2017
Indiana Family Medicine Residencies Exit Survey Report

Indiana Medical Education Board

October 2017

INDIANA UNIVERSITY
SCHOOL OF MEDICINE
Office of Educational Affairs

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Indiana University School of Medicine

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Exit Survey Report

Produced for:

Indiana Medical Education Board

Produced by:

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Executive Summary

Background

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. 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. 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 2017 and the results have been shown in this report.

The *2017 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 2017. 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 2017, a total of 96 residents were graduating from the eleven Indiana Family Medicine residency programs. All 96 residents were invited to participate on the *2017 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 2017. There has been a steady 100 percent response rate over the last 5 years.

Indiana Medical Education Board			
2012-2017 Indiana Family Medicine Residencies Exit Survey Response Rates			
Year	**# of surveys distributed**	**# of surveys completed**	**Response Rate**
2012	78	77	98.7%
2013	76	76	100.0%
2014	82	82	100.0%
2015	92	92	100.0%
2016	96	96	100.0%
2017	96	96	100.0%

Results

Demographics: Almost three-fifths of the respondents were between the ages of 30 and 34 years. Over one-third of the respondents were female. Over four-fifths of the respondents were white. Two percent of the respondents were of Hispanic or Latino ethnicity. Less than one-tenth of the respondents were from another country. Of the majority that indicated they were from United States, about two-fifths were from Indiana. About one-third graduated from a high school or college in Indiana and over one-fourth reported graduating from the Indiana University School of Medicine. Nearly one-fourth of the respondents indicated they were a first generation learner; over one-third came from a rural area, and almost one-tenth indicated they came from an economically or educationally disadvantaged background.

Debt load: One-half of the respondents reported having an educational debt of $200,000 or more. Almost three-fifths of the respondents reported having a total household educational debt of $200,000 or more. Over one-fifth of the respondents and their household members indicated they had 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 the board exams. Almost all respondents felt "fully" competent in patient care, interpersonal and communication skills and professionalism. Over two-thirds of the respondents had received training to serve the rural populations and almost all had received training to serve the underserved populations. Over three-fifths of the respondents felt "fully" competent in providing care to the rural populations and over four-fifths to the underserved populations. All respondents were part of a multi-disciplinary inter-professional team. Almost all respondents were able to participate in a quality improvement project, had the opportunity to serve on a committee or council, and had the opportunity to participate in a cultural competency or diversity training. Over three-fourths of the respondents had participated in a patient safety project. Almost all respondents felt "very competent" or "competent" communicating with team members during the hand-off process.

Over four-fifths of the respondents indicated the quality of their training program was "excellent" or "above average". Over three-fourths of the respondents "strongly agree" or "agree" the faculty in their training program exceeded their expectations and over four-fifths indicated they "strongly agree" or "agree" the overall performance of other residents or fellows in their training program exceeded their expectations. Over one-fourth of the respondents "strongly agree" or "agree" they felt physically burnt out from work; over one-third felt emotionally burnt out from work; over three-fourths indicated they had resources readily available to maintain their wellness; over three-fifths had a "very good" or "good" balance between their personal and professional life; and over four-fifths of the respondents indicated the overall quality of their life was "very good" or "good".

Patient Care: Over four-fifths of the respondents planned to go into "patient care or clinical practice" after completing their training, followed by over one-tenth who planned to enter a fellowship. Over one-half of the respondents planned to practice within Indiana after completing their training. About one-fifth of the respondents indicated they will be entering a group private practice and about three-fourths reported entering a "hospital or health system owned" setting (i.e., inpatient only, outpatient only, and both inpatient *and* outpatient). Almost all respondents indicated they had no obligation or visa requirement to work in a designated HPSA or MUA after completing their training. Over three-fifths of the respondents

expect to see more than 25 percent of the patients from underserved populations in their new practice. Over one-fourth of the respondents expect to earn $200,000 or more during their first year of practice. A majority of the respondents reported that "many jobs" were available within their specialty in Indiana and over two-thirds indicated they had received three or more offers for employment all together.

Main reasons for choosing a practice location:

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

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

- Male respondents appear more likely to "strongly agree" that the training program was helpful in preparing them for their board exam compared to their female counterparts.

Increasing trend was noted among respondents who:

- Were between 25 and 29 years of age (17% in 2012 to 29% in 2017).
- Were male respondents (55% in 2012 to 64% in 2017).
- Identified themselves as white (75% in 2012 to 86% in 2017).
- Were coming from *outside* of Indiana (50% in 2012 to 58% in 2017).
- Had an individual educational debt load of "$200,000 or more" (40% in 2012 to 50% in 2017).
- "Strongly agree" their training program was helpful in preparation for their board exams (31% in 2012 to 48% in 2017).
- Rated the quality of their program as "excellent" (36% in 2012 to 54% in 2017).
- "Strongly agree" that the performance of faculty in their training program had exceeded their expectations (29% in 2012 to 48% in 2017).
- "Strongly agree" that the performance of other residents or fellows in their program had exceeded their expectations (32% in 2012 to 49% in 2017).
- Were going into a "hospital or health system owned – inpatient and outpatient" facility (21% in 2014 to 41% in 2017).
- Expect to see "between 25 and 49 percent" of their patients from underserved populations (23% in 2012 to 35% in 2017).
- Expect to earn between $100,000 and $199,999 during their first year of practice (11% in 2012 to 64% in 2017).
- Received "3 to 4" employment or practice positions all together (29% in 2012 to 39% in 2017).
- Chose to practice at *this* location because they "liked the people" (63% in 2012 to 70% in 2017).
- Chose to practice in Indiana because the "cost of practicing was reasonable in Indiana" (52% in 2013 and 61% in 2017).

- Chose to practice outside Indiana because of "climate" (19% in 2013 to 30% in 2017), "never intended to practice in Indiana" (10% in 2013 to 44% in 2017), and "proximity to their family" (57% in 2013 to 65% in 2017).

Declining trend noted in respondents who:

- Were female respondents (46% in 2012 to 37% in 2017).
- Were coming from *within* Indiana (50% in 2012 to 42% in 2017).
- Had an individual educational debt load "between $100,000 and $200,000" (31% in 2012 to 22% in 2017).
- "Agree" their training program was helpful in in preparation for their board exams (50% in 2012 to 35% in 2017).
- Felt "fully" competent in providing care to the *rural* populations (73% in 2012 to 61% in 2017) and *underserved* populations (97% in 2012 to 89% in 2017).
- Rated the quality of the program as "above average" (45% in 2012 to 28% in 2017).
- "Agree" that the performance of faculty in their training program had exceeded their expectations (48% in 2012 to 28% in 2017).
- "Agree" that the performance of other residents or fellows in their training program had exceeded their expectations (53% in 2012 to 37% in 2017).
- Were going into a "hospital or health system owned – outpatient only" facility (35% in 2014 to 26% in 2017).
- Expect to see "less than 10 percent" of their patients from underserved populations (11% in 2012 to 0% in 2017).
- Expect to earn between $200,000 and $299,999 during their first year of practice (80% in 2012 to 28% in 2017).
- Received "5 or more" employment or practice positions all together (44% in 2012 to 32% in 2017).
- Chose to practice at *this* location because of "salary or compensation" (48% in 2012 to 32% in 2017).
- Chose to practice in Indiana because of "proximity to their spouse or significant other's family" (48% in 2013 and 37% in 2017).

