33%) in Indiana, compared to almost two-fifths of the female respondents (42%, 39%, respectively). About one-fifth of the male (18%) respondents reported graduating from Indiana University School of Medicine (IUSM), compared to 34 percent of the female respondents.

II. MEDICAL SCHOOL TRAINING

IUSM First-Year Campus Location

Table 4.6	IUSM Respondents Only			
	Male (n=10)		Female (n=14)	
If you attended Indiana University School of Medicine, in which campus did you <u>begin your first year</u> ?*	#	%	#	%
Bloomington	1	11.1	3	23.1
Evansville	2	22.2	0	0.0
Fort Wayne	1	11.1	4	30.8
Indianapolis	1	11.1	0	0.0
Lafayette	1	11.1	2	15.4
Muncie	0	0.0	1	7.7
Northwest	0	0.0	1	7.7
South Bend	3	33.3	2	15.4
Terre Haute	0	0.0	0	0.0
Total	9	100.0	13	100.0
Missing	1		1	

*This includes only those respondents who attended IUSM.

Chi-square p -value= 0.345

Table 4.6 shows the IUSM campus at which male and female survey respondents started their first year. Only those respondents who attended IUSM are included in the analysis for this table.

About one-third of male (33%) respondents attended their first year of medical school at South Bend. About one-third of female (31%) respondents attended their first year of medical school at Fort Wayne campus. There was no statistically significant difference between groups.

IUSM Third-Year Family Medicine Rotation Campus Location

Table 4.7	IUSM Respondents Only			
	Male (n=10)		Female (n=14)	
If you attended Indiana University School of Medicine, at which Family Medicine residency program did you complete your 3 rd year required Family Medicine rotation?*	#	%	#	%
Community Health Network, Indianapolis	2	22.2	1	7.1
Deaconess Family Medicine Residency, Evansville	0	0.0	0	0.0
Fort Wayne Medical Education Program, Fort Wayne	1	11.1	1	7.1
Indiana University Health Ball Memorial Hospital, Muncie	0	0.0	1	7.1
Indiana University Methodist Family Medicine Residency, Indianapolis	0	0.0	1	7.1
Memorial Hospital of South Bend	0	0.0	1	7.1
Franciscan St. Francis Health, Beech Grove	0	0.0	3	21.4
St. Joseph Community Hospital of Mishawaka	0	0.0	0	0.0
St. Joseph Regional Medical Center, South Bend	0	0.0	1	7.1
St. Mary's Medical Center, Evansville	0	0.0	0	0.0
St. Vincent Family Medicine Residency, Indianapolis	0	0.0	2	14.3
The Methodist Hospitals Inc., Gary	0	0.0	0	0.0
Union Hospital, Terre Haute	2	22.2	2	14.3
Westview Hospital, Indianapolis	0	0.0	0	0.0
Other	4	44.4	1	7.1
Total	9	100.0	14	100.0
Missing	1		0	

*This includes only those respondents who attended IUSM.

Chi-square p -value= 0.308

Table 4.7 shows the campus at which the male and female survey respondents attended their third-year family medicine rotation. Only those respondents who attended IUSM are included in the analysis for this table. Over two-fifths (44%) of the male respondents completed their third-year family medicine rotations at “Other” locations. Over one-fifth (21%) of the female respondents completed their third-year family medicine rotations at Franciscan St. Francis Health in Beech Grove. There was no statistically difference between groups.

IUSM Fourth-Year Elective or Externship Location

Table 4.8	IUSM Respondents Only	
	Male (n=10)	Female (n=14)
If you attended Indiana University School of Medicine, did you experience a 4th year elective or student externship experience at any of the following sites?*	Number	Number
Community Health Network, Indianapolis	2	3
Deaconess Family Medicine Residency, Evansville	1	1
Fort Wayne Medical Education Program, Fort Wayne	0	0
Indiana University Health Ball Memorial Hospital, Muncie	3	3
Indiana University Methodist Family Medicine Residency, Indianapolis	0	3
Memorial Hospital of South Bend	1	2
Franciscan St. Francis Health, Beech Grove	1	3
St. Joseph Community Hospital of Mishawaka	1	1
St. Joseph Community Regional Medical Center, South Bend	0	1
St. Mary's Medical Center, Evansville	0	0
St. Vincent Family Medicine Residency, Indianapolis	3	7
The Methodist Hospitals Inc., Gary	0	0
Union Hospital, Terre Haute	0	0
Westview Hospital, Indianapolis	0	0
Other	1	0

*This includes only those respondents who attended IUSM.

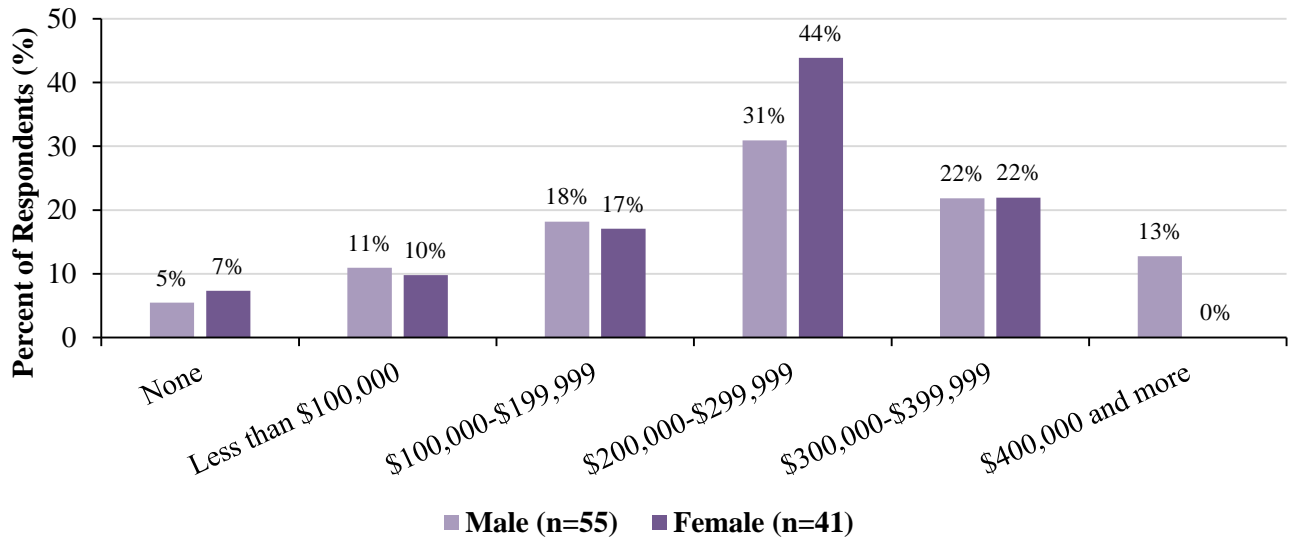
Table 4.8 shows the location at which the male and female survey respondents attended their fourth-year elective or externship experience. Only those respondents who attended IUSM are included in the analysis for this table. Respondents were provided the option to mark all that apply; thus, no percentages have been shown on this table.

Three of the male respondents attended Indiana University Health Ball Memorial Hospital in Muncie and St. Vincent Family Medicine Residency in Indianapolis. Seven of the female respondents attended St. Vincent Family Medicine Residency in Indianapolis.

III. EDUCATIONAL DEBT LOAD

Current Individual Educational Debt by Gender

Figure 4.1: Current Individual Educational Debt (n=96)

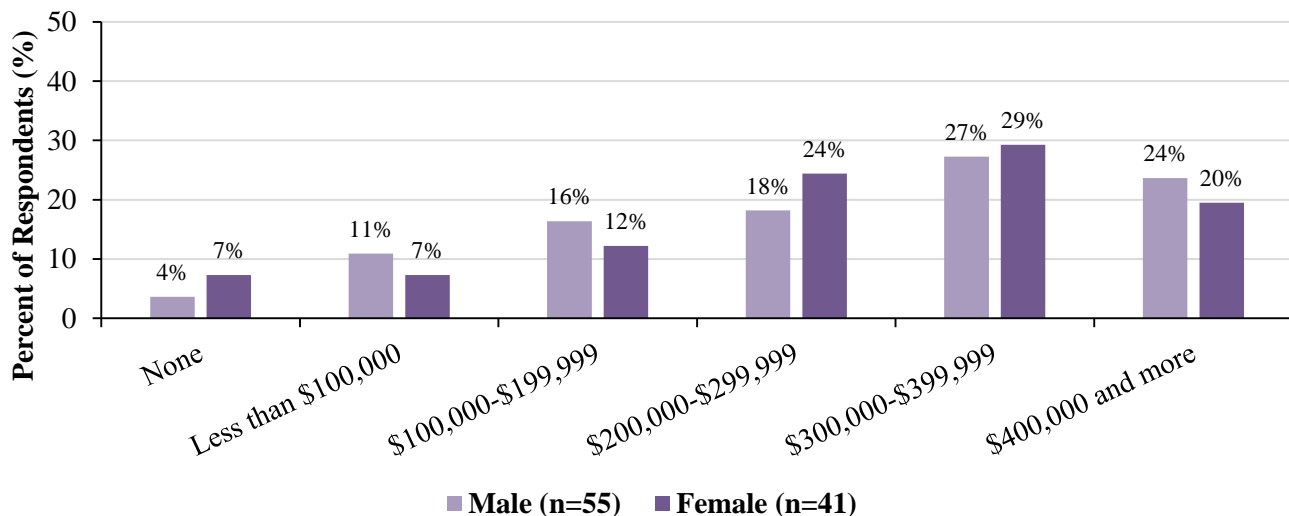


Chi-square p -value= 0.545

Figure 4.1 presents the current level of individual educational debt among the male and female survey respondents. Less than one-tenth of the male (5%) and female (7%) respondents indicated having no educational debt. Two-thirds (66%) of the male and female respondents had an educational debt of \$200,000 or more. There was no statistically significant difference between groups.

Current Total Household Educational Debt by Gender

Figure 4.2: Current Total Household Educational Debt (n=96)



Chi-square p -value= 0.714

Figure 4.2 presents the current level of *total* household educational debt among the male and female survey respondents. Less than one-tenth of the male (4%) and female (7%) respondents indicated having no household educational debt. Over two-thirds of the male (69%) and female (73%) respondents reported having a total household educational debt of \$200,000 or more. There was no statistically significant difference between groups.

IV. PROGRAM ASSESSMENT

Training Program by Gender

Table 4.9	All Respondents			
	Male (n=55)		Female (n=41)	
The Family Medicine residency program was helpful in the preparation for my board exams.	#	%	#	%
Strongly Agree	31	57.4	14	35.0
Agree	18	33.3	18	45.0
Neutral	4	7.4	8	20.0
Disagree	1	1.9	0	0.0
Strongly Disagree	0	0.0	0	0.0
Total	54	100.0	40	100.0
Missing/ Board Exam in my field does not exist	1		1	

Chi-square p -value= 0.078

Table 4.9 shows the male and female survey respondents' assessment of how well the training program prepared them for their board exam. A majority of the male (91%) and female (80%) respondents "strongly agree" or "agree" that their training was help in preparing them for their board exams. There was no statistically significant difference between groups.

ACGME Competency Areas by Gender

Table 4.10	All Respondents											
	Male (n=55)						Female (n=41)					
	Fully		Partially		Not at all		Fully		Partially		Not at all	
How competent do you feel in the following ACGME competencies?	#	%	#	%	#	%	#	%	#	%	#	%
Patient Care	52	96.3	2	3.7	0	0.0	40	97.6	1	2.4	0	0.0
Medical Knowledge	51	94.4	3	5.6	0	0.0	36	87.8	5	12.2	0	0.0
Practice-based learning and improvement	44	81.5	10	18.5	0	0.0	31	75.6	10	24.4	0	0.0
Interpersonal and communication skills	54	100.0	0	0.0	0	0.0	40	97.6	1	2.4	0	0.0
Professionalism	54	100.0	0	0.0	0	0.0	41	100.0	0	0.0	0	0.0
Systems-based practice	48	88.9	6	11.1	0	0.0	31	75.6	10	24.4	0	0.0

Table 4.10 shows the male and female survey respondents' self-rated competency level in the Accredited Council for Graduate Medical Education (ACGME) competency areas. All (100%) male and female respondents felt “fully” competent in the areas of professionalism. Nearly all male and female respondents felt “fully” competent in patient care (96%, 98%), medical knowledge (94%, 88%), and interpersonal and communication skills (100%, 98%) competency areas. Over three-fourths of the male and female respondents felt “fully” competent in practice-based learning (82%, 76%) and systems-based practice (89%, 76%) competency areas. There was no statistically significant difference between groups.

Rural and Underserved Training by Gender

Table 4.11	All Respondents								p-value
	Male (n=55)				Female (n=41)				
	Yes		No		Yes		No		
In your Family Medicine residency program did you receive training to serve the:	#	%	#	%	#	%	#	%	
Rural Population	46	83.6	9	16.4	27	65.9	14	34.1	0.043 [¥]
Underserved Population	54	98.2	1	1.8	41	100.0	0	0.0	0.385

Table 4.11 shows whether the male and female survey respondents' received training to serve the rural and underserved populations during their residency program. Over four-fifths of the male (84%) respondents indicated they had received training to serve the rural populations, compared to 66 percent of the female respondents. The chi-square test of association between the two groups was statistically significant. Male respondents were more likely to indicate they had received training to serve the rural populations.

A majority of the male (98%) and female (100%) respondents reported having received training to serve the underserved populations. There was no statistically significant difference between groups.

Competency in Providing Care to the Rural and Underserved Populations by Gender

Table 4.12	All Respondents											p-value	
	Male (n=55)					Female (n=41)							
	Fully		Partially		Not at all	Fully		Partially		Not at all			
How competent do you feel providing care to the:	#	%	#	%	#	%	#	%	#	%	#	%	
Rural Population	37	67.3	18	32.7	0	0.0	19	46.3	18	43.9	4	9.8	0.019 [¥]
Underserved Population	51	92.7	4	7.3	0	0.0	37	90.2	4	9.8	0	0.0	0.663

Table 4.12 shows the male and female survey respondents' self-rated competency levels in providing care to the rural and underserved populations. Over two-thirds (67%) of the male respondents indicated feeling “fully” competent providing care to the rural populations, compared to 46 percent of the female respondents. The chi-square test of association between the two groups was statistically

significant. Male respondents were more likely to indicate feeling “fully” competent providing care to the rural populations.

A majority of the male (93%) and female (90%) respondents indicated feeling “fully” competent in providing care to the underserved populations. There was no statistically significant difference between groups.

Quality of Program by Gender

Table 4.13	All Respondents			
	Male (n=55)		Female (n=41)	
I would rate the overall <u>quality</u> of my Family Medicine residency program as:	#	%	#	%
Excellent	35	63.6	22	53.7
Above Average	17	30.9	14	34.1
Average	2	3.6	4	9.8
Below Average	1	1.8	1	2.4
Extremely Poor	0	0.0	0	0.0
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value= 0.589

Table 4.13 shows the male and female survey respondents’ overall rating of the quality of their family medicine residency program. Over four-fifths of the male (95%) and female (88%) respondents indicated that the quality of their training program was “excellent” or “above average.” There was no statistically significant difference between groups.

Faculty Assessment by Gender

Table 4.14	All Respondents			
	Male (n=55)		Female (n=41)	
I would rate the overall performance of the <u>faculty</u> in my Family Medicine residency program to have exceeded my expectations.	#	%	#	%
Strongly Agree	26	47.3	20	48.8
Agree	18	32.7	15	36.6
Neutral	7	12.7	5	12.2
Disagree	4	7.3	1	2.4
Strongly Disagree	0	0.0	0	0.0
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value=0.760

Table 4.14 shows the male and female survey respondents' overall performance rating of faculty in their family medicine residency program. Over four-fifths of the male (80%) and female (85%) respondents indicated that they "strongly agree" or "agree" that faculty in their program exceeded their expectations. There was no statistically significant difference between groups.

Assessment of Peer Residents and Fellows by Gender

Table 4.15	All Respondents			
	Male (n=55)		Female (n=41)	
I would rate the overall performance of the <u>other residents</u> in my Family Medicine residency program to have exceeded my expectations.	#	%	#	%
Strongly Agree	28	50.9	24	58.5
Agree	24	43.6	16	39.0
Neutral	2	3.6	1	2.4
Disagree	1	1.8	0	0.0
Strongly Disagree	0	0.0	0	0.0
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value=0.747

Table 4.15 shows the male and female respondents' overall performance rating of other residents and fellows in their family medicine residency program. A majority of the male (95%) and female (98%) respondents indicated that they "strongly agree" or "agree" that other residents in their program had exceeded their expectations. There was no statistically significant difference between groups.

Plans after Completion by Gender

Table 4.16	All Respondents			
	Male (n=55)		Female (n=41)	
What do you expect to be doing after completion of your current Family Medicine residency program? Please mark only ONE option.	#	%	#	%
Patient Care or Clinical Practice (in Non-Training Position)	42	76.4	34	82.9
Fellowship or Additional Subspecialty Training	12	21.8	7	17.1
Academic position (Teaching and/or Research)	1	1.8	0	0.0
Temporarily Out of Medicine	0	0.0	0	0.0
Military	0	0.0	0	0.0
Industry	0	0.0	0	0.0
Other	0	0.0	0	0.0
Undecided or Don't know yet	0	0.0	0	0.0
Total	55	100.0	41	100.0
Missing	0		0	

Chi-square p -value= 0.565

Table 4.16 shows what the male and female survey respondents’ expect to do after completing their current family medicine residency program. Over three-fourths of the male (76%) and female (83%) respondents indicated planning to go into patient care or clinical practice. There was no statistically difference between groups.

NOTE: The following section is only for those individuals who indicated they were going into “patient care or clinical practice” (n=76).