Mapping information

In 2017, a majority of the respondents planned to choose Indiana as their primary location after training, followed by Ohio (n=8), Illinois (n=4), Kansas (n=3), Michigan (n=3), and Virginia (n=3). Of those respondents who chose Indiana as their primary location, nine planned to practice or stay in the central Indiana Metropolitan Statistical Area, followed by St. Joseph county (n=7), Allen county (n=5), Tippecanoe (n=3), and Vigo (n=3) counties.

In 2017, five respondents *each* from IU Health Ball Memorial in Muncie, Memorial Hospital of South Bend, and St. Joseph Regional Medical Center in Mishawaka indicated they were going to a Health Professionals Shortage Area (HPSA) and five respondents from Union Hospital in Terra Haute indicated they were going to a Medically Underserved Area (MUA) after completing their training.

In 2017, four respondents from Fort Wayne Medical Education Program indicated coming from a rural hometown and six respondents from that same program were planning to go back to a rural area for practice after completing their training.

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 *2017 Indiana Family Medicine Residencies Exit Survey*© marks the 6th 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 *2017 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 in Indiana). Chapter 6 shows trending patterns from 2012 to 2017. 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 *2017 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 2017.

[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

The *2017 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 survey has questions on the number of employment offers received all together, within the state, and assessment of their training program. A copy of the *2017 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 2017. The PI then administered this cross-sectional survey to all final-year residents in the eleven family medicine residency programs within the state in May and June, 2017.

The PI contacted program directors and/or program coordinators at each of the eleven family medicine residency sites to schedule a visit to administer surveys in a group setting at each facility. 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 2017 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 2017 has been shown in **Appendix B**.

Completed paper surveys were scanned into an electronic database. Data analysis was performed using statistical software, *IBM SPSS Statistics*, *v24* and mapping software, *ArcGIS 10.5*. 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 Research in Medical Education.

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, "location-specific" reports have also been generated which are 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 *2017 Indiana Family Medicine Residencies Exit Survey©*

This chapter shows responses to questions asked on the *2017 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 3.25 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 attended medical school at Indiana University School of Medicine (n=25);
- indicated they planned to work in "patient care or clinical practice" after graduation (n=74);
- intended to practice in Indiana (n=38); and,
- intended to practice outside Indiana (n=35).

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

All Respondents [n=96]

I. Demographic Characteristics (n=96)

Age

Table 3.1	All Respondents 2017 (n=96)	
Age	**Number**	**Percent**
25-29	27	29.0
30-34	53	57.0
35-39	10	10.8
40-44	2	2.2
45 and over	1	1.1
Total	**93**	**100.0**
Missing	3	

Table 3.1 shows the age distribution of all Indiana family medicine survey respondents. Almost three-fifths (57%) of the respondents indicated they were between the ages of 30 and 34 years. The 6-year average was 61 percent.

Gender

Table 3.2	All Respondents 2017 (n=96)	
Gender	**Number**	**Percent**
Male	61	63.5
Female	35	36.5
Other	0	0.0
Total	**96**	**100.0**
Missing	0	

Table 3.2 shows the gender distribution of all Indiana family medicine survey respondents. Over one-third (37%) of the respondents indicated they were female. The 6-year average was 43 percent.

Race

Table 3.3	All Respondents 2017 (n=96)	
Which of the following describes your race? Please mark ALL that apply.	**Number**	**Percent**
American Indian/Alaskan Native	1	1.1
Asian	8	8.5
Black/African American	4	4.3
Native Hawaiian/Pacific Islander	0	0.0
White	81	86.2
Other	0	0.0
Total	**94**	**100.0**
Missing	2	

Table 3.3 shows the racial distribution of all Indiana family medicine survey respondents. Over four-fifths (86%) of the respondents indicated they were white, followed by 9 percent of the respondents who indicated they were Asian. The 6-year average was 79 percent and 11 percent for white and Asian respondents, respectively.

Ethnicity

Table 3.4	All Respondents 2017 (n=96)	
Do you consider yourself Hispanic or Latino?	**Number**	**Percent**
Yes, Hispanic/Latino	2	2.1
No, not Hispanic/Latino	94	97.9
Total	**96**	**100.0**
Missing	0	

Table 3.4 shows the ethnicity of all Indiana family medicine survey respondents. Two percent of the respondents indicated they were of Hispanic or Latino ethnicity. The 6-year average was 6 percent.

Respondents Coming From

Table 3.5	All Respondents 2017 (n=96)	
Where are the respondents coming from?	**Number**	**Percent**
Outside USA	7	7.3
Within USA	89	92.7
Outside Indiana	*52*	*58.4*
Within Indiana	*37*	*41.6*
Total	**96**	**100.0**
Missing	0	

Table 3.5 shows where the Indiana family medicine survey respondents were coming from. Less than one-tenth (7%) of the respondents indicated they were from another country. A majority (93%) of the respondents indicated they were from United States. Of the 89 respondents who indicated they were from United States, about two-fifths (42%) were from Indiana, with a 6-year average of 49 percent.

Respondents who have an Indiana Connection

Table 3.6	All Respondents 2017 (n=96)	
Respondents who have an Indiana…	**Number**	**Percent**
High school	31	32.3
College	35	36.5
Medical School	25	26.0

Table 3.6 shows the Indiana family medicine survey respondents who graduated from a high school, college, or medical school in Indiana. About one-third of the respondents indicated they had graduated from a high school (32%) or college (37%) in Indiana. The 6-year average for respondents graduating from a high school or college in Indiana was 37 percent. Over one-fourth (26%) of the respondents reported graduating from the Indiana University School of Medicine (IUSM), with a 6-year average of 26 percent.

Learner Background

Table 3.7	All Respondents 2017 (n=96)	
Do you consider yourself:	**Number**	**Percent**
First generation learner	23	24.0
Learner from a rural area	33	34.4
Economically or educationally disadvantaged	9	9.4
None of the above	41	42.7

Table 3.7 shows the Indiana family medicine survey respondents' learner and socioeconomic background. This question was not asked on the survey in previous years. Nearly one-fourth (24%) of the respondents indicated they were a first generation learner. Over one-third (34%) of the respondents indicated they came from a rural area, and almost one-tenth (9%) indicated they came from an economically or educationally disadvantaged background.

II. Medical School Training (n=25)

NOTE- This section includes only those respondents who indicated they attended medical school at Indiana University School of Medicine (IUSM).

IUSM First-Year Campus Location

Table 3.8	IUSM Respondents Only 2017 (n=25)	
If you attended Indiana University School of Medicine, in which campus did you begin your first year?	**Number**	**Percent**
Bloomington	0	0.0
Evansville	3	12.5
Fort Wayne	0	0.0
Indianapolis	7	29.2
Lafayette	5	20.8
Muncie	3	12.5
Northwest	1	4.2
South Bend	2	8.3
Terre Haute	3	12.5
Total	**24**	**100.0**
Missing	1	

Table 3.8 shows the IUSM campus at which the survey respondents started their first year. Over one-fourth (29%) of the respondents reported beginning their first year of medical school at the Indianapolis campus and about one-fifth (21%) reported beginning their first year at the Lafayette campus. The 6-year average for the Indianapolis and Lafayette campuses was 32 percent and 7 percent, respectively.

IUSM Third-Year Family Medicine Rotation Campus Location

Table 3.9	IUSM Respondents Only 2017 (n=25)	
If you attended Indiana University School of Medicine, at which Family Medicine residency program did you complete your 3rd year required Family Medicine rotation?	**Number**	**Percent**
Community Hospital East Family Medicine Residency, Indianapolis	2	8.3
Deaconess Family Medicine Residency, Evansville	2	8.3
Fort Wayne Medical Education Program, Fort Wayne	1	4.2
Indiana University Health Ball Memorial Hospital, Muncie	2	8.3
Indiana University Methodist Family Medicine Residency, Indianapolis	1	4.2
Memorial Hospital of South Bend	2	8.3
Franciscan Health Family Medicine Residency, Indianapolis	1	4.2
St. Joseph Regional Medical Center, Mishawaka	1	4.2
St. Vincent Family Medicine Residency, Indianapolis	0	0.0
Union Hospital Family Medicine Residency, Terre Haute	2	8.3
Community Westview Osteopathic Family Medicine Residency, Indianapolis	0	0.0
Other	10	41.7
Total	**24**	**100.0**
Missing	1	

Table 3.9 shows the family medicine residency program at which the survey respondents attended their third-year family medicine rotation. Over two-fifths (42%) of the respondents reported completing their third-year family medicine rotation at "other" locations. Eight percent of the respondents reported completing their third-year family medicine rotation at Community Hospital East Family Medicine Residency in Indianapolis, Deaconess Family Medicine Residency in Evansville, Indiana University Health Ball Memorial Hospital in Muncie, Memorial Hospital of South Bend, and Union Hospital Family Medicine Residency in Terre Haute. The 6-year average was 22 percent for "other".

IUSM Fourth-Year Elective or Externship Location

Table 3.10	IUSM Respondents Only 2017 (n=25)	
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**	**Percent**
Community Hospital East Family Medicine Residency, Indianapolis	3	12.0
Deaconess Family Medicine Residency, Evansville	2	8.0
Fort Wayne Medical Education Program, Fort Wayne	3	12.0
Indiana University Health Ball Memorial Hospital, Muncie	5	20.0
Indiana University Methodist Family Medicine Residency, Indianapolis	3	12.0
Memorial Hospital of South Bend	3	12.0
Franciscan Health Family Medicine Residency, Indianapolis	2	8.0
St. Joseph Regional Medical Center, Mishawaka	2	8.0
St. Vincent Family Medicine Residency, Indianapolis	8	32.0
Union Hospital Family Medicine Residency, Terre Haute	2	8.0
Community Westview Osteopathic Family Medicine Residency, Indianapolis	0	0.0
Other	3	12.0

Table 3.10 shows the location at which the survey respondents completed their fourth-year elective or externship. About one-third (32%) of the respondents reported completing their fourth-year elective or an externship experience at St. Vincent Family Medicine Residency in Indianapolis, followed by one-fifth (20%) of the respondents who reported completing their fourth-year elective or an externship experience at Indiana University Health Ball Memorial Hospital in Muncie.

Current Individual Educational Debt

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

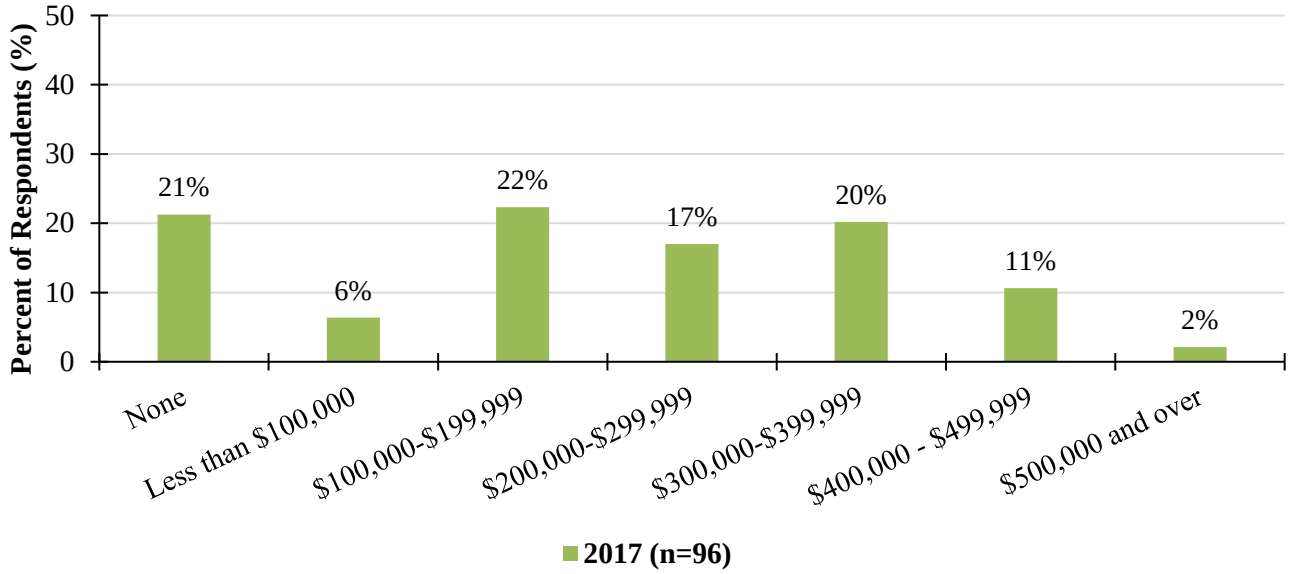


Figure 3.1 presents the current level of individual educational debt among the Indiana family medicine survey respondents. Over one-fifth (21%) of the respondents indicated they had no educational debt, with a 6-year average of 16 percent. One-half (50%) of the respondents reported having an educational debt of $200,000 or more, with a 6-year average of 51 percent.

Current Total Household Educational Debt

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

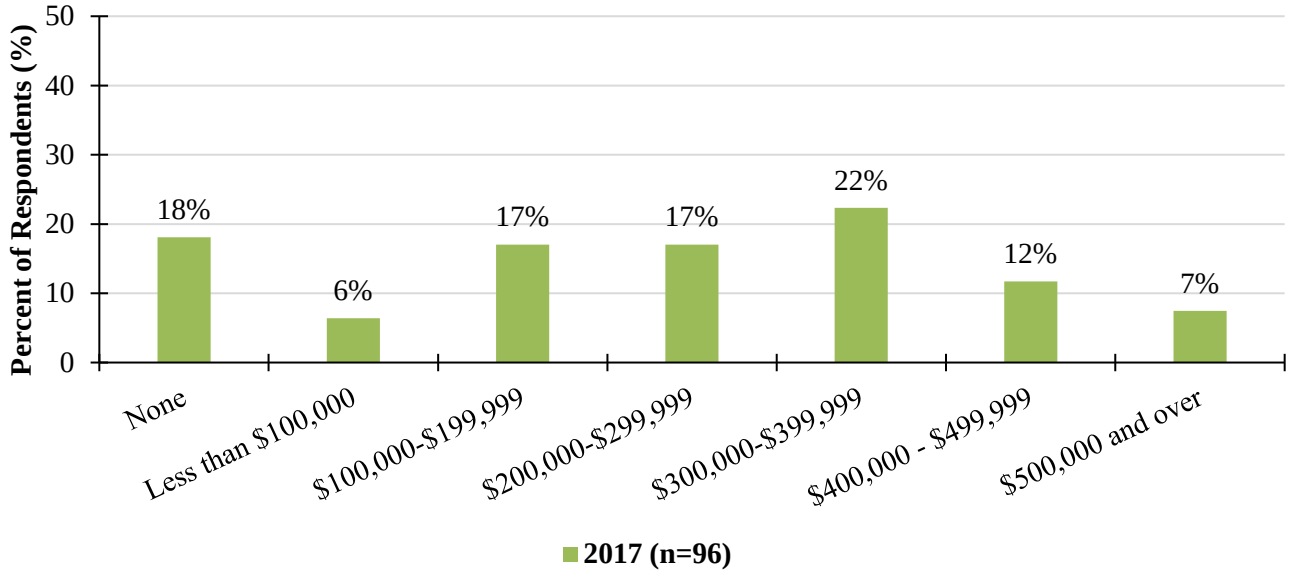


Figure 3.2 presents the current level of total household educational debt among the Indiana family medicine survey respondents. About one-fifth (18%) of the respondents indicated they had no household educational debt, with a 6-year average of 13 percent. Almost three-fifths (59%) of the respondents reported having a total household educational debt of $200,000 or more, with a 6-year average of 57 percent.