V. PRACTICE CHARACTERISTICS

This section includes only those going into “patient care or clinical care practice”

Primary Practice Location by Gender

Table 4.17	Clinical Care Respondents			
	Male (n=42)		Female (n=34)	
Where is the location of your primary activity after completing your current Family Medicine residency program?	#	%	#	%
Same city of country as current training	10	23.8	12	40.0
Same region in Indiana, but different city or county	11	26.2	9	30.0
Other area in Indiana	4	9.5	3	10.0
Other U.S. state (not Indiana)	15	35.7	6	20.0
Outside of U.S.	2	4.8	0	0.0
Total	42	100.0	30	100.0
Missing/Undecided	0		4	

Chi-square p -value= 0.134

Table 4.17 shows the location of the male and female survey respondents’ primary activity after completing their family medicine residency program. Three-fifths of the male (60%) respondents indicated they planned to practice within Indiana, compared to 80 percent of the female respondents. There was no statistically significant difference between groups.

Type of Practice by Gender

Table 4.18	Clinical Care Respondents			
	Male (n=42)		Female (n=34)	
Which best describes the principal type of Patient Care Practice you will be entering?	#	%	#	%
Private practice-Solo	1	2.6	1	3.7
Private Practice-Group or Partnership (2 or more persons)	6	15.8	4	14.8
Hospital or health system owned- inpatient only	1	2.6	1	3.7
Hospital or health system owned- outpatient only	15	39.5	15	55.6
Hospital or health system owned- inpatient and outpatient	13	34.2	5	18.5
Urgent care facility	1	2.6	1	3.7
Managed care organization or insurance company	0	0.0	0	0.0
Free-standing health center or clinic	0	0.0	0	0.0
Nursing home or institutional residential facility	0	0.0	0	0.0
Other	1	2.6	0	0.0
Total	38	100.0	27	100.0
Missing	4		7	

Chi-square p -value= 0.785

Table 4.18 shows the principal type of patient care practice setting the male and female survey respondents' will be entering after completing their training. About one-fifth of the male (18%) and female (19%) respondents reported entering a "private practice" (solo and group) setting. Over three-fourths of the male (76%) and female (78%) respondents planned to practice in a "hospital or health system owned" setting. There was no statistically significant difference between groups.

Amount of Direct Patient-Care Activities by Gender

Table 4.19	Clinical Care Respondents			
	Male (n=42)		Female (n=34)	
In your upcoming position, what amount of direct patient-care activities will you do?	#	%	#	%
No patient-care activities	1	2.4	0	0.0
Part-time patient-care activities	1	2.4	3	9.1
Full-time patient-care activities	40	95.2	30	90.9
Total	42	100.0	33	100.0
Missing	0		1	

Chi-square p -value= 0.304

Table 4.19 shows the male and female survey respondents' expected amount of time spent in direct-patient-care activities in their upcoming position. A majority of the male (95%) and female (91%) respondents indicated they will be working "full-time" in direct-patient-care activities. There was no statistically significant difference between groups.

In addition, a majority of the male (86%) and female (85%) respondents indicated they had no obligation or visa requirement.

Percentage of Patients Expected to be seen from Underserved Populations by Gender

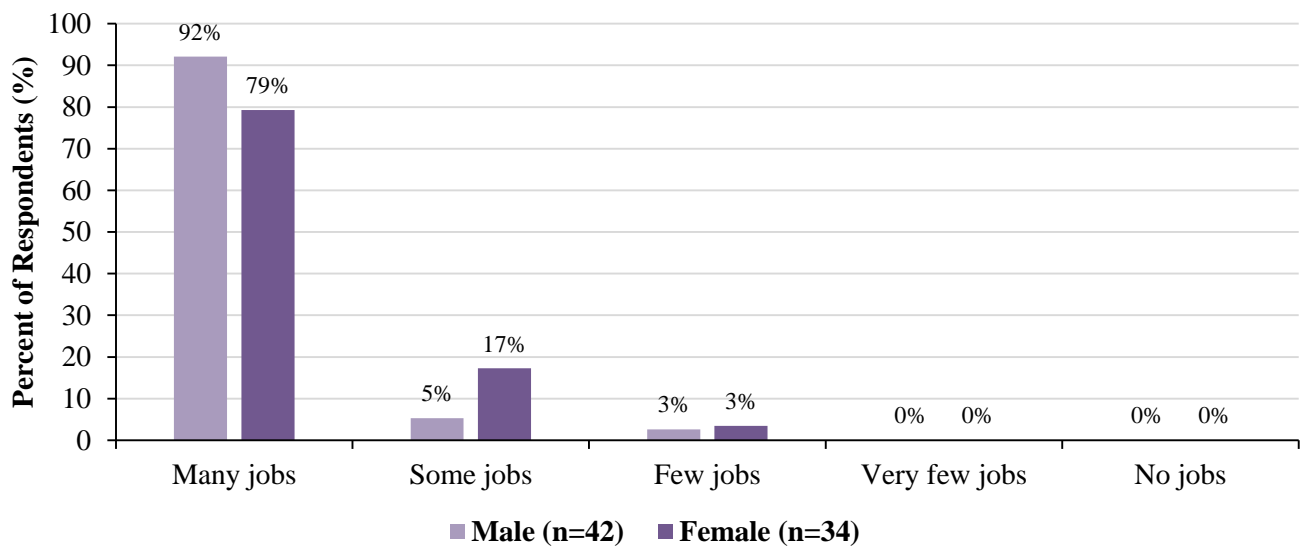
Table 4.20	Clinical Care Respondents			
	Male (n=42)		Female (n=34)	
In your new practice, what percentage of the patients do you expect to see from underserved populations?	#	%	#	%
Less than 10 percent	2	5.3	2	7.1
10-24 percent	14	36.8	12	42.9
25-49 percent	11	28.9	9	32.1
50-74 percent	9	23.7	2	7.1
More than 75 percent	2	5.3	3	10.7
Total	38	100.0	28	100.0
Missing	4		6	

Chi-square *p*-value= 0.467

Table 4.20 shows the percentage of patients that the male and female survey respondents’ expect to see from underserved populations (Medicaid or self-pay, educationally or economically disadvantaged) in their new practice. One-half of the male (58%) and female (50%) respondents expect to see 25 percent or more of the underserved populations in their new practice. There was no statistically significant difference between groups.

Opportunities in Indiana by Gender

Figure 4.3: Overall Assessment of Practice Opportunities (n=76)

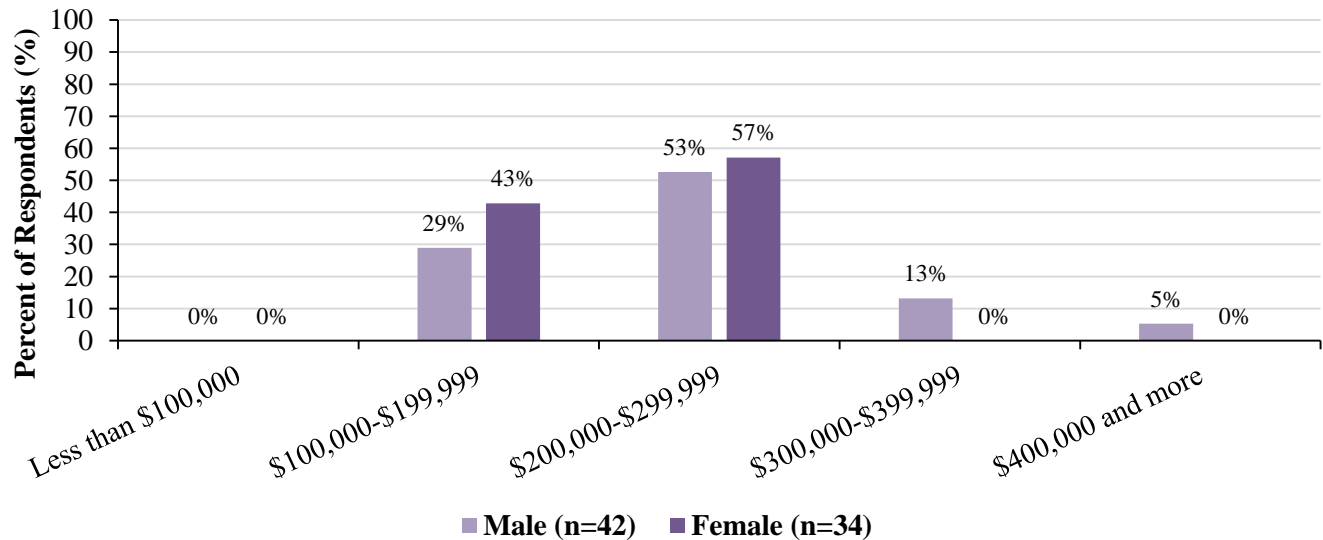


Chi-square *p*-value= 0.272

Figure 4.3 presents the overall assessment of practice opportunities for the male and female survey respondents within their specialty in Indiana. Almost all of the male (92%) respondents reported that there were “many jobs” available within family medicine in Indiana, compared to 79 percent of the female respondents. There was no statistically significant difference between groups.

Expected Gross Income by Gender

Figure 4.4: Expected Gross Income (n=76)



Chi-square p -value=0.201

Figure 4.4 presents the gross income (salary plus incentives) that the male and female survey respondents’ expect to earn during their first year or practice. Over two-thirds of the male (71%) respondents expect to earn \$200,000 or more during their first year of practice, compared to 57 percent of the female respondents. There was no statistically significant difference between groups.

Job Offers All Together by Gender

Table 4.21	Clinical Care Respondents			
	Male (n=42)		Female (n=34)	
How many offers for employment/practice positions did you receive <u>all together</u> ?	#	%	#	%
0	0	0.0	0	0.0
1	3	8.3	3	11.1
2	5	13.9	5	18.5
3	9	25.0	8	29.6
4	3	8.3	3	11.1
5 or more	16	44.4	8	29.6
Total	36	100.0	27	100.0
Missing/Did not seek employment position at the time	6		7	

Chi-square p -value= 0.818

Table 4.21 shows the *total* number of job offers the male and female survey respondents’ received for employment or practice positions. Over two-thirds of the male (78%) and female (70%) respondents were offered three or more employment positions all together. There was no statistically significant difference between groups.

Main Reasons to Practice at this Location by Gender

Figure 4.5: Main Reasons to Practice at this Location (n=76)

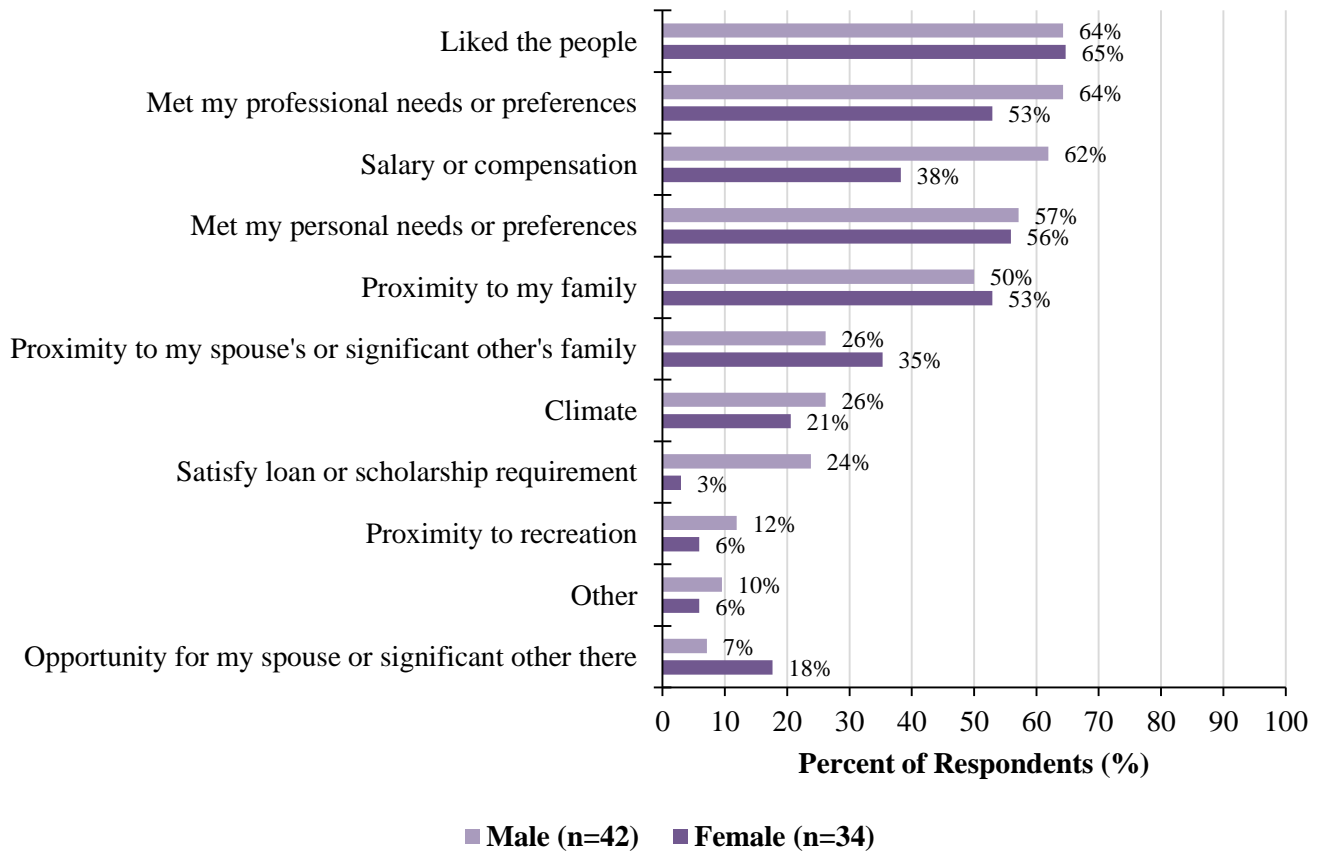


Figure 4.5 presents the main reasons the male and female survey respondents’ chose to practice at this location. The top three reasons given by the male respondents for choosing to practice at this location were: “liked the people” (64%), “met my professional needs or preferences” (64%), and “salary or compensation” (62%). The top reasons given by female respondents for choosing to practice at this location were: “liked the people” (65%), “met my personal needs or preferences” (56%), “met my professional needs or preferences” (53%), and “proximity to my family” (53%). There was no statistically significant difference between groups.

Job Offers in Indiana by Gender

Table 4.22	Clinical Care Respondents			
	Male (n=25)		Female (n=24)	
How many offers for employment/practice positions did you receive <u>in Indiana</u> ?*	#	%	#	%
0	0	0.0	0	0.0
1	1	4.5	3	13.6
2	3	13.6	3	13.6
3	10	45.5	7	31.8
4	2	9.1	2	9.2
5 or more	6	27.3	7	31.8
Total	22	100.0	22	100.0
Missing/Did not seek employment position at the time	3		2	

*Reflects responses from only those respondents who indicated their primary practice location was in Indiana.

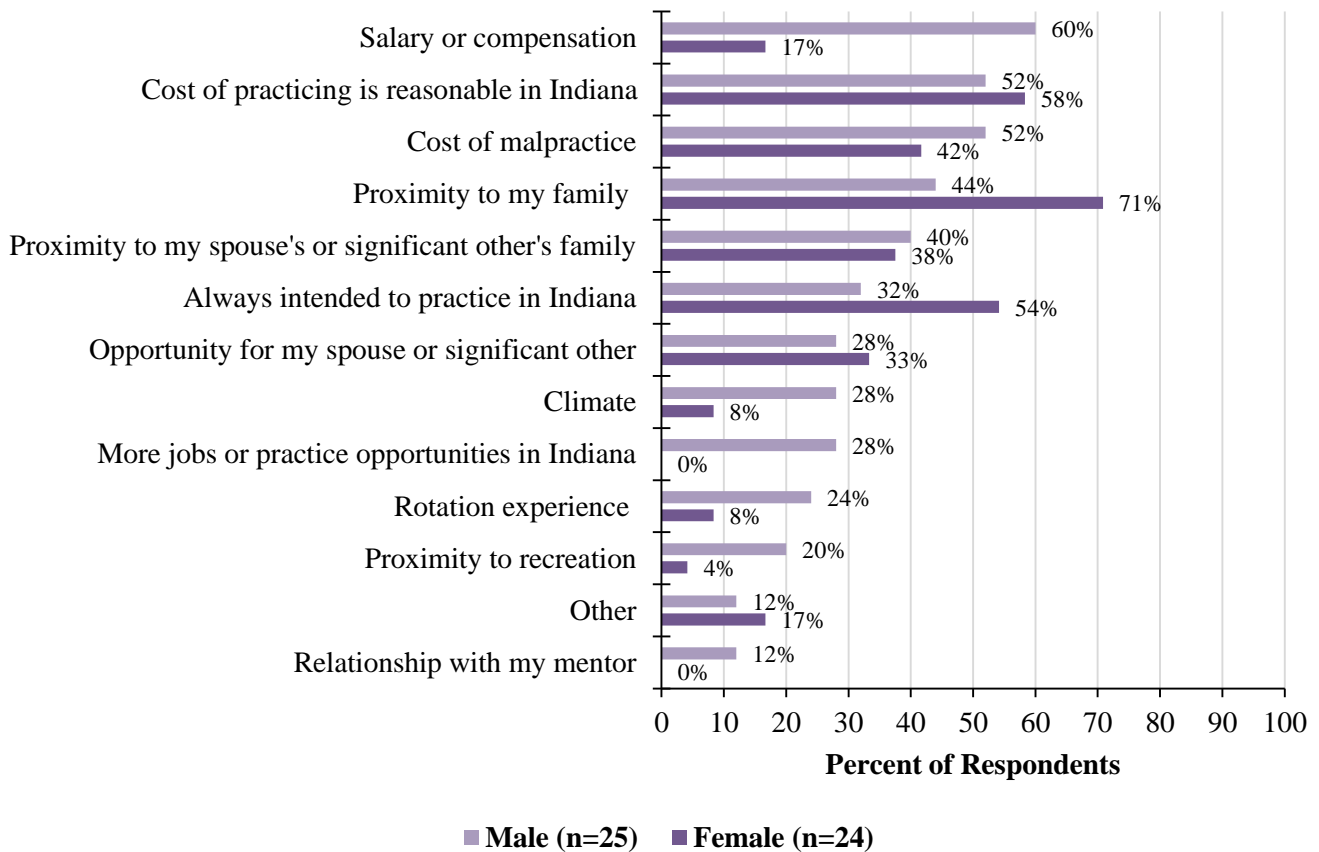
Chi-square p -value= 0.764

Table 4.22 shows the number of job offers the male and female respondents' received for employment or practice positions in Indiana. Only those respondents who planned to practice in Indiana were included in the analysis for this table.

Of those intending to practice in Indiana, almost three-fourths of the male (82%) and female (73%) respondents were offered three or more employment positions in Indiana. There was no statistically significant difference between groups.

Main Reasons to Practice in Indiana by Gender

Figure 4.6: Main Reasons to Practice in Indiana (n=49)*



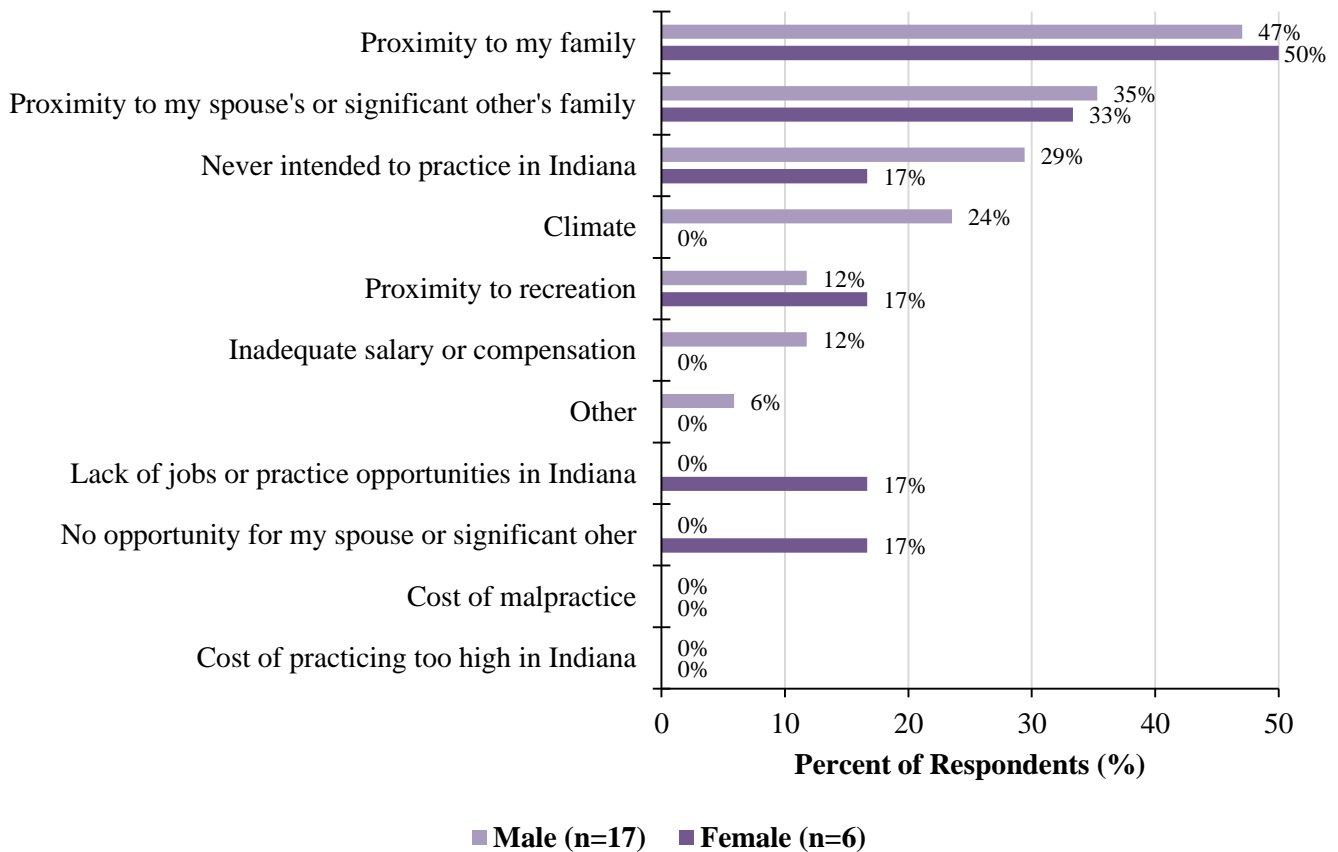
*Reflects responses from only those respondents who indicated their primary practice location was in Indiana.

Figure 4.6 presents main reasons the male and female survey respondents' chose to practice in Indiana. Only those respondents who indicated their primary practice location was in Indiana were included in the analysis for this graph.

The top three reasons given by male respondents for choosing to practice in Indiana were: “salary or compensation” (60%), “cost of practicing is reasonable in Indiana” (52%), and “cost of malpractice” (52%). The top three reasons given by the female respondents were: “proximity to my family” (71%), “cost of practicing is reasonable in Indiana” (58%), and “always intended to practice in Indiana” (54%). There was no statistically significant difference between groups.

Main Reasons not to Practice in Indiana by Gender

Figure 4.7: Main Reasons Not to Practice in Indiana (n=23)*



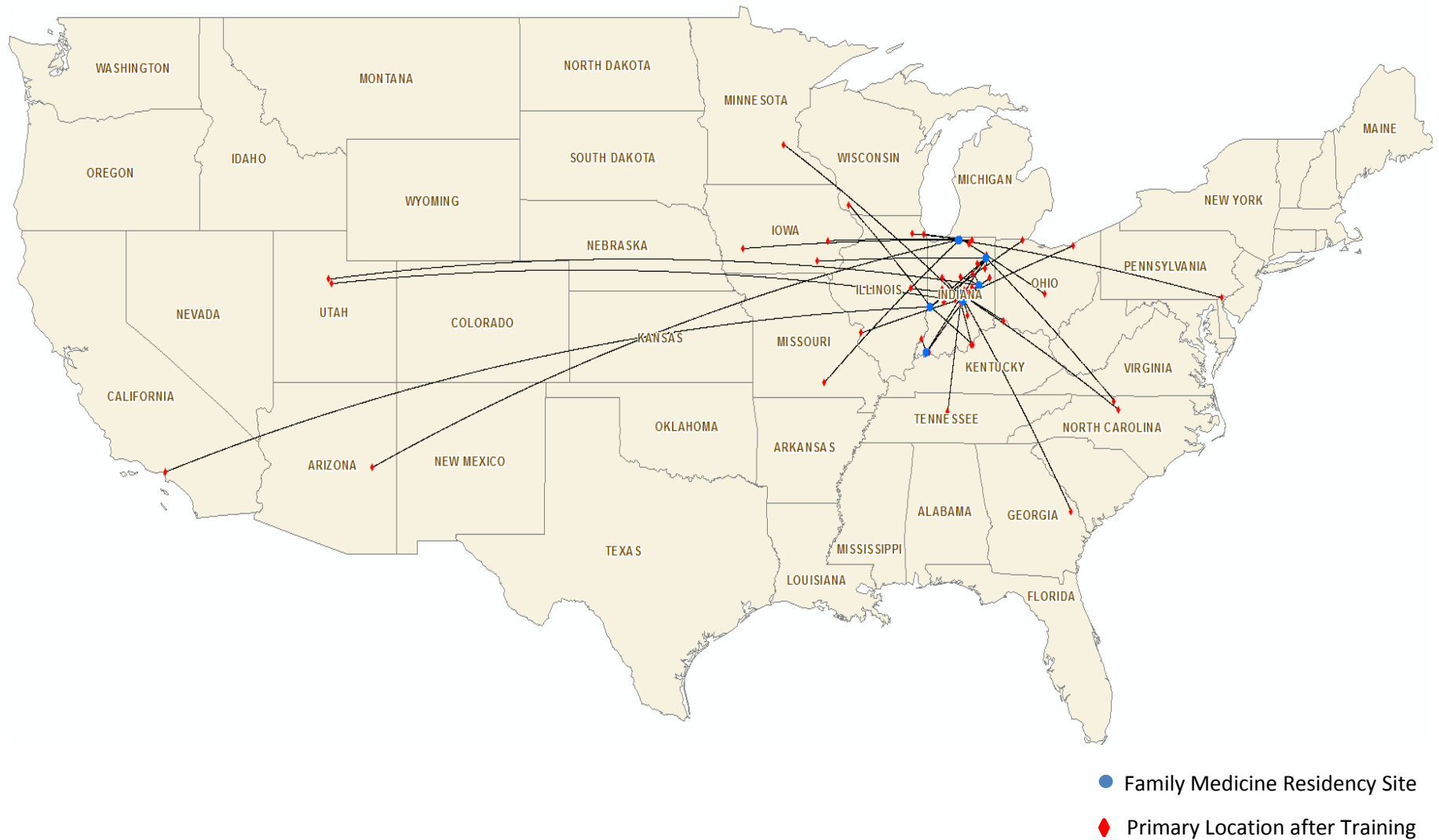
*Reflects responses from only those respondents who indicated their primary practice location was outside Indiana.

Figure 4.7 presents main reasons the male and female survey respondents chose not to practice in Indiana. Only those respondents who indicated their primary practice location was outside Indiana were included in the analysis for this graph.

The top three reasons given by the male respondents for choosing not to practice in Indiana were: “proximity to my family” (47%), “proximity to my spouse’s or significant other’s family” (35%), and “never intended to practice in Indiana” (29%). The top reasons given by the female respondents for choosing not to practice in Indiana were: “proximity to my family” (50%) and “proximity to my spouse’s or significant other’s family” (33%). There was no statistically significant difference between groups.

CHAPTER 5: LINKING RESIDENCY SITE WITH PRIMARY LOCATION AFTER TRAINING

Map 5.1: U.S. Map Linking Family Medicine Residency Program Site with Primary Location after Training



Data analysis was performed using geographic information mapping software, *ArcGIS 10.4*.

Map 5.1 depicts the survey respondents' family medicine residency site and primary locations after training. This map includes respondents going into clinical practice as well as those entering fellowship training or accepting an academic position. **Blue** icons represent the family medicine residency program site and **red** icons represent their primary location after completion of training.

In 2016, eighty-one respondents listed *both*, their family medicine residency site as well as their primary location after training. These have been shown on the map using “connecting lines.” A majority of the respondents indicated they planned to practice or stay in Indiana (n=55), Illinois (n=4), Iowa (n=3), Kentucky (n=3), and Ohio (n=3).

Table 5.1 shows a breakdown (**by state**) of where the respondents were going after completing their training from 2012 to 2016.

Table 5.1: Primary Location in the U.S. after Completing Training								
County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Allen	Fort Wayne Medical Education Program, Fort Wayne	Florida	1	0	0	0	0	1
		Iowa	1	0	0	0	1	2
		Indiana	4	9	6	8	7	34
		Kansas	1	0	0	1	0	2
		Nevada	1	0	0	0	0	1
		North Carolina	0	0	0	0	1	1
		Wyoming	1	0	0	0	0	1

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Delaware	IU Health Ball Memorial Hospital, Muncie	Arizona	0	0	0	1	0	1
		Idaho	0	0	1	0	0	1
		Illinois	1	0	0	0	0	1
		Indiana	1	5	2	5	6	19
		Kentucky	2	0	0	0	0	2
		Michigan	0	0	0	1	0	1
		Minnesota	0	0	1	0	0	1
		Missouri	1	0	1	0	0	2
		New Mexico	0	0	1	0	0	1
		Utah	1	0	0	0	1	2

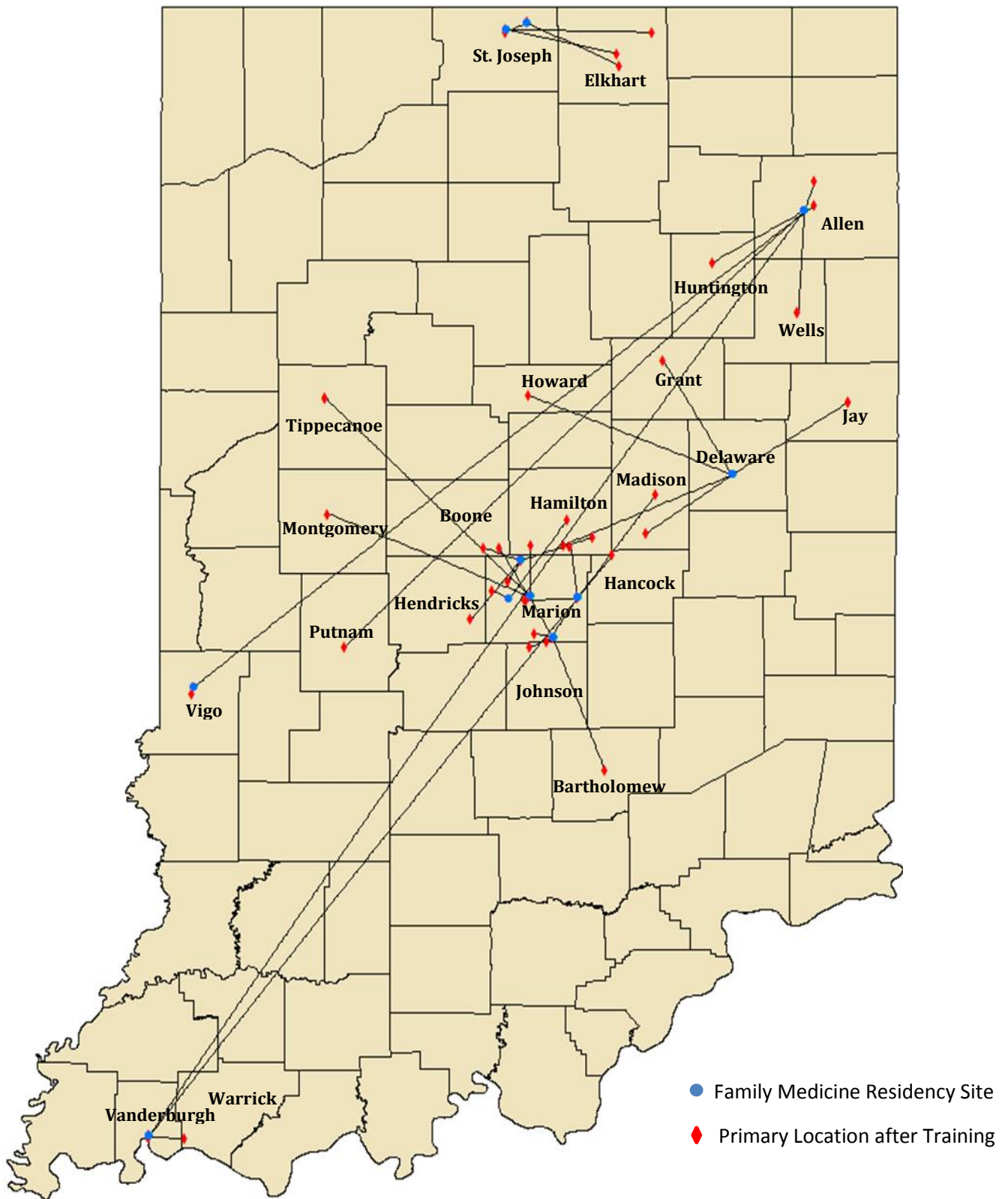
County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Marion	Community Health Network, Indianapolis	Florida	0	1	0	0	0	1
		Georgia	0	1	0	0	0	1
		Idaho	0	1	0	0	0	1
		Illinois	0	2	0	0	0	2
		Indiana	5	0	6	5	7	23
		Minnesota	0	0	1	0	0	1
		Missouri	0	0	0	0	1	1
	Wisconsin	0	0	1	0	0	1	
	Franciscan St. Francis Health, Beech Grove	Arizona	0	0	0	1	0	1
		Illinois	1	0	0	0	0	1
		Indiana	4	6	7	5	5	27
		Kansas	1	0	0	0	0	1
		Minnesota	0	0	0	0	1	1
		Utah	0	0	0	0	1	1
	IU Methodist Family Medicine Residency, Indianapolis	Colorado	0	0	0	1	0	1
		Illinois	1	0	0	1	0	2
		Indiana	4	7	7	5	6	29
		Kentucky	0	0	0	1	0	1
		Maryland	1	0	0	0	0	1
		New York	1	0	0	0	0	1
		Ohio	0	0	0	0	1	1
		Oregon	0	0	1	0	0	1
		Tennessee	0	0	1	0	1	2
		Washington	0	0	0	1	0	1
		Canada	1	0	0	0	0	1
	St. Vincent Family Medicine Residency, Indianapolis	Georgia	0	0	0	1	1	2
		Illinois	0	0	0	0	1	1
		Indiana	6	0	4	6	6	22
		Kentucky	0	0	0	0	1	1
		Michigan	0	2	0	0	0	2
		Minnesota	0	1	0	0	0	1
		Missouri	0	1	0	0	0	1
		North Carolina	0	0	0	0	1	1
Ohio		0	1	1	1	0	3	
Tennessee	0	0	1	0	0	1		
Westview Hospital, Indianapolis	Indiana	1	1	3	3	2	10	
	Kentucky	0	0	0	0	1	1	
	Washington	0	1	0	0	0	1	

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Saint Joseph	Memorial Hospital of South Bend	Delaware	0	0	0	0	1	1
		Florida	0	0	0	2	0	2
		Illinois	1	0	0	0	0	1
		Indiana	6	4	5	6	5	26
		Iowa	0	0	0	0	1	1
		Michigan	0	0	0	1	0	1
		Missouri	0	0	0	0	1	1
		Montana	0	0	0	1	0	1
		North Dakota	0	0	1	0	0	1
	Saint Joseph Regional Medical Center, South Bend	Arizona	0	0	0	0	1	1
		California	0	0	1	0	0	1
		Illinois	0	0	0	0	2	2
		Indiana	3	2	3	4	3	15
		Iowa	0	0	0	0	1	1
		Kentucky	0	1	0	1	0	2
		Massachusetts	0	0	0	1	0	1
		Michigan	0	1	0	0	0	1
		North Dakota	0	0	0	2	0	2
		Ohio	1	0	2	0	1	4
		Oregon	1	0	0	0	0	1
		Pennsylvania	0	0	0	1	0	1
		Virginia	0	0	1	0	0	1

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Vanderburgh	Deaconess Family Medicine Residency, Evansville	Illinois	0	1	2	1	1	5
		Indiana	1	4	3	4	5	17
		Kentucky	2	0	0	0	0	2
		Louisiana	0	0	1	0	0	1
		Missouri	0	0	0	1	0	1
		North Carolina	1	0	0	0	0	1
		Wisconsin	1	0	0	0	0	1

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Vigo	Union Hospital, Terra Haute	California	0	0	0	0	1	1
		Florida	0	0	0	1	0	1
		Illinois	1	0	4	1	0	6
		Indiana	2	0	2	0	3	7
		Kentucky	0	0	0	0	1	1
		Massachusetts	0	0	0	1	0	1
		North Dakota	1	0	0	0	0	1
		Ohio	0	1	1	0	1	3
		Oklahoma	0	2	0	0	0	2
		Pennsylvania	0	0	0	1	0	1
Wisconsin	0	0	0	0	1	1		

Map 5.2: Indiana Map Linking Family Medicine Residency Site with Primary Location after Training



Map 5.2 is an enhanced view of the Indiana map showing the survey respondents’ family medicine residency site and primary locations after training. This map includes respondents going into clinical practice as well as those entering fellowship training or accepting an academic position. **Blue** icons represent the family medicine residency program site and **red** icons represent their primary location after completing training.