IV. Program Assessment (n=96)

Training Program

Table 3.11	All Respondents 2017 (n=96)	
The Family Medicine residency program was helpful in the preparation for my board exams.	**Number**	**Percent**
Strongly Agree	46	47.9
Agree	34	35.4
Neutral	13	13.5
Disagree	3	3.1
Strongly Disagree	0	0.0
Total	**96**	**100.0**
Missing/ Board Exam in my field does not exist	0	

Table 3.11 shows the Indiana family medicine survey respondents' assessment of how helpful their training program was in preparing them for the board exams. Over four-fifths (83%) of the respondents indicated they "strongly agree" or "agree" that the family medicine residency program was helpful in preparing them for the board exams. The 6-year average was 87 percent.

ACGME Competency Areas

Table 3.12	All Respondents 2017 (n=96)					
How competent do you feel in the following ACGME competencies?	**Fully**		**Partially**		**Not at all**	
	#	**%**	**#**	**%**	**#**	**%**
Patient Care	90	93.8	6	6.3	0	0.0
Medical Knowledge	82	85.4	14	14.6	0	0.0
Practice-based learning and improvement	80	83.3	16	16.7	0	0.0
Interpersonal and communication skills	93	96.9	3	3.1	0	0.0
Professionalism	90	93.8	6	6.3	0	0.0
Systems-based practice	81	84.4	15	15.6	0	0.0

Table 3.12 shows the Indiana family medicine survey respondents' self-rated competency level in the six Accredited Council for Graduate Medical Education (ACGME) competency areas. Almost all respondents indicated they felt "fully" competent in patient care (94%), interpersonal and communication skills (97%) and professionalism (94%). The 6-year average for patient care, interpersonal and communication skills, and professionalism was 96 percent each.

Four-fifths of the respondents indicated they felt "fully" competent in medical knowledge (85%), practice-based learning and improvement (83%) and systems-based practice (84%). The 6-year average for medical knowledge, practice-based learning and improvement, and systems-based practice was 89 percent, 8 percent, and 84 percent, respectively.

Rural and Underserved Training

Table 3.13	All Respondents 2017 (n=96)			
In your Family Medicine residency program did you receive training to serve the:	**Yes**		**No**	
	Number	**Percent**	**Number**	**Percent**
Rural Population	67	70.5	28	29.5
Underserved Population	94	97.9	2	2.1

Table 3.13 shows whether the Indiana family medicine survey respondents received training to serve the rural and underserved populations during their training program. Over two-thirds (71%) of the respondents indicated they had received training to serve the rural populations. The 6-year average was 73 percent. Almost all (98%) respondents indicated they had received training to serve the underserved populations. The 6-year average was 99 percent.

Competency in Providing Care to the Rural and Underserved Populations

Table 3.14	All Respondents 2017 (n=96)					
How competent do you feel providing care to the:	**Fully**		**Partially**		**Not at all**	
	#	**%**	**#**	**%**	**#**	**%**
Rural Population	58	61.1	35	36.8	2	2.1
Underserved Population	85	88.5	11	11.5	0	0.0

Table 3.14 shows the Indiana family medicine survey respondents' self-rated competency levels in providing care to the rural and underserved populations. Over three-fifths (61%) of the respondents indicated they felt "fully" competent in providing care to the rural populations. The 6-year average was 64 percent. Over four-fifths (89%) of the respondents indicated they felt "fully" competent in providing care to the underserved populations. The 6-year average was 92 percent.

Program Opportunities

Table 3.15	All Respondents 2017 (n=96)			
	Yes		No	
In the current academic year, did you:	Number	Percent	Number	Percent
Have an opportunity to be part of a multi-disciplinary inter-professional team to provide care?	96	100.0	0	0.0
Participate in a quality improvement project to improve health outcome?	94	97.9	2	2.1
Participate in patient safety project?	75	78.1	21	21.9
Have an opportunity to serve on a committee or council?	91	94.8	5	5.2
Have an opportunity to participate in a cultural competency or diversity training?	86	89.6	10	10.4

Table 3.15 shows if there were any program opportunities available for the Indiana family medicine survey respondents to participate in their training program. This question was not asked on the survey in previous years. All (100%) respondents indicated they were part of a multi-disciplinary inter-professional team. Almost all respondents indicated they were able to participate in a quality improvement project (98%), had the opportunity to serve on a committee or council (95%), and had the opportunity to participate in a cultural competency or diversity training (90%). Over three-fourths (78%) of the respondents indicated they had participated in a patient safety project.

Competency in Communicating during the Hand-Off Process

Table 3.16	All Respondents 2017 (n=96)	
How competent do you feel in communicating with team members in the hand-off process?	Number	Percent
Very competent	74	77.1
Competent	21	21.9
Neutral	0	0.0
Incompetent	1	1.0
Very incompetent	0	0.0
Total	**96**	**100.0**
Missing	0	

Table 3.16 shows the Indiana family medicine survey respondents' self-rated competency levels in communicating with team members during the hand-off process. This question was not asked on the survey in previous years. Almost all (99%) respondents indicated they felt "very competent" or "competent" communicating with team members during the hand-off process.

Quality of Program

Table 3.17	All Respondents 2017 (n=96)	
I would rate the overall quality of my Family Medicine residency program as:	**Number**	**Percent**
Excellent	52	54.2
Above Average	27	28.1
Average	13	13.5
Below Average	4	4.2
Extremely Poor	0	0.0
Total	**96**	**100.0**
Missing	0	

Table 3.17 shows the Indiana family medicine survey respondents' overall rating of the quality of their training program. Over four-fifths (82%) of the respondents indicated the quality of their training program was "excellent" or "above average". The 6-year average was 88 percent.

Faculty Assessment

Table 3.18	All Respondents 2017 (n=96)	
I would rate the overall performance of the faculty in my Family Medicine residency program to have exceeded my expectations.	**Number**	**Percent**
Strongly Agree	46	47.9
Agree	27	28.1
Neutral	13	13.5
Disagree	8	8.3
Strongly Disagree	2	2.1
Total	**96**	**100.0**
Missing	0	

Table 3.18 shows the Indiana family medicine survey respondents' overall performance rating of faculty in their training program. Over three-fourths (76%) of the respondents indicated they "strongly agree" or "agree" the faculty in their training program exceeded their expectations. The 6-year average was 82 percent.

Assessment of Peer Residents and Fellows

Table 3.19	All Respondents 2017 (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	47	49.0
Agree	35	36.5
Neutral	10	10.4
Disagree	3	3.1
Strongly Disagree	1	1.0
Total	**96**	**100.0**
Missing	0	

Table 3.19 shows the Indiana family medicine survey respondents' overall performance rating of other residents and fellows in their training program. Over four-fifths (85%) of the respondents indicated they "strongly agree" or "agree" the overall performance of other residents or fellows in their training program exceeded their expectations. The 6-year average was 92 percent.