In 2016, fifty-five respondents listed *both*, their family medicine residency site as well as their primary location after training. These have been shown on the map using “connecting lines.” Of the respondents who chose Indiana as their primary location, a majority (n=26) planned to practice or stay in the central Indiana Metropolitan Statistical Area (Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Putnam, Shelby)⁵, followed by five respondents each in St. Joseph and Vanderburgh counties and three in Elkhart county.

Table 5.2 shows a breakdown (**by county**) of where the respondents were going after completing their training in 2012 to 2016.

Table 5.2: Primary Location in Indiana after Completing Training								
County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Allen	Fort Wayne Medical Education Program, Fort Wayne	Adams	1	0	0	0	0	1
		Allen	2	0	1	6	1	10
		Huntington	0	0	0	0	1	1
		Marion	0	3	0	0	0	3
		Putnam	0	0	0	0	1	1
		Shelby	0	0	0	1	0	1
		Vanderburgh	0	0	0	0	2	2
		Wells	0	0	0	1	2	3
		Whitley	1	0	1	0	0	2

⁵ Metropolitan and Micropolitan Statistical Areas Wall Maps. Retrieved October 12, 2016, from <https://www.census.gov/geo/maps-data/maps/cbsacs.html>

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Delaware	IU Health Ball Memorial Hospital, Muncie	Delaware	1	0	1	2	0	4
		Grant	0	0	0	0	1	1
		Hamilton	0	0	0	0	1	1
		Hendricks	0	1	0	0	0	1
		Howard	0	0	0	0	1	1
		Jay	0	0	0	0	2	2
		Johnson	0	2	0	0	0	2
		Madison	0	0	0	0	1	1
		Marion	0	0	0	1	0	1
		Morgan	0	1	0	0	0	1
		Putnam	0	0	0	1	0	1
Spencer	0	0	0	1	0	1		

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Marion	Community Health Network, Indianapolis	Hamilton	1	0	0	0	1	2
		Johnson	0	0	1	1	1	3
		Madison	0	0	0	1	1	2
		Marion	2	0	1	3	4	10
		Ohio	0	0	1	0	0	1
		Saint Joseph	0	0	1	0	0	1
	Franciscan St. Francis Health, Beech Grove	Allen	0	0	1	0	0	1
		Bartholomew	0	0	0	0	1	1
		Boone	0	0	0	0	1	1
		Hamilton	0	1	0	0	0	1
		Hendricks	0	0	1	0	0	1
		Howard	0	1	0	0	0	1
		Johnson	1	0	1	0	1	3
		Marion	2	3	2	3	2	12
		Morgan	0	0	0	2	0	2
		Putnam	0	1	0	0	0	1
		Ripley	0	0	1	0	0	1
		White	1	0	0	0	0	1

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Marion (cont.)	IU Methodist Family Medicine Residency, Indianapolis	Bartholomew	0	1	0	0	0	1
		Blackford	0	1	0	0	0	1
		Boone	0	1	0	0	0	1
		Delaware	0	2	0	0	0	2
		Hamilton	0	0	0	0	1	1
		Howard	0	0	1	0	0	1
		Marion	4	1	1	5	2	13
		Monroe	0	1	0	0	0	1
		Montgomery	0	0	1	0	1	2
		Starke	0	0	1	0	0	1
	Tippecanoe	0	0	0	0	2	2	
	St. Vincent Family Medicine Residency, Indianapolis	Boone	0	0	0	0	1	1
		Hamilton	0	0	0	2	1	3
		Hendricks	1	0	0	0	1	2
		Kosciusko	0	0	1	0	0	1
		Madison	1	0	0	1	0	2
		Marion	4	0	3	3	3	13
	Westview Hospital, Indianapolis	Decatur	1	0	0	0	0	1
		Hamilton	0	0	0	0	1	1
		Jackson	0	0	0	1	0	1
		Jefferson	0	0	1	0	0	1
Madison		0	0	1	0	0	1	
Marion		0	0	0	2	1	3	

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Saint Joseph	Memorial Hospital of South Bend	Boone	0	1	0	0	0	1
		Elkhart	0	0	0	1	2	3
		LaGrange	1	0	0	0	0	1
		Marion	0	1	0	0	0	1
		Marshall	0	1	0	0	0	1
		Saint Joseph	5	1	1	4	3	14
		Sullivan	0	0	0	1	0	1
	Saint Joseph Regional Medical Center, South Bend	Boone	0	0	1	0	0	1
		Elkhart	0	0	0	0	1	1
		Greene	1	0	0	0	0	1
		Huntington	0	0	1	0	0	1
		LaPorte	0	0	0	1	0	1
		Marion	0	2	0	0	0	2
Saint Joseph	2	0	2	3	2	9		

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Vanderburgh	Deaconess Family Medicine Residency, Evansville	Dubois	0	0	0	1	0	1
		Gibson	1	0	0	0	0	1
		Hancock	0	0	0	1	1	2
		Marion	0	2	0	0	0	2
		Pike	0	0	1	0	0	1
		Saint Joseph	0	1	0	0	0	1
		Vanderburgh	0	0	1	1	3	5
		Vigo	0	0	1	0	0	1
		Warrick	0	0	0	1	1	2
		White	0	1	0	0	0	1

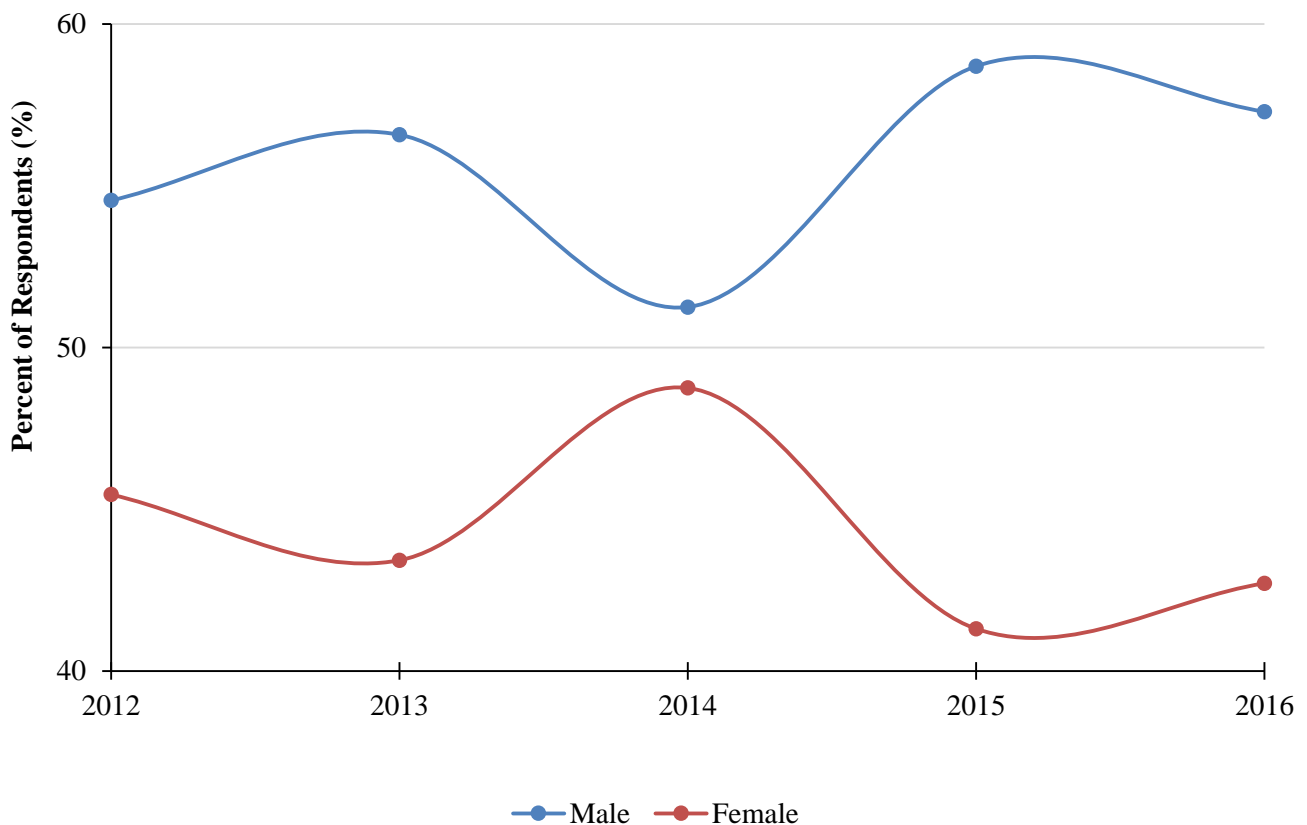
County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	Total
Vigo	Union Hospital, Terra Haute	Allen	0	0	0	0	1	1
		Clay	1	0	0	0	0	1
		Greene	0	0	1	0	0	1
		Montgomery	1	0	0	0	0	1
		Vigo	0	0	1	0	2	3

CHAPTER 6: TRENDING PATTERNS: 2012-2016

This chapter shows a comparison of responses to the *Indiana Family Medicine Residencies Exit Survey*® from the time of its inception in 2012 through 2016. Trends for all respondents have been shown in figures 6.1 to 6.8. The remaining figures show responses from only those survey respondents' who indicated they planned to work in "patient care or clinical practice" after graduation; who intended to practice in Indiana; and, those who intended to practice outside Indiana. For ease of interpretation, the percentages in the text have been rounded off to the nearest decimal point.

All Respondents, 2012-2016

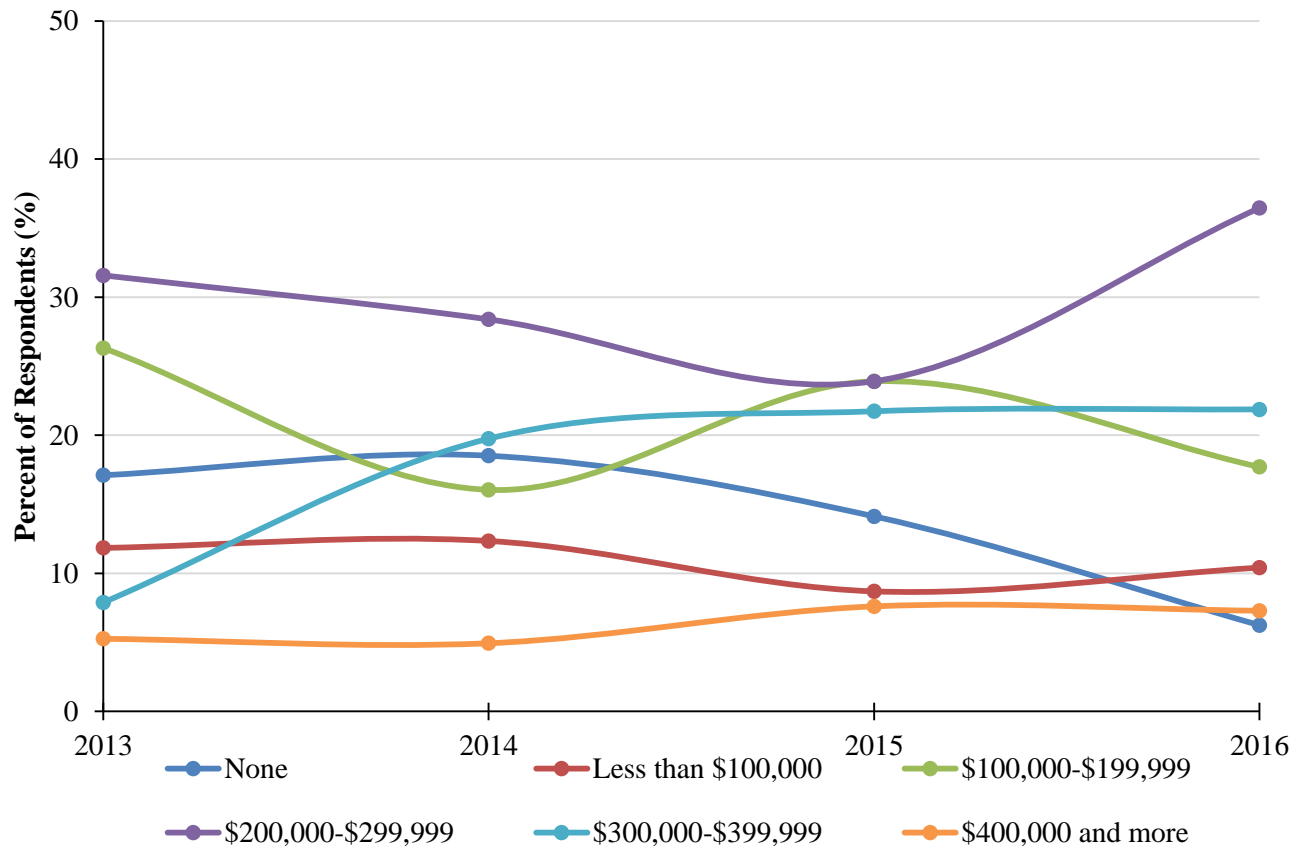
Figure 6.1: Trends showing Gender, 2012-2016*



**This graph has been zoomed in to improve visualization.*

Figure 6.1 shows trends in gender distribution for survey respondents from 2012 to 2016. This graph has been zoomed in to improve visualization. A slight drop was noted in the percentage of female respondents from 2012 (46%) to 2016 (43%). The 5-year average was 44 percent.

Figure 6.2: Trends showing Individual Educational Debt, 2013-2016*



*Response categories differed in the 2012 *Indiana Family Medicine Residencies Exit Survey*[®] and were excluded from this graph.

Figure 6.2 shows trends for the survey respondents' current level of educational debt from 2013 to 2016. Response categories differed in the 2012 *Indiana Family Medicine Residencies Exit Survey*[®] and were excluded from this graph.

An increasing trend was noted among respondents that reported having an individual educational debt load of \$200,000 to \$299,999 from 2013 (32%) to 2016 (37%). A drop was noted among respondents that reported having an individual educational debt load of \$100,000 to \$199,999 from 2013 (26%) to 2016 (18%). The 4-year average was 21 percent. A declining trend was noted among respondents who indicated having no educational debt from 2013 (17%) to 2016 (6%). The 4-year average was 14 percent.

Figure 6.3: Trends showing the Training Program was Helpful in Board Exam Preparation, 2012-2016

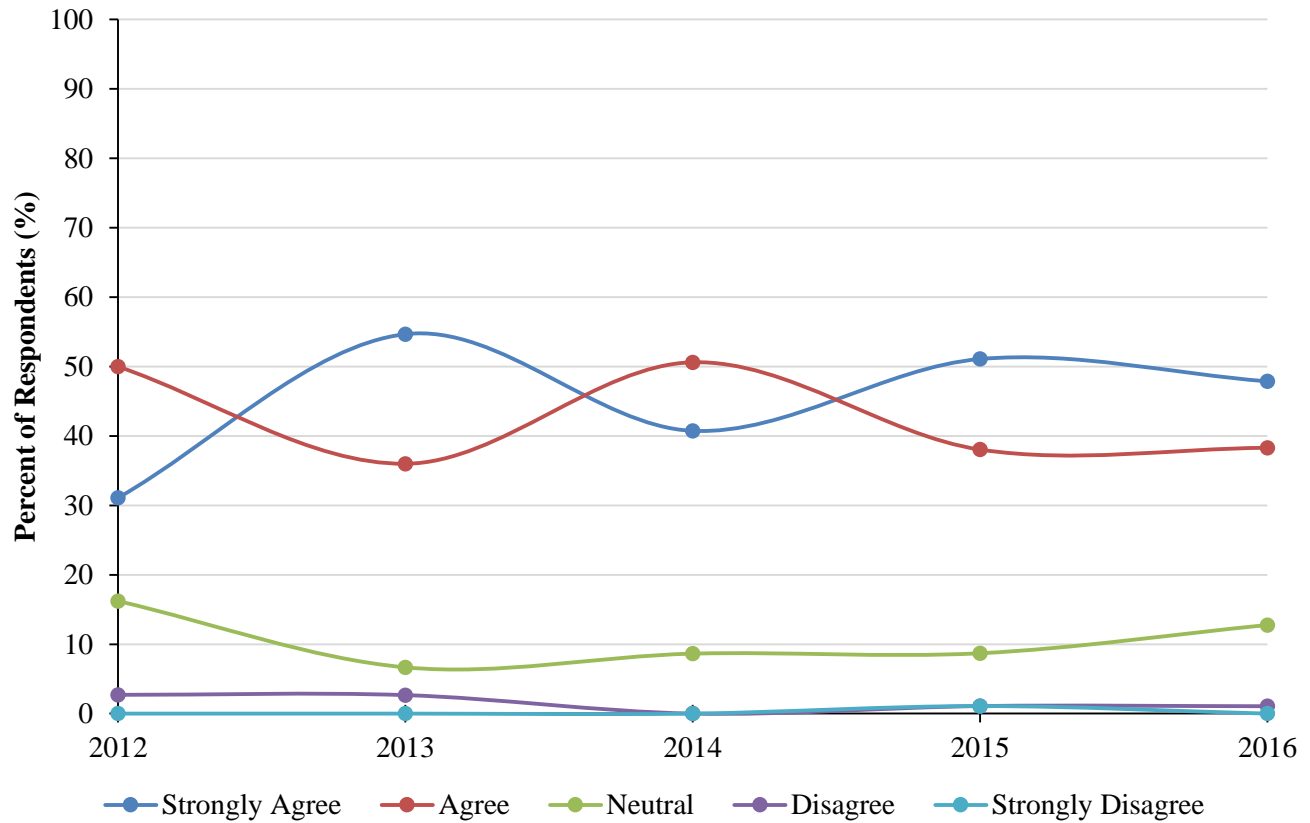
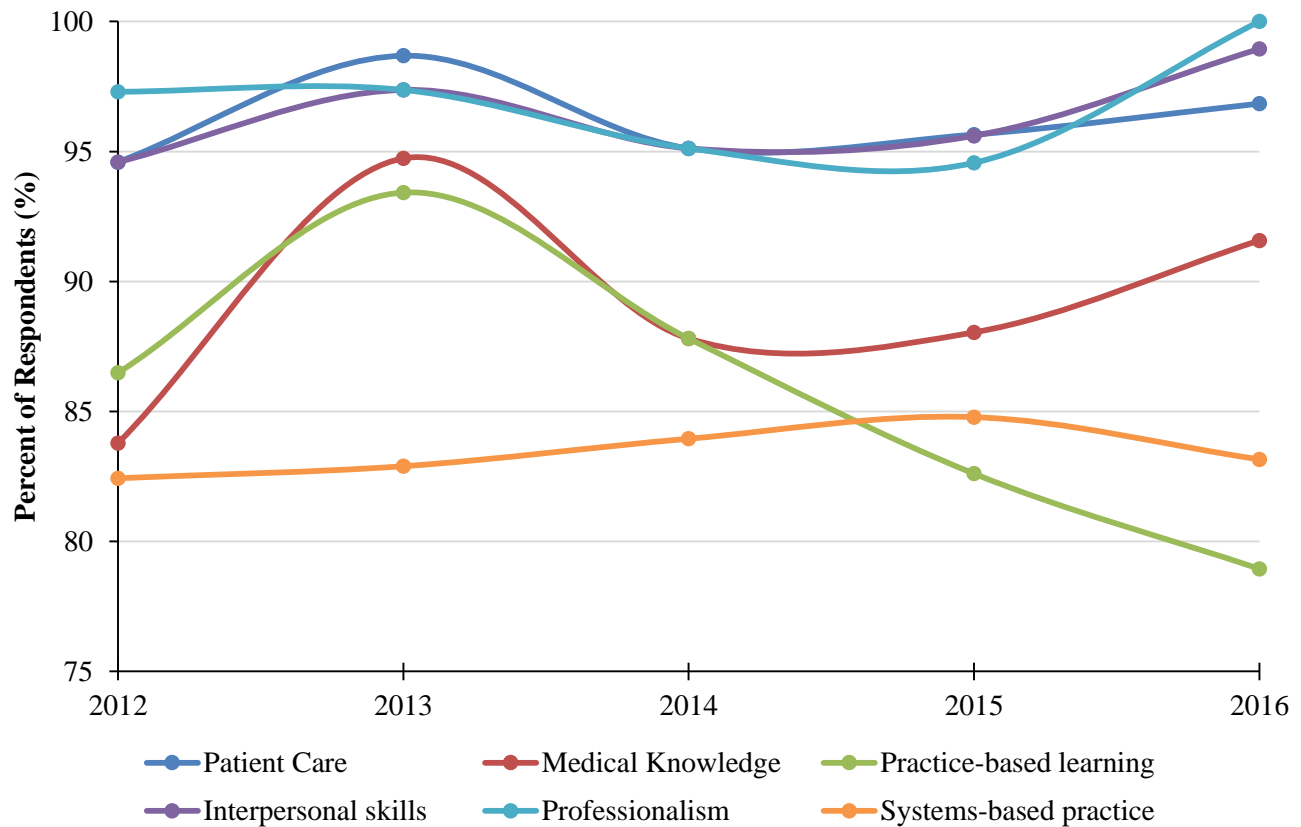


Figure 6.3 shows the trends for how helpful the training program was in preparing the survey respondents' for the board exams from 2012 to 2016.

An increasing trend was noted among respondents who “strongly agree” that the training program was helpful in preparing them for their board exams from 2012 (31%) to 2016 (48%). The 5-year average was 45 percent. A drop was noted among respondents who “agree” that the training program as helpful in preparing them for the board exams from 2012 (50%) to 2016 (38%). The 5-year average was 43 percent.

Figure 6.4: Trends showing Fully Competent responses for ACGME Competencies, 2012-2016*

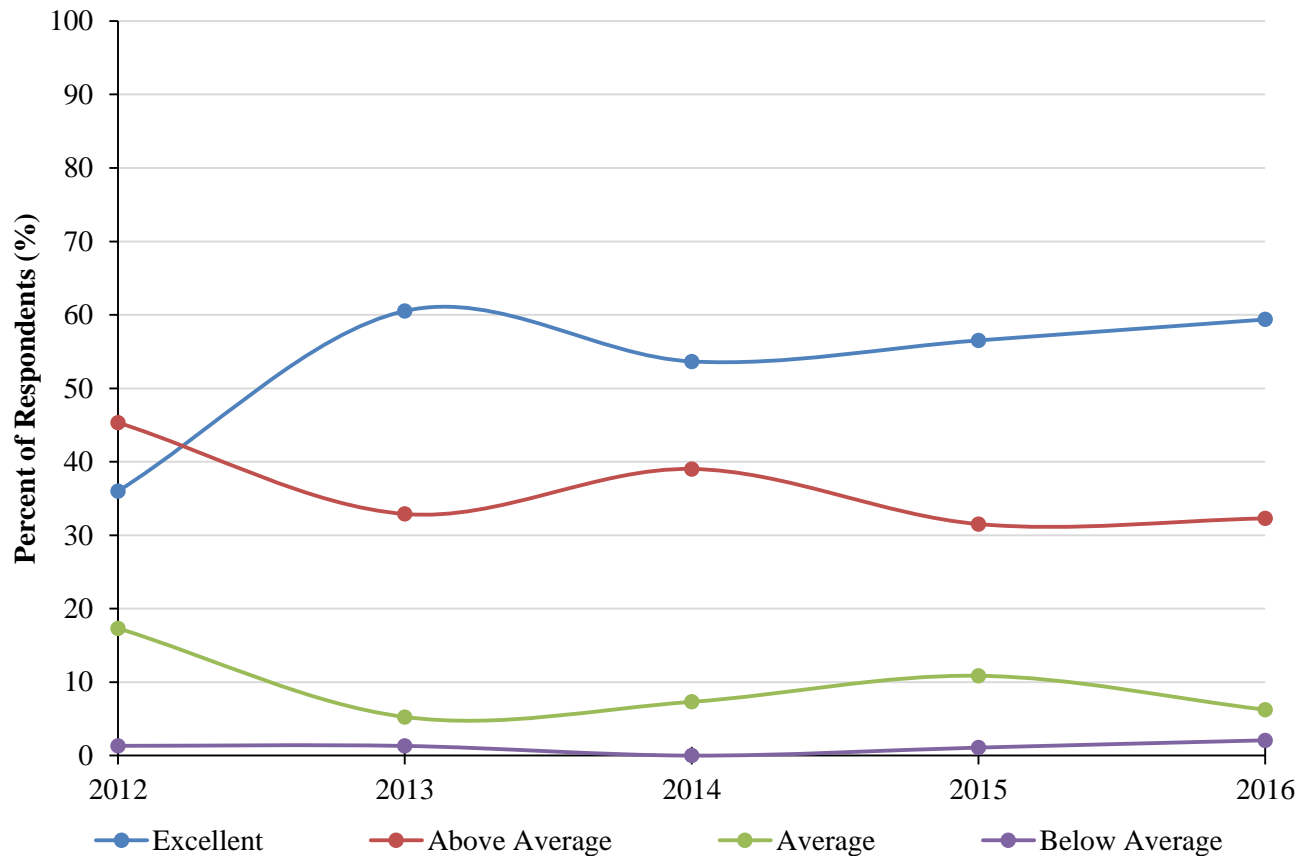


**Reflects responses from only those respondents who indicated feeling “fully” competent in the six ACGME competency areas. This graph has been zoomed in to improve visualization.*

Figure 6.4 shows trends for the survey respondents’ self-rated competency level in the ACGME competency areas from 2012 to 2016. This graph has been zoomed in to improve visualization.

An increasing trend was noted respondents who indicated feeling “fully” competent in medical knowledge and interpersonal skills from 2012 (84%, 95%) to 2016 (92%, 99%), respectively. A drop was noted among respondents who indicated feeling “fully” competent in practice based learning competency area from 2012 (87%) to 2016 (79%).

Figure 6.5: Trends showing Quality of the Program, 2012-2016*

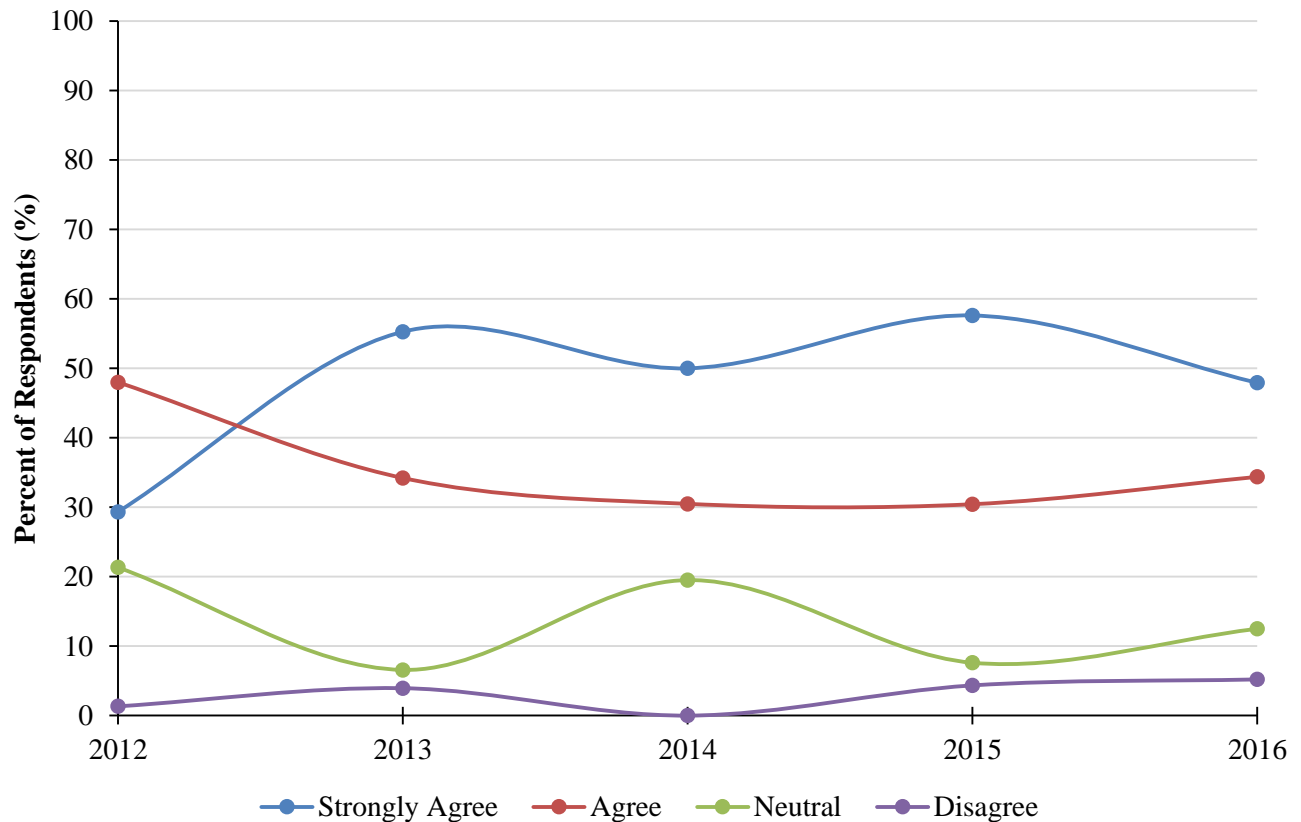


**None of the respondents marked the response option “Extremely Poor” from 2012-2016, thus it has not been shown on the graph.*

Figure 6.5 shows trends for the survey respondents’ assessment of the overall quality of their residency program from 2012 to 2016. None of the respondents marked the response option “Extremely Poor” from 2012 to 2016, thus it has not been shown on the graph.

An increasing trend was noted among respondents who rated the overall quality of the program as “excellent” from 2012 (36%) to 2016 (59%). The 5-year average was 53 percent. A drop was noted among respondents who rated the overall quality of the program as “above average” from 2012 (45%) to 2016 (32%). The 5-year average was 36 percent.

Figure 6.6: Trends showing Overall Faculty Performance, 2012-2016*



**None of the respondents marked the option “Strongly Disagree” from 2012-2016, thus it has not been shown on the graph.*

Figure 6.6 shows trends for survey respondents’ overall performance rating of faculty in their residency program from 2012 to 2016. None of the respondents marked the response option “Extremely Poor” from 2012 to 2016, thus it has not been shown on the graph.

An increasing trend was noted among respondents who indicated they “strongly agree” that faculty in their training program exceeded their expectations from 2012 (29%) to 2016 (48%). The 5-year average was 48 percent. A drop was noted among respondents who indicated they “agree” that faculty in their training program exceeded their expectations from 2012 (48%) to 2016 (34%). The 5-year average was 36 percent.

Figure 6.7: Trends showing Overall Peer Performance, 2012-2016

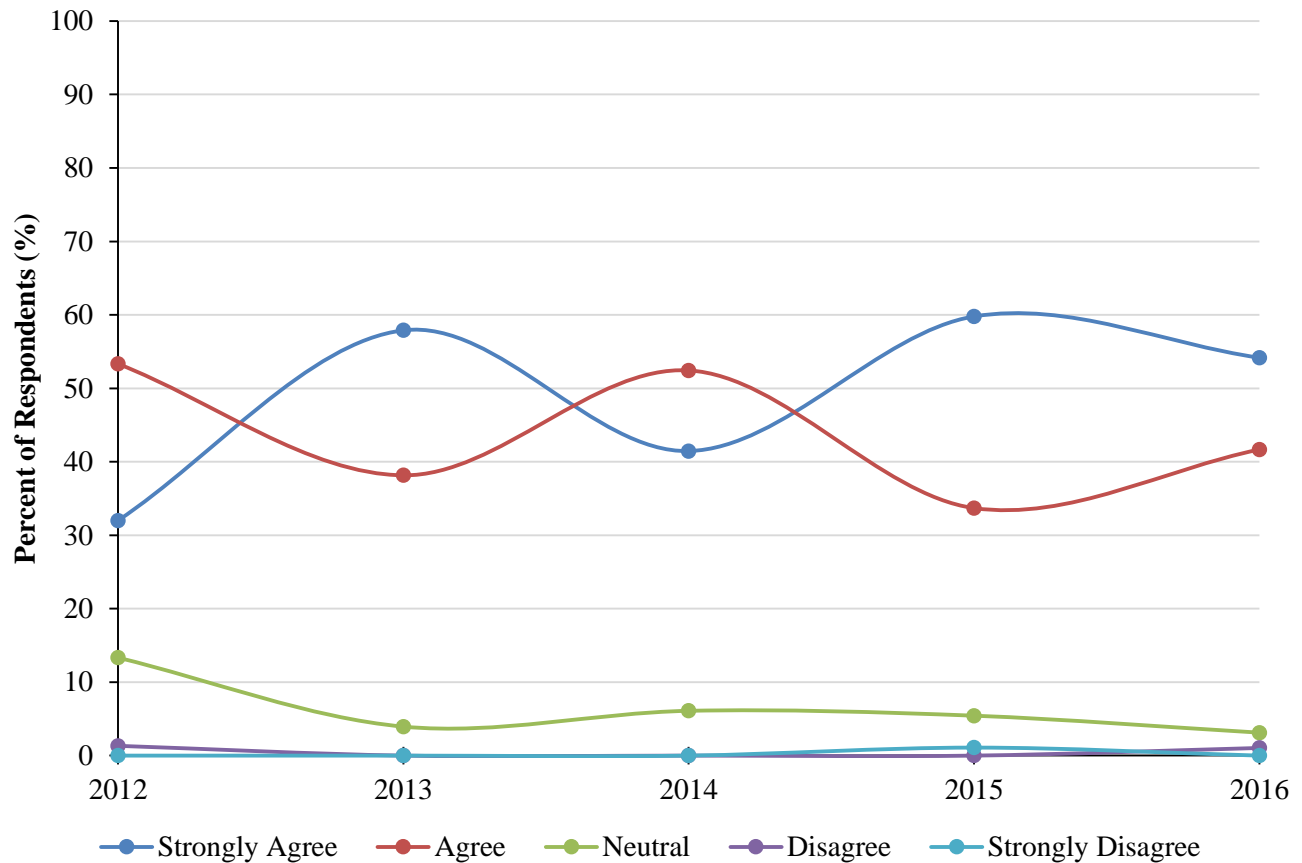


Figure 6.7 shows trends for the survey respondents' overall performance rating of other residents and fellows in their family medicine residency program from 2012 to 2016.

An increasing trend was noted among respondents who indicated they “strongly agree” other residents and fellows in their program exceeded their expectations from 2012 (32%) to 2016 (54%). The 5-year average was 49 percent. A drop was noted among respondents who indicated they “agree” that the other residents and fellows in their program exceeded their expectations from 2012 (53%) to 2016 (42%). The 5-year average was 44 percent. In addition, those who remained “neutral” in their response also dropped from 2012 (13%) to 2016 (3%).