Physical Burnout

Table 3.20	All Respondents 2017 (n=96)	
At this time, I feel…Physically "burnt out" from my work	**Number**	**Percent**
Strongly Agree	12	12.5
Agree	16	16.7
Neutral	19	19.8
Disagree	34	35.4
Strongly Disagree	15	15.6
Total	**96**	**100.0**
Missing	0	

Table 3.20 shows the Indiana family medicine survey respondents' overall feeling of physical burnout. This question was not asked on the survey in previous years. Over one-fourth (29%) of the respondents indicated they "strongly agree" or "agree" they felt physically burnt out from work.

Emotional Burnout

Table 3.21	All Respondents 2017 (n=96)	
At this time, I feel…Emotionally "burnt out" from my work	**Number**	**Percent**
Strongly Agree	15	15.6
Agree	20	20.8
Neutral	23	24.0
Disagree	24	25.0
Strongly Disagree	14	14.6
Total	**96**	**100.0**
Missing	0	

Table 3.21 shows the Indiana family medicine survey respondents' overall feeling of emotional burnout. This question was not asked on the survey in previous years. Over one-third (36%) of the respondents indicated they "strongly agree" or "agree" they felt emotionally burnt out from work.

Resources Available

Table 3.22	All Respondents 2017 (n=96)	
I have resources readily available to maintain my wellness	**Number**	**Percent**
Strongly Agree	41	42.7
Agree	32	33.3
Neutral	18	18.8
Disagree	4	4.2
Strongly Disagree	1	1.0
Total	**96**	**100.0**
Missing	0	

Table 3.22 shows the Indiana family medicine survey respondents' overall ability to use readily available resources to maintain their wellness. This question was not asked on the survey in previous years. Over three-fourths (76%) of the respondents indicated they "strongly agree" or "agree" they had readily available resources to maintain their wellness.

Personal-Professional Balance

Table 3.23	All Respondents 2017 (n=96)	
I would rate the overall: Balance between my personal and professional life as…	**Number**	**Percent**
Very Good	20	20.8
Good	39	40.6
Fair	25	26.0
Poor	11	11.5
Very Poor	1	1.0
Total	**96**	**100.0**
Missing	0	

Table 3.23 shows the Indiana family medicine survey respondents' overall rating of balance between their personal and professional life. This question was not asked on the survey in previous years. Over three-fifths (61%) of the respondents indicated they had a "very good" or "good" balance between their personal and professional life.

Quality of Life

Table 3.24	All Respondents 2017 (n=96)	
I would rate the overall: Quality of my life as…	**Number**	**Percent**
Very Good	32	33.3
Good	48	50.0
Fair	13	13.5
Poor	3	3.1
Very Poor	0	0.0
Total	**96**	**100.0**
Missing	0	

Table 3.24 shows the Indiana family medicine survey respondents' overall rating of their quality of life. This question was not asked on the survey in previous years. Over four-fifths (83%) of the respondents indicated the overall quality of their life was "very good" or "good".

Plans after Graduation

Table 3.25	All Respondents 2017 (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)	74	82.2
Fellowship or Additional Subspecialty Training	11	12.2
Military	1	1.1
Non Patient Care-based activities (e.g., research, administration)	0	0.0
Temporarily Out of Medicine	0	0.0
Other	2	2.2
Undecided or Don't know yet	2	2.2
Total	**90**	**100.0**
Missing	6	

Table 3.25 shows what the Indiana family medicine survey respondents expect to do after completing their current training program. Over four-fifths (82%) of the respondents indicated they planned to go into patient care or clinical practice after completing their training, followed by over one-tenth (12%) of the respondents who indicated they planned to enter a fellowship. The 6-year average for respondents going into patient care or clinical practice was 80 percent.

NOTE: The following section is only for those survey respondents who indicated they were going into "patient care or clinical practice" after completing their training (n=74).

V. Practice Characteristics (n=74)

Primary Practice Location

Table 3.26	Clinical Care Respondents 2017 (n=74)	
Where is the location of your primary activity <u>after</u> completing your current Family Medicine residency program?	**Number**	**Percent**
Same city of country as current training	15	20.5
Same region in Indiana, but different city or county	13	17.8
Other area in Indiana	10	13.7
Other U.S. state (not Indiana)	30	41.1
Outside of U.S.	5	6.8
Total	**73**	**100.0**
Missing/Undecided	1	

Table 3.26 shows the location of the Indiana family medicine survey respondents' primary activity after completing their current training program. Over one-half (52%) of the respondents indicated they planned to practice within Indiana after completing their training. Almost one-half (48%) of the respondents indicated they planned to practice outside Indiana after completing their training. One respondent was undecided at the time the survey was administered. The 6-year average for respondents planning to practice within Indiana and outside Indiana was 62 percent and 35 percent, respectively.

Type of Practice

Table 3.27	Clinical Care Respondents 2017 (n=74)	
Which best describes the principal type of Patient Care Practice you will be entering?	**Number**	**Percent**
Private practice - Solo	0	0.0
Private Practice - Group or Partnership (2 or more persons)	12	17.4
Hospital or health system owned - inpatient only	5	7.2
Hospital or health system owned - outpatient only	18	26.1
Hospital or health system owned - inpatient *and* outpatient	28	40.6
Urgent care facility	0	0.0
Managed care organization or insurance company	0	0.0
Free-standing health center or clinic (Federal, state, local government or community board led, etc.)	2	2.9
Nursing home or institutional residential facility	1	1.4
Other	3	4.3
Total	**69**	**100.0**
Missing	5	

Table 3.27 shows the principal type of patient care practice setting the Indiana family medicine survey respondents will be entering after completing their training. The response options for this question have been changed from previous years. About one-fifth (17%) of the respondents indicated they will be entering a group private practice. About three-fourths (74%) of the respondents reported entering a "hospital or health system owned" setting: inpatient only (7%), outpatient only (26%), and both inpatient *and* outpatient (41%).

Obligation or Visa Requirement

Table 3.28	Clinical Care Respondents 2017 (n=74)	
Do you have an obligation or visa requirement to work in a designated HPSA or MUA when you complete your training in the Family Medicine residency program?	**Number**	**Percent**
Yes	5	6.8
No	68	93.2
Total	**73**	**100.0**
Missing	1	

Table 3.28 shows the Indiana family medicine survey respondents' obligation or visa requirement to work in a designated HPSA or MUA after completing their training. Almost all (93%) respondents indicated they had no obligation or visa requirement to work in a designated HPSA or MUA after completing their training. The 6-year average was 86 percent.

Percentage of Patients Expected to be seen from Underserved Populations

Table 3.29	Clinical Care Respondents 2017 (n=74)	
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)	**Number**	**Percent**
Less than 10 percent	0	0.0
10-24 percent	27	39.1
25-49 percent	24	34.8
50-74 percent	14	20.3
More than 75 percent	4	5.8
Total	**69**	**100.0**
Missing	5	

Table 3.29 shows the percentage of patients that the Indiana family medicine survey respondents' expect to see from underserved populations (Medicaid or self-pay, educationally or economically disadvantaged) in their new practice. Over three-fifths (61%) of the respondents indicated they expect to see more than 25 percent of the patients from underserved populations in their new practice. The 6-year average was 52 percent.