The following section includes only those going into “Patient Care or Clinical Practice.”

Figure 6.8: Trends showing Primary Practice Location after Training, 2012-2016

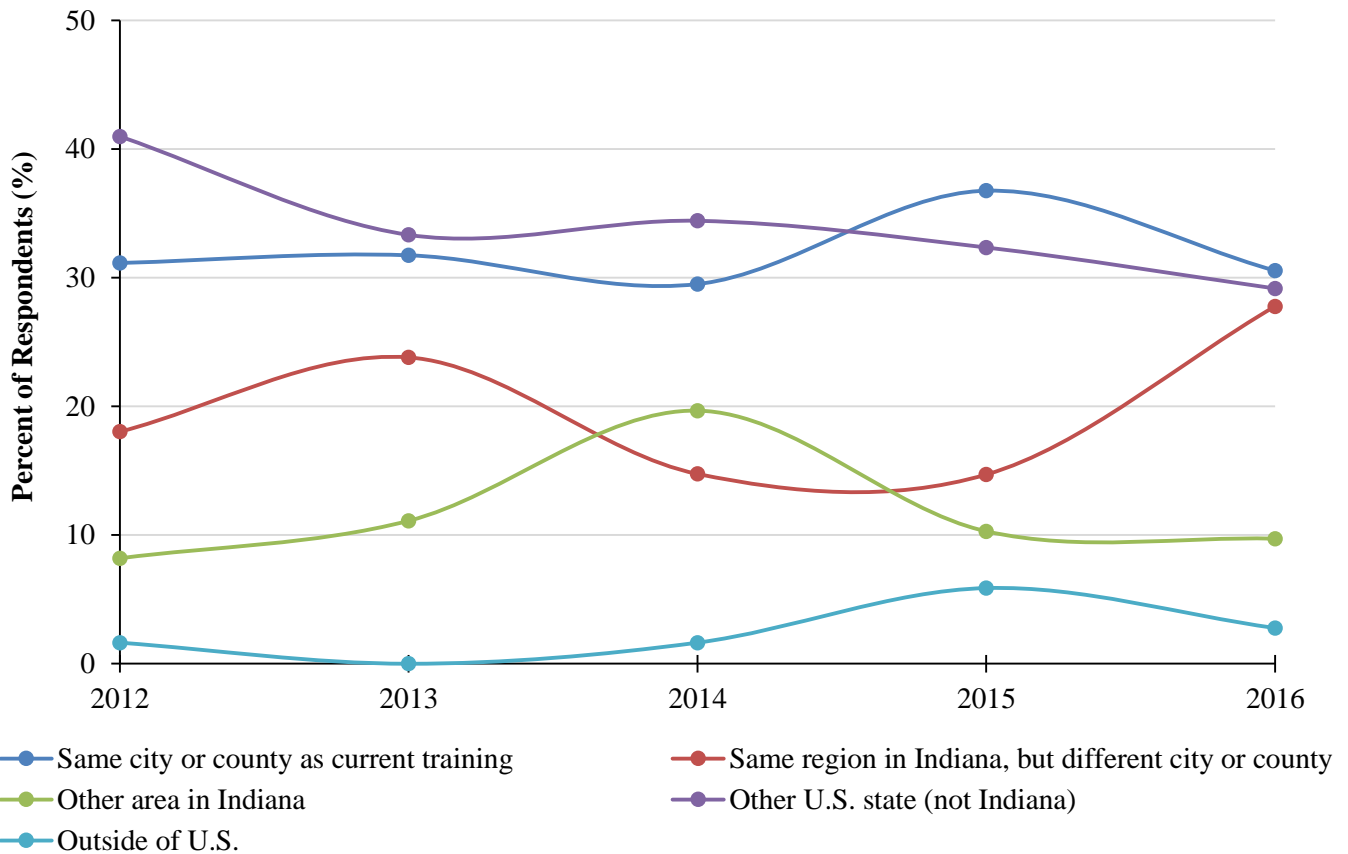
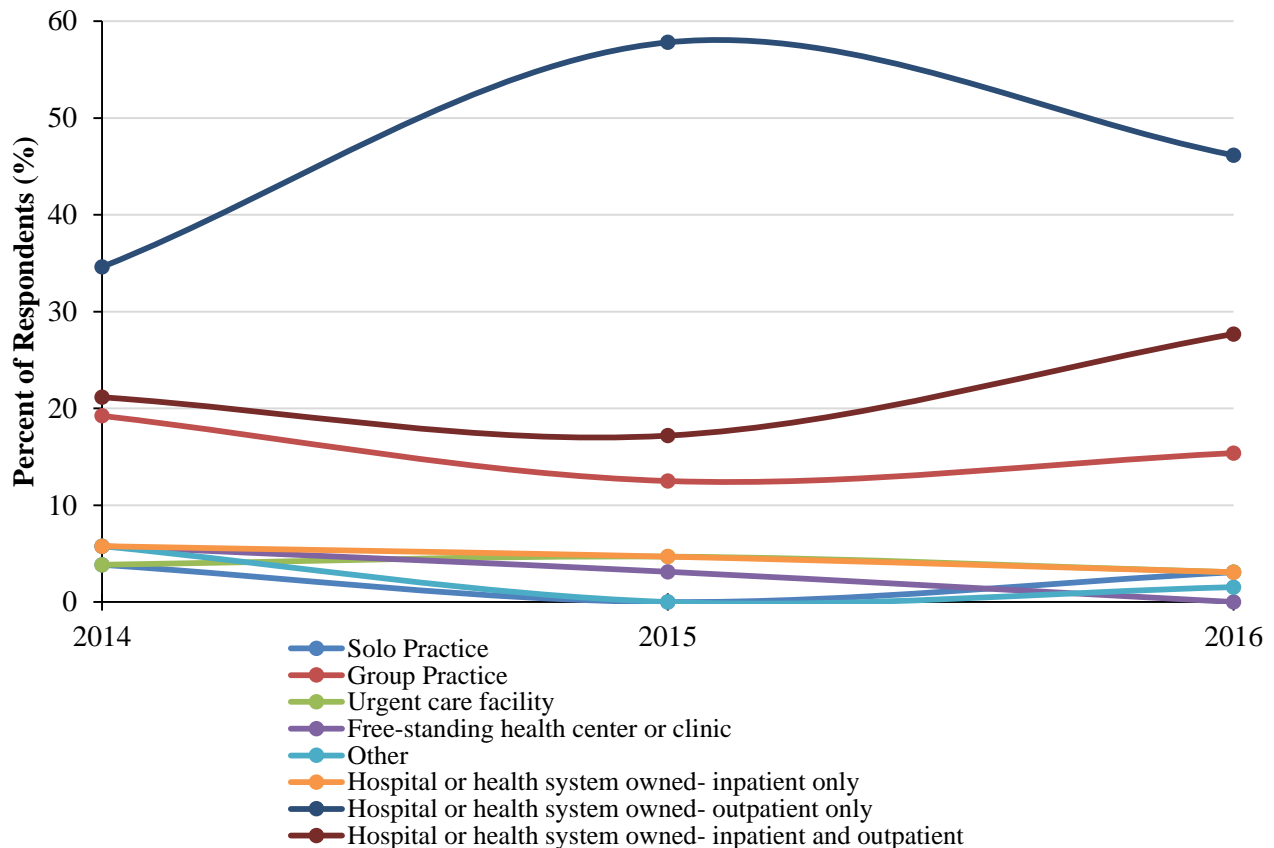


Figure 6.8 shows trends among survey respondents and the location in which they plan to practice after completing their training program from 2012 to 2016.

An increasing trend was noted among respondents who indicated having a primary practice location within Indiana from 2012 (57%) to 2016 (68%), in particular for those who indicated they were going to be within the “same region but a different city or county” from 2012 (18%) to 2016 (28%). The 5-year average for respondents planning to practice within Indiana was 64 percent.

Figure 6.9: Trends showing Principal Type of Patient Care Practice, 2014-2016*



*Response categories differed in the 2012 and 2013 Indiana Family Medicine Residencies Exit Survey[®] and were excluded from this graph.

Figure 6.9 shows trends among survey respondents and the principal type of practice setting they will be entering after completing their training program from 2014 to 2016. Response categories differed in the 2012 and 2013 Indiana Family Medicine Residencies Exit Survey[®] and were excluded from this graph.

An increasing trend was noted among respondents who reported entering a “hospital or health system owned - outpatient only” setting from 2014 (35%) to 2016 (46%). An increasing trend was noted among respondents who reported entering a “hospital or health system owned – inpatient and outpatient” setting from 2014 (21%) to 2016 (28%). A declining trend was noted among respondents who reported entering a “free-standing health center or clinic” setting from 2014 (6%) to 2016 (0%). A drop was noted among respondents who reported entering a “hospital or health system owned – inpatient only” setting from 2014 (6%) to 2016 (3%).

Figure 6.10: Trends showing Expected Percent of Patients to be Seen from Underserved Populations, 2012-2016

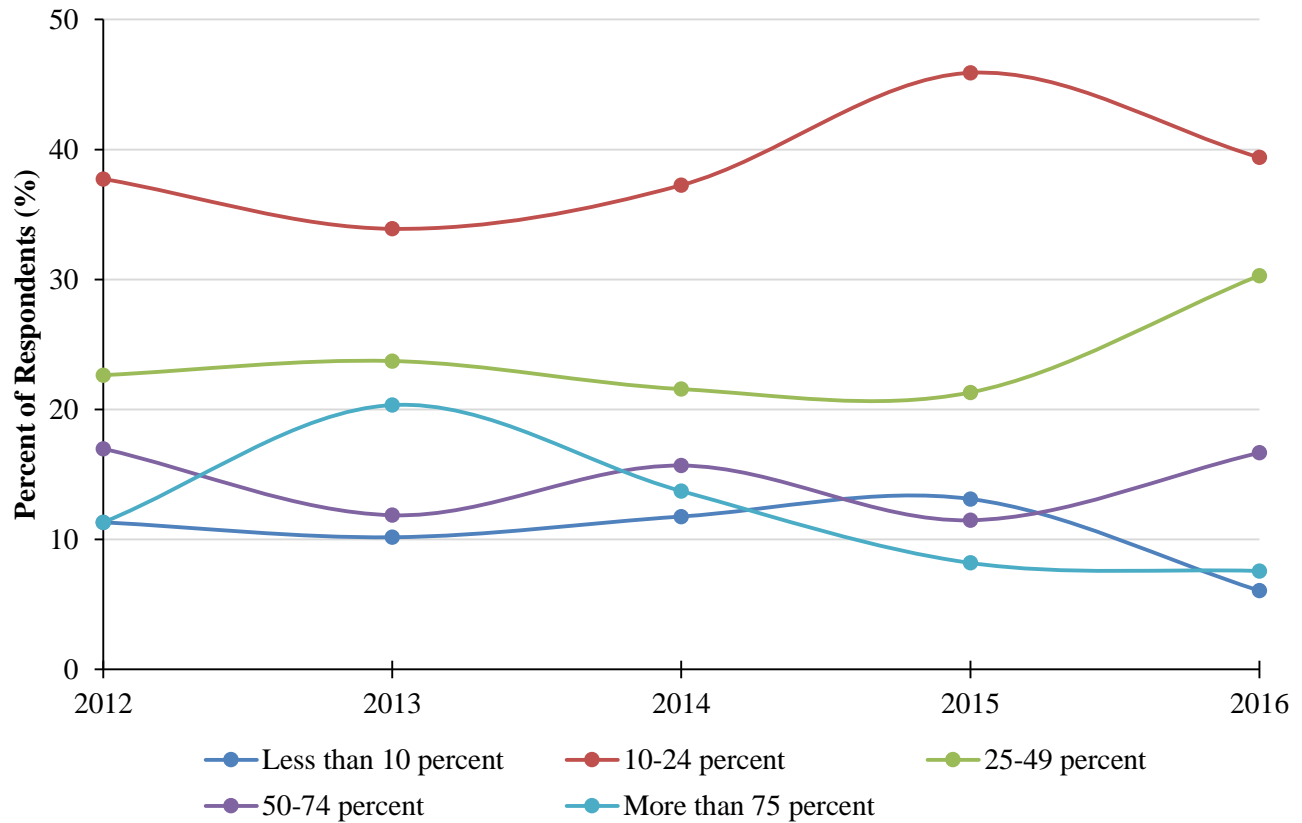
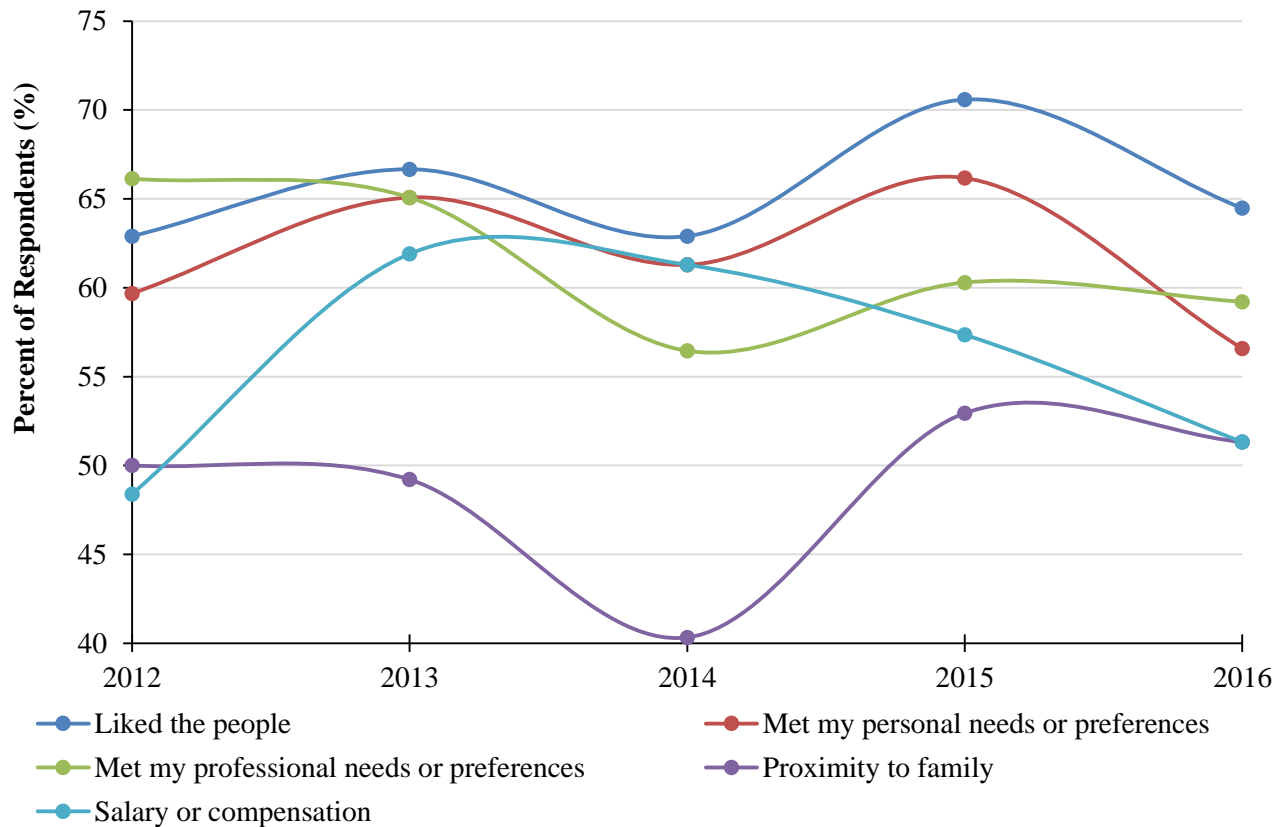


Figure 6.10 shows trends among survey respondents and the percentage of patients they expect to see from the underserved populations in their new practice from 2012 to 2016.

An increasing trend was noted among respondents who expect to see between 25 and 49 percent of the underserved populations in their new practice from 2012 (23%) to 2016 (30%). The 5-year average was 24 percent. A drop was noted among respondents who expect to see less than 10 percent of the underserved populations in their new practice from 2012 (11%) to 2016 (6%). The 5-year average was 11 percent.

Figure 6.11: Trends showing Main Reasons to Practice at this Location, 2012-2016*

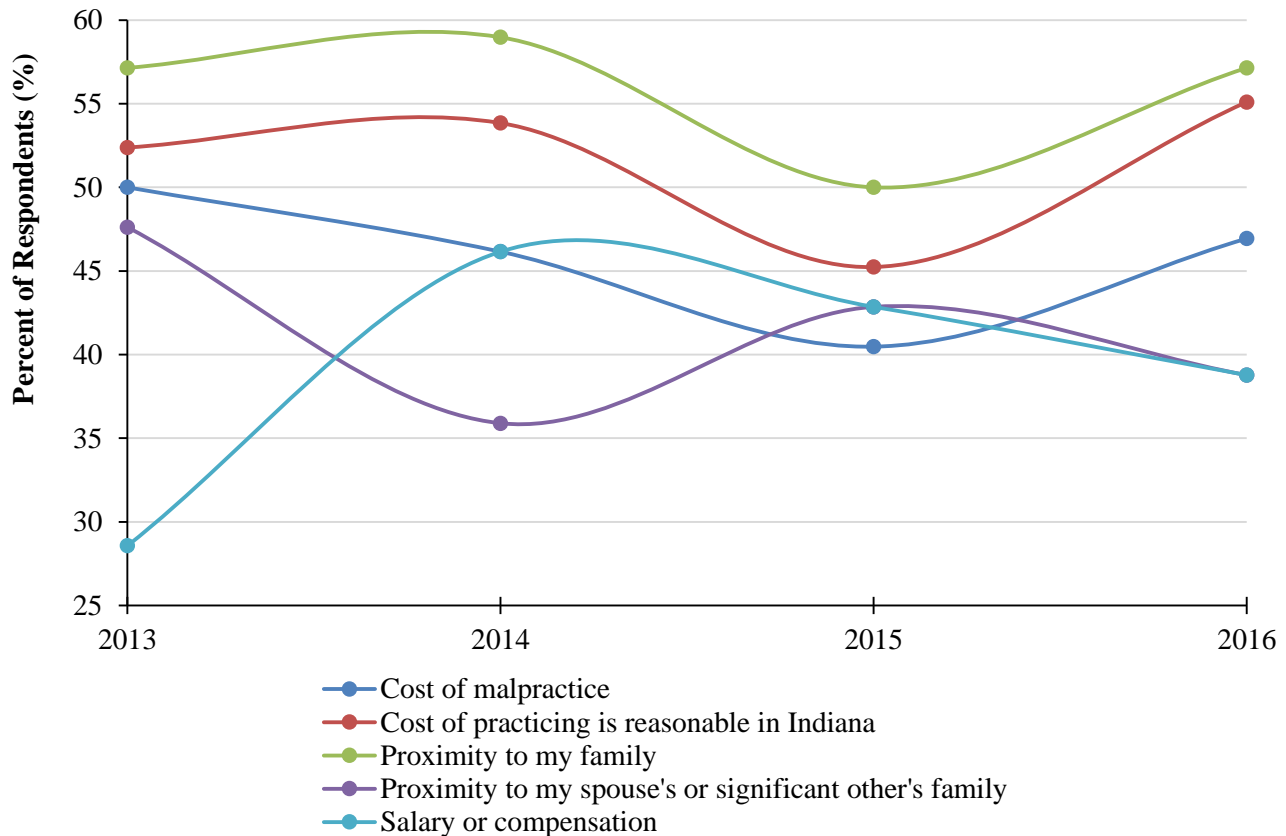


**This graph has been zoomed in to improve visualization.*

Figure 6.11 shows trends among the survey respondents and the reasons the **top 5** reasons they chose to practice at this location from 2012 to 2016. This graph has been zoomed in to improve visualization.