Opportunities in Indiana

Figure 3.3: Overall Assessment of Practice Opportunities in Indiana (n=74)

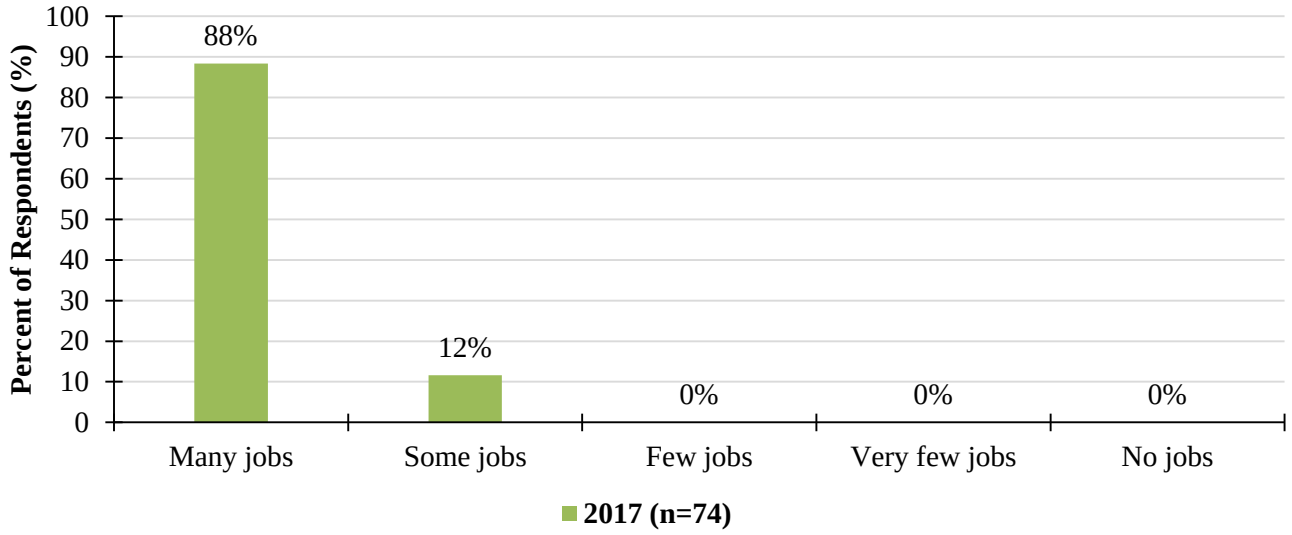


Figure 3.3 presents the overall assessment of practice opportunities for Indiana family medicine survey respondents within their specialty in Indiana. A majority (88%) of the respondents reported that "many jobs" were available within their specialty in Indiana. The 6-year average was 84 percent.

Expected Gross Income

Figure 3.4: Expected Gross Income (n=74)

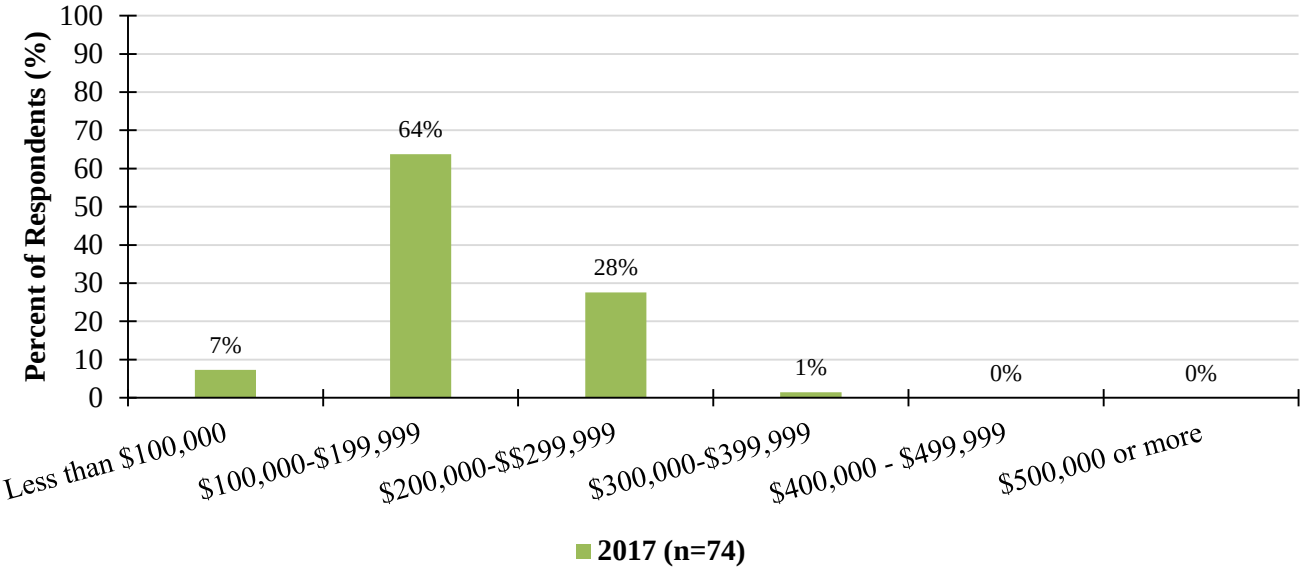


Figure 3.4 presents the gross income (salary plus incentives) that Indiana family medicine survey respondents expect to earn during their first year of practice. Over one-fourth (29%) of the respondents indicated they expect to earn $200,000 or more during their first year of practice. The 6-year average was 60 percent.

Job Offers All Together

Table 3.30	Clinical Care Respondents 2017 (n=74)	
How many offers for employment/practice positions did you receive all together?	**Number**	**Percent**
0	0	0.0
1	8	11.6
2	12	17.4
3	16	23.2
4	11	15.9
5 or more	22	31.9
Total	**69**	**100.0**
Missing/Did not seek employment position at the time	5	

Table 3.30 shows the total number of offers the Indiana family medicine survey respondents received for employment or practice positions. Over two-thirds (71%) of the respondents indicated they had received three or more offers for employment all together. The 6-year average was 72 percent.

Main Reasons to Practice at this Location

Figure 3.5: Main Reasons to Practice at this Location (n=74)