From 2012 to 2016, the **top 5** reasons to practice at this location have remained the same and a fairly steady trend has been noted for them. However, a slight drop was noted among respondents who indicated “met my professional needs or preferences” as a main reason to practice at this location from 2012 (66%) to 2016 (59%).

Figure 6.12: Trends showing Main Reasons to Practice in Indiana, 2013-2016*



*Response categories differed in the 2012 Indiana Family Medicine Residencies Exit Survey[®] and were excluded from this graph. This graph has been zoomed in to improve visualization.

Figure 6.12 shows trends among the survey respondents and the **top 5** reasons they chose to practice In Indiana from 2013 to 2016. Response categories differed in the 2012 Indiana Family Medicine Residencies Exit Survey[®] and were excluded from this graph. This graph has been zoomed in to improve visualization.

From 2013 to 2016, the **top 5** reasons to practice in Indiana have remained the same and a fairly steady trend has been noted for them. However, an increasing trend was noted among respondents who indicated “salary or compensation” as a main reason to practice in Indiana from 2013 (29%) to 2016 (39%). In addition, a slight drop was noted among respondents who indicated “proximity to my spouses’ or significant other’s family” as a main reason to practice in Indiana from 2013 (48%) to 2016 (39%).

CHAPTER 7: SURVEY RESPONDENTS' COMMENTS

Two-open ended questions were asked on the *2016 Indiana Family Medicine Residencies Exit Survey*[®]. The questions asked for suggestions to improve the program and new ideas for the residency curriculum. Responses to the two questions have been summarized into broad categories shown below.

I. RESPONDENTS' SUGGESTIONS TO IMPROVE THE PROGRAM

DIDACTICS

2016

- Improve Pediatric educational content during didactics.
- Improve MSK lectures during didactics including injections, suturing/casts/braces.
- Better lectures.
- Underserved medicine.
- Increase amount of visiting lecturers in order to improve didactics.
- EBM, not bad, not great. I just wish it felt more practical and less academic.
- More Internal Medicine didactics.
- More medical knowledge/didactic training especially regarding first steps in work-up and when to refer.
- Balance the curriculum better.
- More guest speakers/experts to come lecture during didactics.
- Improvement in the curriculum for geriatrics with structured reading.
- Psych curriculum and rotations are needed.
- Provide a "Boot camp" of common issues that arise daily-especially 1st year, so that more time is spent on learning more in depth topics 1st year after mastering "Basics".
- Less underserved and non-English speaking.

2015

- Rural track, hospitalist track, OB track.
- Add special tracks to curriculum.
- More faculty teaching.
- Need to focus on education and evidence based medicine.
- More board study opportunities.

2014

- More board preparation. More academic teaching (involving residents in teaching).

- More structure to academics.
- Offer more electives for medicine subspecialties.

2013

- Very nice program catering to needs of each individual resident. More structured didactic.
- Increase pediatric education as well as psych and cath.
- More education during didactics to prepare for boards.
- More structure, skills lab (SIM center).
- More research opportunities.
- Provide set electives so residents can just pick/choose from the list and not randomly look for faculty/staff willing to take them in.
- Increase 3rd year elective time.
- Streamline academic/research activity that is required.
- More specific review of disease processes, presentation, physiology, and specific algorithmic treatment. Infectious disease they are going to be asked on boards.

2012

- More variety of education from preceptors.
- Increasing direct patient care in electives.
- More hands on didactics, more time for personal education.
- Worry more about teaching and less about ACGME guidelines.
- Revamp AM lecture series to reflect medical knowledge needs in family medicine.
- Update curriculum, Patient Care focus.

TRAINING

2016

- It would be nice to convene with other programs in leadership training for IN residents.
- Improve outside and specialist providers to help us get educated.
- Make the obstetrical training optional.
- Increase the number of simulations.
- Increased certifications ATLS, PALS, etc.
- More exposure to common family med procedures.
- Less OB emphasis.
- More opportunities for procedural training.

- More inpatient procedures.
- Improved obstetrical experience/location.
- Allow outside rotations outside Fort Wayne to work at potential employment sites in Indiana.
- More training in orthopedic injury management and radiology.
- Psychiatry.
- Residents might benefit from having more FM outpatient rotations at community clinics to see the practice. As many of the residents end up practicing in community setting.
- More procedures.
- More opportunities for procedure training.
- Increased procedure opportunities.
- I would have appreciated more outpatient training during the first two years but this did not significantly affect my ability to care for patients in the outpatient setting.
- More focus on outpatient medicine.
- Less OB.
- More focus on outpatient procedures.
- Increase the focus on outpatient medicine.
- More focus on reading x-rays, MRIs, etc.
- Decrease amount of OB training.
- Improve Psychiatric training.
- Improve electives so they are more than shadowing experiences.
- More procedures.
- Focus on outpatient medicine.

2015

- More experience with procedures.
- More acute care, more inpatient procedures, more responsibilities inpatient, higher complexity and acute care patients for FM.
- More training available outside of Francis group (for rotations).
- More procedure training (mandatory).
- More training in psychiatry, more procedure opportunity.
- Trying to incorporate more geriatrics.
- Improving/ facilitating opportunities for procedural training that could be applied in post-graduation (i.e. office based procedures, colonoscopy, colposcopy).

- More procedure training, in-office procedures.
- More outpatient need to see.
- Expand rotation opportunities. Continue to improve quality of didactics.
- Better rotation goals and objectives. Increase of feedback.
- Decreased requirements for OB-More focus on patient care and education than numbers and money.
- More procedures, scopes, dermatology.
- Decrease emphasis on OB as family medicine is moving away from this focus.
- Procedure day.
- Offer Lafayette as a site for OB rotation.
- Clinic flow, more time on rotations.
- The clinic experience was not ideal...short staffed and technology issues. This is improving some.
- Teaching rounds.
- Decrease required exposure for OB.
- Decrease focus on OB training.

2014

- Separate rotation in research (optional) instead of incorporating it in other rotations.
- Increase procedure exposure.
- Improve support towards developing skills residents will be using in their future practices. Same opportunities to develop those skills for every resident.
- Less OB.
- Remove duty hour restriction.
- Increase office-based procedure education.
- Less outpatient visits and more preventative medications.
- Less surgery rotations.
- Adjust our OB call so that we are not required to do all H and P's for very laboring patient who get admitted.
- Shift of focus more toward outpatient care.
- Less oversight to allow us to make mistakes on occasion for more hands on learning.

2013

- It would be nice to have more procedure training.

- Increasing the number of specialty attending to increase the number of rotations available; somehow increase the number of in-office procedures.
- Find a way to deal with the decreasing OB numbers. More evidence-based hormonal therapy training.
- Find a way to limit OB and inpatient exposure (some is necessary, but the current amount is overkill).
- Increase urgent care experience both in established urgent cares and our chief clinic.

2012

- More geriatric learning opportunities.
- Setting better expectations for rotations.
- Mentoring programs with physicians in the community would help prepare more fully for life after residency.
- Decreasing amount of OB responsibility?
- More business training.
- More procedures, less required time in nursing home, only one month of surgery.
- Need more procedural training!
- More instruction in proactive management, systems-based practices, medical economics, and business related to medicine.
- Streamline paperwork, remove unneeded meetings.
- Eliminate shadowing rotations.
- To allow either more electives or more rotations.
- More rural training, more rotations with outpatient family medicine offices, less inpatient medicine rotations, and less OB.

FACULTY INVOLVEMENT

2016

- Increase faculty/staff: resident ratio.
- More faculty members.
- More lectures from faculty.
- More teaching from faculty.
- Faculty preceptors from outside Family Medicine.
- Improving communication between faculty and resident.

- Diversity directors (Most are young and all graduated from this residency).
- More teaching from the experience of the faculty.
- Stronger advising, take quarterlies more seriously and allow adequate time for them.
- Hire more faculty which we are in process of doing.
- Dr. Brown is really doing a great job to transition the program.

2015

- Less focus on looking good on paper and more focus on education by the faculty.
- Need more faculty, more evidence-based medicine, increased qualification of faculty in teaching.
- More engaged faculty and PD, improved clinic flow and management.
- Better communication from high ups.
- Getting more faculty with different views not just from our program.

2014

- There needs to be accountability when educational expectations are not met. Faculty needs to actively push residents and actively participate in learning.
- Increased faculty with current skills in EMRs.
- We need to hold our faculty responsible to teach more.
- Thanks for adding our pediatrician. We need more community pediatric faculty.
- Less administrative based distribution, less redundant paperwork, more teaching, more faculty involvement (lectures and patient care).
- More faculty available in clinic, more efficient running of clinic with better trained staff and being one of the resident advocates.
- As program grows, need more faculty, more organized teaching (lectures, etc.)
- Improved faculty lectures, improved OB numbers. More responsibility on specialty rotations, more attentive program CEO who would listen to residents.
- We need additional faculty currently being addressed. Needs to be more academic-based with more procedure availability.
- More faculty. One nurse per resident clinic. Lessen time logging on to the computer programs.

2013

- No comments.

2012

- More fully envelop the program when recruiting; highlighting pros and cons. Gaining more faculty who have not graduated from the program.

- Positions of director of medical education and residency director should be split into two positions, not held by one individual.
- More encouragement from faculty. As a medical student moving to residency, along with loan debt burden, it is stressful.
- More supportive staff.
- More faculty teaching.
- Having more exposure to female medical physicians on faculty.
- 1) More faculty 2) Improve efficiency of the family medicine clinic.

GENERAL

2016

- Improve website to access educational materials.
- Continue to do lifelong learning!
- Increase the attendance at national conferences, CME, etc.
- Would like to have more protected educational and study time.
- Program does a great job and any suggestions we have, they do well to implement when the concern arises.
- More autonomy for the residents.
- Too many ACGME "Requirements" keep us from learning or being able to focus on key essentials.
- Accountability (in both residents and faculty). Consistency in how and when rules are enforced.
- Better preparation for boards.
- Better lunch options i.e. catering company, otherwise great program.
- Less red tape.
- Try to run as a residency, not as a business. We lost teaching/learning experiences because of this.
- Clinic efficiency.
- Clinic dictation software or less "click-heavy" EMR.
- Improving work flow in clinic.
- Improved EMR - flows from inpatient to outpatient.
- Dictation software for clinic documentation.
- Individual responsibility has become less important. Part of the problem with the "team approach" is that individual responsibility becomes less important. I think this should be balanced.

- Continued mutual respect and cordial communication: I feel that as an intern I was treated as a colleague and my opinion was valued; I felt that as this years progressed I observed a drift in the culture and a level of hierarchy developed that had not been there before (At least not there formally). I felt that micromanagement also increased drastically. I lament that this program I was recruited to and this one I am leaving feel very different.
- More director involvement directly in our education.
- There has been a trend away from resident physician autonomy. The oversight has become more and more extensive each year. This process produces residents who are unable to make independent decisions and who will be dangerous as new independent physicians after graduation. It has to stop.
- Needs more director involvement and less political red tape.
- Interpreting rules beyond what they were originally intended for is counterproductive and harmful.
- Fair and equal opportunity to be given to all residents.
- The NP provider doing OB care is unprofessional, narcissistic, vulgar and blatantly inappropriate. Time spent on rounds is used to discuss life stories (which are often inappropriate) rather than teaching. She is the only thing I would change about the program.
- Less OB provider time (NP person) spends too much time being inappropriate or less time teaching.
- Seek out resident (2nd/3rd) interested in teaching junior residents to do this (or when we offer, respond to our emails).
- As changes to curriculum are made and requirements are added, make sure to continue to balance work responsibilities and not only just add on more responsibilities. If new requirements is added take something out to balance.
- Provide more education on practice management and the process of finding employment.
- More competitive pay. Hurts to see 40 hours on salaried pay stub when realistically 60-70+ as intern. Other programs have much more competitive compensations/salaries.
- Not anything major.
- Helping with tasks.
- More admin time.
- Residency was just as I expected and overall what I needed as well.
- This was a wonderful program and adequately prepared me to practice on my own.

- I do not think this program needs much improvement. It has improved greatly over the past 3 years and is continuing to improve in all areas of family medicine.
- None currently; continue progression toward new facility and accreditation.
- Great experience; other than a few scheduling tweaks not much to add.
- Stability of program.
- No suggestions. (2x)
- None specifically.
- None. (2x)
- N/A

2015

- None, wonderful program.
- N/A
- FPC- Clinic time organization.
- None.
- This residency is great but could use different angles/points of view room outside the residency.
- Allowing for as much autonomy as possible.
- Improve awareness and prevention of resident fatigue.
- Less clinic hours/less "busy work" to allow for self-study/ more time per patient.
- Less clinic patients per hour until maybe last 6 months of 3rd year (work knowledge before speed).
- More positions per year. Need good medical insurance for residents.
- Great program and training.
- Improve scheduling.
- Improve office efficiency.

2014

- Better communication with network and residency.
- Need to make decision based on the specific circumstances encountered in Lafayette- RIGGS; not on the needs of the Indianapolis program.
- Need to be more strategic thinking. Focus more on things that we will see on a routine basis. Training with ancillary staff and professions is okay if rare, but not if present.
- Our program is undergoing a transition in focus and leadership. It has improved from when I started but I feel it would benefit from a stronger emphasis on medical education with specialists in the network.

- Becoming more "corporate" and less community based is concerning in my opinion. Overall great program.
- Less formality, more outside activity. More transparency regarding large decisions made.
- Increase compensation.
- Continue to seek strong students and residents.
- The culture of primary care is excellent; however, there seems to be little interest among the faculty and residents to provide in-depth care beyond basic office visits in any area aside from women's health (such as colonoscopy). Ignored are such areas as men's health, a significant amount of dermatology. Also, many procedures in clinic are lost to podiatry because of a podiatry training program.
- We need to be a provider clinic run by the physician and not the ancillary staff.
- I think for professional development purposes there should be a portion dedicated to leadership training and conflict resolution training.
- Become more competitive with salary and benefits to continue to attract strong residents.
- Making a lot of great changes, need to keep challenging residents.
- None- It is awesome in Muncie!
- It is great!
- Program is doing fine especially with changes in curriculum that are ongoing.
- Continue improving feedback to the residents that is timely and constructive. There have been improvements this year, but there needs to be increased verbal feedback, particularly positive feedback to help resident morale.
- Doing great with the improvements (new building, adding more residents).
- It's awesome!

2013

- More clearly defined responsibilities and expectations.
- More help with employment and contract negotiations.
- Great job! My training experience was first rate!
- My FM Residency program is excellent and constantly improving.
- Continued innovation, reduction in inpatient responsibilities.
- Retire program director. Multiple ways to specialize within program.
- 24-hour intern call (ACGME changes). Remove night float.
- Change nursing home care from acute rehab to long-term care.

- Financial counseling (loan management / options).
- Less focus on "checking boxes" so to avoid probation. Being shady with patient numbers reported. Clinic trumps all rotations and education.
- Getting rid of duty hours - they only restricted my education.
- Opening opportunities to rotate in other hospital systems throughout the city and state. All of the systems are concerned with protecting their own interests at the expense of good education opportunities.

2012

- Cast off overly burdensome ACGME hour restrictions.
- More hands on management of office function/day to day.
- More visits to FP offices to see how they are run.
- Keep up the excellent work!
- Do not change what was promised to a resident.
- Need to be more consistent across the board.
- Clinical experience has been limited due to other non-clinical obligations, during limited exposure to direct patient care and so forth.

II. RESPONDENTS' SUGGESTIONS LISTING NEW IDEAS FOR THE RESIDENCY CURRICULUM

DIDACTICS

2016

- Dedicated lectures for outpatient care.
- Patient safety.
- Rural, US.
- More sim labs during didactics, especially before recertification classes.
- Evidenced-Based Noon CONF (Changes that are happening).
- Bigger focus on OP topics with less emphasis on IP and OB topics.
- More emphasis on geriatric care.
- Increase the focus on mental health care.
- Electives catalogue to make best use of this valuable month.
- More electives.

2015

- Stronger procedure curriculum that is implemented rather than just finding opportunities.
- Teaching rounds.
- Rural health.
- Education on improving work load and how to run an efficient clinic with the increasing demands of meaningful use requirements.

2014

- More elective rotations.
- Ethics curriculum, palliative care rotation, addiction medicine.
- More journal clubs.
- International curriculum and sports medicine curriculum.
- Including lectures on spiritual health, obtaining spiritual surveys; include lectures on nutrition and the various diets and how they impact health.
- Specific curriculums for areas of interest.

2013

- Implement more curriculum board review.
- We recently began a patient-centered medical home curriculum.
- Having a more rigid and clearly defined curriculum so that all residents receive similar training and educational experiences.

2012

- Refine curriculum to fit ABFM testing scheme.
- More electives.
- More lectures that have resident participation.
- Urban Underserved Curriculum.

TRAINING

2016

- More full clinic days.
- Less 1/2 day rotational experiences and more full day rotations.
- Urgent care/outpatient rotation.
- More underserved opportunities.
- Offer underserved opportunities.
- More rural rotations/education.
- Would love to have more opportunity with underserved urban population health and public health policy exposure.
- More FQHC training.
- Practice Management.
- Business management (coding/billing).
- Public Health. (2x)
- Palliative care. (2x)
- Bariatric Medicine.
- More focus on reading EKGs, Radiographs.
- Specific tracts such as outpatient, Hospitalist, OB, ER.
- We should have sent contacts for rotations that we can reach out to.
- More focus on specialty areas Sports Med, Hospitalist, Global Health etc.
- Opportunity for dedicated rural FM experiences where resident can "practice" without being pulled away from clinic/didactics etc. at least for a month.
- I do like OB or Non-OB tracks as ability to focus.
- Urgent/acute care area of concentration.
- Scope track.
- Increase focus on procedures.

- Some way to increase procedures.
- Adding a procedures month.
- More specialist to choose to do rotation with.
- FMC rotation to increase clinic numbers.
- Replacing a core with either an outpatient FM block or an ambulatory block with multiple subspecialties like Cards/Derm/Resp/Endo/Nephro.
- More simple dermatologic procedures including some cosmetics.
- Ultrasound training. (2x)
- Ultrasound.
- Already exploring these-more ultrasound trainings more practice management training.
- System procedures/organized fashion.
- Student health and acute care training setting.
- Healthy lifestyles/Nutrition.
- LGBTQ sensitive Care.
- Trans health.

2015

- Nontraditional: Psych, Geriatrics, End of life care, Rural.
- Rural, hospitalist, OB, ED, Administrative, Sports med.
- Lower surgery requirements, lower ER requirements.
- More workshops.
- Lengthening clinic appt times to be able to learn more in clinic.
- Fewer patients in clinic, more time on electives, increase procedures.
- More procedural.
- Exposure to more fellowships opportunities.
- Improve rural experience, improve understanding/ education of job types/process of finding job and understanding contracts.
- Procedures.
- Tailor training for interests of the resident.
- More procedures.
- Pain medicine, urgent care.
- Increase OB experience.
- Home visits, rural medicine, evidence-based medicine integration.

- Procedure day.

2014

- Procedures are minimal. The spectrum of a good FM physician can be expanded without having to spend thousands after graduation. Also the few procedural activities should not be reserved to specific residents.
- More community outreach would be welcome.
- More dermatology clinic exposure.
- Maybe try to use the ambulatory curriculum to increase resident exposure to how life is as an attending clinician. It was great on rural medicine to see a family practitioner in their office with their staff but this exposure needs to be increased with faculty and maybe community physicians.
- Focused tracks for rural residency.
- More procedures, business of medicine, and rural medicine.
- More sports medicine, more dermatology, and less social work.
- More inpatient experience. More consistent time with cardiology, pulmonology, and maybe pain management as our clinic saw a great deal of these conditions. Also nephrology.
- Continue doing practical application: coding, knowing insurance systems (navigating Medicare/Medicaid vs private insurance).
- Sports medicine program that actually teaches sports medicine.
- More surgery.
- More local outpatient pediatrics.
- Palliative care as a required rotation.
- Consider high and low OB tracks and hiring an OB fellow.
- Make endocrinology a required rotation.
- A good dermatology rotation, outpatient OB/GYN.
- Less general surgery, less clinic on short rotations.
- Procedures clinics. Stronger musculoskeletal education.
- Better geriatrics.
- Wound care and geriatrics.
- Spirituality in medicine and patient care.

2013

- Academic and leadership training.
- Better organization for procedure rotation.

- Incorporate medicine block rotations.
- More exposure to geriatric patients.
- Integrative medicine.
- More procedures in clinic, colonoscopy.
- Sleep medicine. Men's health, Pain management.
- Better coordination with clinic schedules and rotations with preceptor.
- Technology in medicine.
- Less OB.
- Add out-patients adult and child psychiatry rotation apart from addiction medicine.

2012

- Adding new fellowship opportunities; OB, Geriatrics, Rural medicine.
- More geriatrics.
- More intense international health training.
- More inpatient education, more hands on procedure.
- 1) Management 2) Urgent care counting towards ER obligation vs urgent care rotation. We have acute clinics but zero urgent care experience under moonlighting. I will be in level 2 ER when I leave. Would like some rural ER training.
- Cosmetic.
- 1) sports medicine 2) more structured/stronger ICU rotation.
- Procedures!
- Focus mostly on the most commonly seen disorders in both ambulatory and hospital care.
- Journal Club should be included.
- Outpatient family medicine.

GENERAL

2016

- Help teach residents to be better teachers in the future.
- Improvement in financial discussions/education-loan repayment options, income based repayment, loan forgiveness program, long-term disability, etc.
- Resident wellbeing.
- Telemedicine.
- Travel medicine.

- Less formal evaluations and more face-to-face small group discussion.
- Improve the process and helping to organize electives (if in system) to make it easier for residents.
- Allow more personal tailoring of experience.
- Indianapolis, Bloomington.
- N/A
- Unsure
- None. (6x)

2015

- Include underserved areas outside of central Indiana.
- None. (3x)
- Allowing individualizing learner experience as residency progresses.
- Continue expansion to Lafayette IN.
- N/A.
- Health reform, value emphasis.
- More practice/ billing/coding.
- Office- how to run/flow.
- Decrease the busy paperwork. Increase patient care and procedures.
- Family medicine needs to protect their education in regards to maintaining a high level of sick/complicated patients in the hospital setting.

2014

- There is a significant difference in compensation between Indiana and other states; it is tremendous. Indiana is below par.
- Technology and tools in medicine.
- Professional development- future faculty training, hospitalist, preparation for fellowships.
- None.
- Leadership skills, effective communication, team building, conflict resolution management.

2013

- N/A.
- No new areas needed at this time.
- I would say the business side of medicine- but we should have people doing this already for physicians if we are going to have combined requirements to abide by in medicine. I went to medical school to treat disease and help people, not to learn billing.

- Anything you would want could be done as an elective.
- Financial planning starting in second year.
- Allow residents to explore direct pay practices.
- 1 travel abroad (with funding provided) to spend more time on underestimating the costs of healthcare for our patients.

2012

- Further/more integration into the other community hospitals i.e., rotate/partner.
- I like where maternal child health is going right now.
- List for resident input.
- 4-year residency.
- More exposure for contract and debt resolution.

APPENDIX A

INDIANA MEDICAL EDUCATION BOARD - 2016 INDIANA FAMILY MEDICINE RESIDENCIES EXIT SURVEY®

In an effort to improve our program and document where our graduates go after completing their residency program, we would like you to please respond to the following questions. **Your responses to these questions will be kept strictly confidential.** A summary report will be created and only aggregated results will be shared with the program director. Your responses are very important to us, but if you do not wish to answer a question, you may leave it blank. Your decision to participate in this survey will not affect your graduation from the program.

DEMOGRAPHIC CHARACTERISTICS

1. Birth year: _ _ _ _
2. Gender: Male Female
3. Which of the following describes your race? **Please mark ALL that apply.**
 - American Indian/ Alaskan Native
 - Asian
 - Black/African American
 - Native Hawaiian/ Pacific Islander
 - White
 - Other (please specify): _____
4. Do you consider yourself to be Hispanic or Latino?
 - Yes, Hispanic/Latino
 - No, not Hispanic/Latino
5. Where do you consider your hometown?
 - State _____
 - Outside of US
- 6a. Where was the high school located from which you graduated?
 - State _____
 - Outside of U.S.
- 6b. Where was the college located from which you graduated?
 - State _____
 - Outside of U.S.
- 6c. Where was the medical school located from which you graduated?
 - In Indiana
 - Outside Indiana
 - Outside U.S.

If you did NOT attend Indiana University School of Medicine, please SKIP to Question 8.

7a. If you attended Indiana University School of Medicine, in which campus did you begin your first year?

- Bloomington
- Evansville
- Fort Wayne
- Indianapolis
- Lafayette
- Muncie
- Northwest
- South Bend
- Terre Haute

7b. If you attended Indiana University School of Medicine, at which Family Medicine residency program did you complete your 3rd year required Family Medicine rotation?

- Community Health Network, Indianapolis
- Deaconess Family Medicine Residency, Evansville
- Fort Wayne Medical Education Program, Fort Wayne
- Indiana University Health Ball Memorial Hospital, Muncie (formerly Ball Memorial Hospital)
- Indiana University Methodist Family Medicine Residency, Indianapolis
- Memorial Hospital of South Bend
- Franciscan St. Francis Health, Beech Grove (formerly St. Francis Hospital)
- St. Joseph Community Hospital of Mishawaka
- St. Joseph Regional Medical Center, South Bend
- St. Mary's Medical Center, Evansville
- St. Vincent Family Medicine Residency, Indianapolis
- The Methodist Hospitals, Inc., Gary
- Union Hospital, Terre Haute
- Westview Hospital, Indianapolis
- Other (please specify): _____

7c. If you attended Indiana University School of Medicine, did you experience a 4th year elective or student externship experience at any of the following sites?

- Community Health Network, Indianapolis
- Deaconess Family Medicine Residency, Evansville
- Fort Wayne Medical Education Program, Fort Wayne
- Indiana University Health Ball Memorial Hospital, Muncie (formerly Ball Memorial Hospital)
- Indiana University Methodist Family Medicine Residency, Indianapolis
- Memorial Hospital of South Bend
- Franciscan St. Francis Health, Beech Grove (formerly St. Francis Hospital)
- St. Joseph Community Hospital of Mishawaka
- St. Joseph Regional Medical Center, South Bend
- St. Mary's Medical Center, Evansville
- St. Vincent Family Medicine Residency, Indianapolis
- The Methodist Hospitals, Inc., Gary
- Union Hospital, Terre Haute

- Westview Hospital, Indianapolis
- Other (please specify): _____

8. What is your current level of educational debt?

- None
- Less than \$50,000
- \$50,000 - \$99,999
- \$100,000 - \$149,999
- \$150,000 - \$199,999
- \$200,000 - \$249,999
- \$250,000 - \$299,999
- \$300,000 - \$349,999
- \$350,000 - \$399,999
- \$400,000 - \$449,999
- \$450,000 and over

9. Considering others in your household, what is the current total level of educational debt?

- None
- Less than \$50,000
- \$50,000 - \$99,999
- \$100,000 - \$149,999
- \$150,000 - \$199,999
- \$200,000 - \$249,999
- \$250,000 - \$299,999
- \$300,000 - \$349,999
- \$350,000 - \$399,999
- \$400,000 - \$449,999
- \$450,000 and over

10. What do you expect to be doing after completion of your current Family Medicine residency program?

Please mark only ONE option.

- Patient Care or Clinical Practice (in Non-Training position)
- Fellowship or Additional Subspecialty Training (please specify): _____
- Academic position (Teaching and/or Research)
- Temporarily Out of Medicine
- Military
- Industry
- Other (please specify): _____
- Undecided or Don't know yet

11. In your upcoming position, what amount of direct patient-care activities will you do?

- No patient-care activities
- Part-time patient-care activities
- Full-time patient-care activities

12. Where is the location of your primary activity after completing your current Family Medicine residency program?

- Same city or county as current training

- Same region in Indiana, but different city or county
- Other area in Indiana
- Other U.S. state (not Indiana)
- Outside of U.S.
- Undecided

13. Do you have an obligation or visa requirement to work in a designated health professional shortage area (HPSA) or medically underserved area (MUA) when you complete your training in the Family Medicine residency program?

- Yes
- No

14. What is the name and address of your principal work location AFTER completing your current Family Medicine residency program?

Name of facility: _____

Street address: _____

City: _____ State: _____ Zip code: _____

If you have NOT accepted a position in patient care practice, please SKIP to Question 24.

PRACTICE CHARACTERISTICS

15. Which best describes the principal type of Patient Care Practice you will be entering?

- Private practice-Solo
- Private practice- Group or Partnership (2 or more persons)
- Hospital or health system owned – inpatient only
- Hospital or health system owned- outpatient only
- Hospital or health system owned- inpatient and outpatient
- Urgent care facility
- Managed care organization or insurance company
- Free-standing health center or clinic (Federal, state, local government or community board led, etc.)
- Nursing home or institutional residential facility
- Other (please specify): _____

16. In your new practice, what percentage of the patients do you expect to see from underserved populations? (Medicaid or self-pay, educationally or economically disadvantaged)

- Less than 10 percent
- 10- 24 percent
- 25- 49 percent
- 50- 74 percent
- More than 75 percent

17. What are the main reasons you decided to practice at this location? **Please mark ALL that apply.**

- Climate
- Liked the people
- Met my personal needs or preferences
- Met my professional needs or preferences
- Opportunity for my spouse or significant other there
- Proximity to my family
- Proximity to my spouse's or significant other's family
- Proximity to recreation
- Salary or compensation
- Satisfy loan or scholarship requirement
- Other (please specify): _____

18. If you plan to practice in Indiana, please indicate the main reasons why? **Please mark ALL that apply.**

- Always intended to practice in Indiana
- Climate
- Cost of malpractice
- Cost of practicing is reasonable in Indiana
- More jobs or practice opportunities in Indiana
- Opportunity for my spouse or significant other
- Proximity to my family
- Proximity to my spouse's or significant other's family
- Proximity to recreation
- Relationship with my mentor
- Rotation experience
- Salary or compensation
- Other (please specify): _____

19. If you are not planning to practice in Indiana, please indicate the main reasons why? **Please mark ALL that apply.**

- Climate
- Cost of malpractice
- Cost of practicing too high in Indiana
- Inadequate salary or compensation
- Lack of jobs or practice opportunities in Indiana
- Never intended to practice in Indiana
- No opportunity for my spouse or significant other
- Proximity to my family
- Proximity to my spouse's or significant other's family
- Proximity to recreation
- Other (please specify): _____

20. Expected gross income (salary + incentives) during your first year of practice:

- | | |
|--|--|
| <input type="checkbox"/> Less than \$50,000 | <input type="checkbox"/> \$50,000 - \$99,999 |
| <input type="checkbox"/> \$100,000 - \$149,999 | <input type="checkbox"/> \$150,000 - \$199,999 |
| <input type="checkbox"/> \$200,000 - \$249,999 | <input type="checkbox"/> \$250,000 - \$299,999 |
| <input type="checkbox"/> \$300,000 - \$349,999 | <input type="checkbox"/> \$350,000 - \$399,999 |

- \$400,000 - \$449,999
- \$500,000 or more

- \$450,000 - \$499,999

21. How many offers for employment/practice positions did you receive all together?

- Did not seek an employment position at the time
- 0
- 1
- 2
- 3
- 4
- 5 or more

22. How many offers for employment/practice positions did you receive in Indiana?

- Did not seek employment positions in Indiana
- 0
- 1
- 2
- 3
- 4
- 5 or more

23. What is your overall assessment of practice opportunities in Family Medicine in Indiana?

- Many jobs
- Some jobs
- Few jobs
- Very few jobs
- No jobs

PROGRAM ASSESMENT

24. The Family Medicine residency program was helpful in the preparation for my board exams.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree
- Board exam in my field does not exist

25. How competent do you feel in the following ACGME competencies?

Competency area	Fully	Partially	Not at all
a. Patient care			
b. Medical knowledge			
c. Practice-based learning and improvement			
d. Interpersonal and communication skills			
e. Professionalism			
f. Systems-based practice			

26. In your Family Medicine residency program did you receive training to serve the:

- a. Rural population Yes No
- b. Underserved population Yes No

27. How competent do you feel providing care to the:

- a. Rural population Fully Partially Not at all
- b. Underserved population Fully Partially Not at all

28. I would rate the overall quality of my Family Medicine residency program as:

- Excellent
- Above Average
- Average
- Below Average
- Extremely Poor

29. I would rate the overall performance of the faculty in my Family Medicine residency program to have exceeded my expectations.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

30. I would rate the overall performance of the other residents in my Family Medicine residency program to have exceeded my expectations.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

31. Please add your **suggestions for improving** the Family Medicine residency program.

32. Please **list your ideas for new areas** for the Family Medicine residency curriculum.

Q32 is the last question!

Thank you for completing the 2016 Indiana Family Medicine Residencies Exit Survey®!

APPENDIX B

INDIANA FAMILY MEDICINE RESIDENCIES EXIT SURVEY RESPONSE RATES: 2012-2016

Residency Program	Surveys Distributed and Completed: 2012-2016									
	2012		2013		2014		2015		2016	
	Distributed	Completed	Distributed	Completed	Distributed	Completed	Distributed	Completed	Distributed	Completed
Community Health Network	7	7	6	6	8	8	8	8	10	10
Deaconess Family Medicine Residency	5	5	6	6	6	6	6	6	6	6
Franciscan St Francis Health	6	6	6	6	7	7	7	7	7	7
Ft Wayne Medical Education Program	10	9	10	10	10	10	10	10	10	10
IU Methodist Family Medicine Residency	10	10	10	10	11	11	14	14	10	10
IU Health Ball Memorial Hospital	8	8	7	7	8	8	8	8	14	14
Memorial Hospital of South Bend	8	8	8	8	6	6	10	10	9	9
St. Joseph Regional Medical Center	7	7	8	8	8	8	9	9	9	9
St. Vincent Family Medicine Residency	10	10	8	8	7	7	9	9	10	10
Union Hospital	6	6	5	5	7	7	7	7	7	7
Westview Hospital	1	1	2	2	4	4	4	4	4	4
Total	78	77	76	76	82	82	92	92	96	96
Response Rate	98.7%		100.0%		100.0%		100.0%		100.0%	