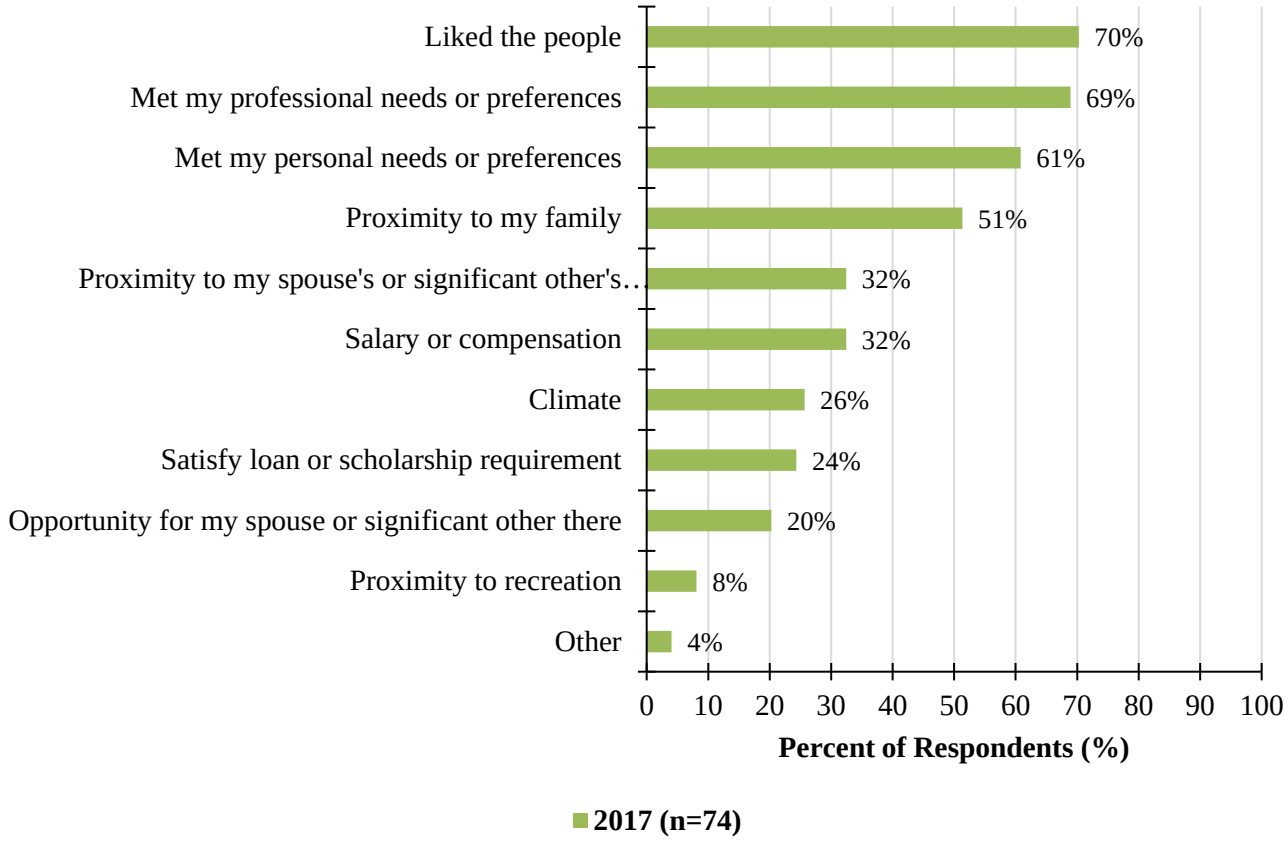


Figure 3.5 presents the main reasons influencing the Indiana family medicine survey respondents' choice of practice location. The main reasons given by respondents to practice at this location were: "liked the people" (70%), "met my professional needs or preferences" (69%), "met my personal needs or preferences" (61%), and "proximity to my family" (51%).

Job Offers in Indiana

Table 3.31	Clinical Care Respondents 2017 (n=38)	
How many offers for employment/practice positions did you receive in Indiana?	**Number**	**Percent**
0	0	0.0
1	4	11.4
2	10	28.6
3	8	22.9
4	6	17.1
5 or more	7	20.0
Total	**35**	**100.0**
Missing/Did not seek employment position at the time	3	

Table 3.31 shows the number of offers the Indiana family medicine survey respondents received for employment or practice positions in Indiana. Only those respondents who indicated their primary practice location was in Indiana were included in the analysis for this table. Of those 38 respondents, three-fifths (60%) of the respondents indicated they had received three or more offers for employment in the state. The 6-year average was 63 percent.

Main Reasons to Practice in Indiana

Figure 3.6: Main Reasons to Practice in Indiana (n=38)

Figure 3.6 presents the main reasons influencing the Indiana family medicine survey respondents' choice of practice location in Indiana. Only those 38 respondents who indicated their primary practice location was in Indiana were included in the analysis for this graph. The main reasons given by respondents to practice in Indiana were: "cost of practicing is reasonable in Indiana" (61%), "proximity to my family" (58%), "cost of malpractice" (45%), "always intended to practice in Indiana" (37%), and "proximity to my spouse's or significant other's family" (37%).

Main Reasons Not to Practice in Indiana

Figure 3.7: Main Reasons Not to Practice in Indiana (n=35)

Figure 3.7 presents the main reasons influencing Indiana family medicine survey respondents' choice of practice location outside Indiana. Only those 35 respondents who indicated their primary practice location was outside Indiana were included in the analysis for this graph. The main reasons given by respondents for not practicing in Indiana were: "proximity to my family" (43%), "proximity to my spouse's or significant other's family" (29%), "never intended to practice in Indiana" (29%), and "other" (23%).

Chapter 4: Comparison of Responses by Gender, 2017

The survey respondents were asked a question about gender (Question 2 on the *2017 Indiana Family Medicine Residencies Exit Survey*©). Based on their responses, they were stratified into a male, female, and other categories. Of the 96 respondents, 61 reported their gender as male and 35 as female, and none as other, as shown in tables 4.1 to 4.24 and figures 4.1 to 4.2. The remaining tables and figures show responses from only those survey respondents who:

- indicated they attended medical school at Indiana University School of Medicine: males (n=16) and females (n=9);
- indicated that they planned to work in "patient care or clinical practice" after graduation: males (n=47) and females (n=27);
- intended to practice in Indiana: males (n=23) and females (n=15); and,
- intended to practice outside Indiana: males (n=24) and females (n=11).

Data analysis was performed using statistical software, *IBM SPSS Statistics*, *v24*. Chi-square tests were used to compare responses between groups. *P*-values less than 0.05 were considered statistically significant and are 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 (n=96)

Age

Table 4.1	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
Age	**Number**	**Percent**	**Number**	**Percent**
25-29	14	23.7	13	38.2
30-34	34	57.6	19	55.9
35-39	8	13.6	2	5.9
40-44	2	3.4	0	0.0
45 and over	1	1.7	0	0.0
Total	**59**	**100.0**	**34**	**100.0**
Missing	2		1	

Chi-square *p*-value = 0.622

Table 4.1 shows the age distribution of the male and female survey respondents. Over four-fifths (81%) of the male respondents indicated they were between the ages of 25 and 34 years, compared to 94 percent of the female respondents. There was no statistically significant difference between the two groups.

Race

Table 4.2	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
Which of the following describes your race? Please mark ALL that apply.	**Number**	**Percent**	**Number**	**Percent**
American Indian/Alaskan Native	1	1.7	0	0.0
Asian	5	8.3	3	8.8
Black/African American	2	3.3	2	5.9
Native Hawaiian/Pacific Islander	0	0.0	0	0.0
White	52	86.7	29	85.3
Other	0	0.0	0	0.0
Total	**60**	**100.0**	**34**	**100.0**
Missing	1		1	

Chi-square *p*-value = 0.823

Table 4.2 shows the racial distribution of the male and female survey respondents. A majority of the male (87%) and female (85%) respondents indicated they were white. Almost one-tenth of the male (8%) and female (9%) respondents indicated they were Asian. There was no statistically significant difference between the two groups.

Ethnicity

Table 4.3	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
Do you consider yourself Hispanic or Latino?	**Number**	**Percent**	**Number**	**Percent**
Yes, Hispanic/Latino	2	3.3	0	0.0
No, not Hispanic/Latino	59	96.7	35	100.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.279

Table 4.3 shows the ethnicity of the male and female survey respondents. A majority of the male (97%) and female (100%) respondents indicated they had a non-Hispanic or Latino ethnicity. There was no statistically significant difference between the two groups.

Respondents Coming From

Table 4.4	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
Where are the respondents coming from?	**Number**	**Percent**	**Number**	**Percent**
Outside USA	6	9.8	1	2.9
Within USA	55	90.2	34	97.1
Outside Indiana	*31*	*56.4*	*21*	*61.8*
Within Indiana	*24*	*43.6*	*13*	*38.2*
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.326

Table 4.4 shows where the male and female survey respondents were coming from. One-tenth (10%) of the male respondents indicated they were from another country, compared to 3 percent of the female respondents. Of the 55 male and 34 female respondents who indicated they were from United States, over two-fifths (44%) of the male respondents indicated they were from Indiana, compared to 38 percent of the female respondents. There was no statistically significant difference between the two groups.

Respondents who have an Indiana Connection

Table 4.5	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
Respondents who have an Indiana…	**Number**	**Percent**	**Number**	**Percent**
High school	18	29.5	13	37.1
College	19	31.1	16	45.7
Medical School	16	26.2	9	25.7

Table 4.5 shows the male and female survey respondents who graduated from a high school, college, or medical school in Indiana. About one-third of the male (30%) and female (37%) respondents indicated they had graduated from a high school in Indiana. About one-third (31%) of the male respondents indicated they had graduated from a college in Indiana, compared to 46 percent of the female respondents. Over one-fourth of the male (26%) and female (26%) respondents indicated they had graduated from the Indiana University School of Medicine (IUSM). There was no statistically significant difference between the two groups.

Learner Type

Table 4.6	All Respondents (n=96)			
	Males (n=61)		Female (n=35)	
Do you consider yourself:	**Number**	**Percent**	**Number**	**Percent**
First generation learner	15	24.6	8	22.9
Learner from a rural area	18	29.5	15	42.9
Economically or educationally disadvantaged	6	9.8	3	8.6
None of the above	30	49.2	11	31.4

Table 4.6 shows the male and female survey respondents' learner and socioeconomic background. About one-fourth of the male (25%) and female (23%) respondents indicated they were a first generation learner. About one-third (30%) of the male respondents indicated they came from a rural area, compared to 43 percent of the female respondents. One-tenth of the male (10%) and female (9%) respondents indicated they came from an economically or educationally disadvantaged background. There was no statistically significant difference between the two groups.

II. Medical School Training (n=25)

NOTE- This section includes only those respondents who attended medical school at Indiana University School of Medicine.

IUSM First-Year Campus Location

Table 4.7	IUSM Respondents Only (n=25)			
	Male (n=16)		Female (n=9)	
If you attended Indiana University School of Medicine, in which campus did you begin your first year?	**Number**	**Percent**	**Number**	**Percent**
Bloomington	0	0.0	0	0.0
Evansville	1	6.7	2	22.2
Fort Wayne	0	0.0	0	0.0
Indianapolis	5	33.3	2	22.2
Lafayette	2	13.3	3	33.3
Muncie	2	13.3	1	11.1
Northwest	1	6.7	0	0.0
South Bend	2	13.3	0	0.0
Terre Haute	2	13.3	1	11.1
Total	**15**	**100.0**	**9**	**100.0**
Missing	1		0	

Chi-square p-value = 0.643

Table 4.7 shows the IUSM campus at which the male and female survey respondents started their first year of medical school. One-third (33%) of the male respondents indicated they attended their first year of medical school at the Indianapolis campus. One-third (33%) of the female respondents indicated they attended their first year of medical school at the Lafayette campus. There was no statistically significant difference between the two groups.

IUSM Third-Year Family Medicine Rotation Campus Location

Table 4.8	IUSM Respondents Only (n=25)			
	Male (n=16)		Female (n=9)	
If you attended Indiana University School of Medicine, at which Family Medicine residency program did you complete your 3rd year required Family Medicine rotation?	**Number**	**Percent**	**Number**	**Percent**
Community Hospital East, Indianapolis	1	6.7	1	11.1
Deaconess Family Medicine Residency, Evansville	1	6.7	1	11.1
Fort Wayne Medical Education Program, Fort Wayne	1	6.7	0	0.0
Indiana University Health Ball Memorial Hospital, Muncie	1	6.7	1	11.1
Indiana University Methodist Family Medicine Residency, Indianapolis	1	6.7	0	0.0
Memorial Hospital of South Bend	2	13.3	0	0.0
Franciscan Health, Indianapolis	1	6.7	0	0.0
St. Joseph Regional Medical Center, Mishawaka	1	6.7	0	0.0
St. Vincent Family Medicine Residency, Indianapolis	0	0.0	0	0.0
Union Hospital, Terre Haute	2	13.3	0	0.0
Community Westview Osteopathic, Indianapolis	0	0.0	0	0.0
Other	4	26.7	6	66.7
Total	**15**	**100.0**	**9**	**100.0**
Missing	1		0	

Chi-square *p*-value = 0.600

Table 4.8 shows the family medicine residency program at which the male and female survey respondents indicated completing their third-year family medicine rotation. Over one-fourth (27%) of the male respondents indicated they had completed their third-year family medicine rotations at "other" locations, compared to 67 percent of the female respondents. There was no statistically significant difference between the two groups.

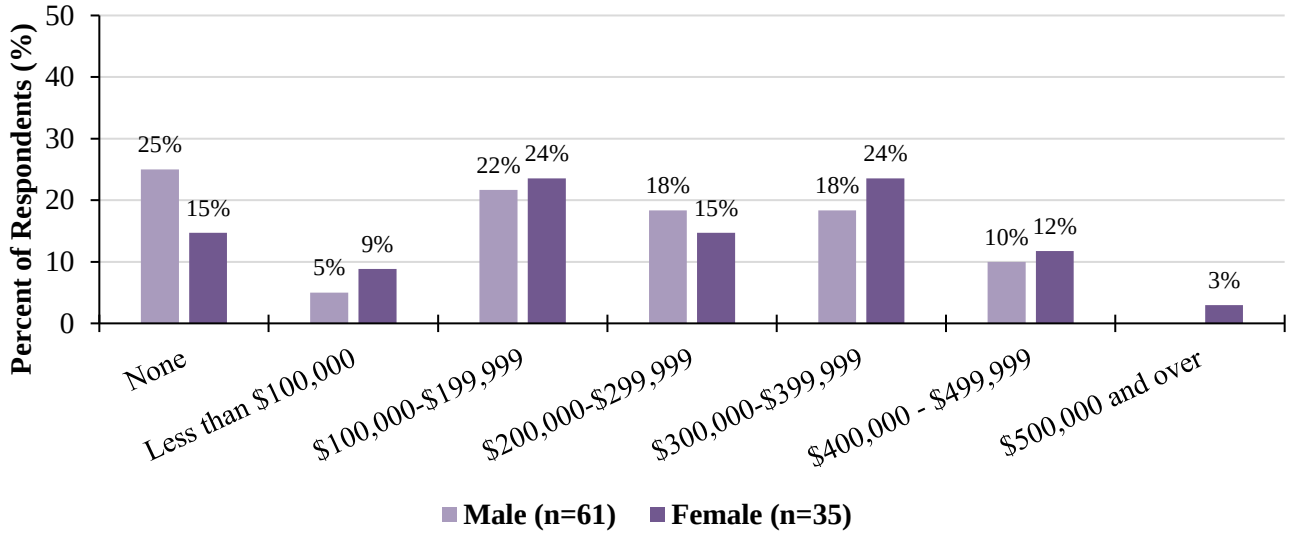
IUSM Fourth-Year Elective or Externship Location

Table 4.9	IUSM Respondents Only (n=25)			
	Male (n=16)		Female (n=9)	
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**	**Percent**	**Number**	**Percent**
Community Hospital East, Indianapolis	1	6.3	2	22.2
Deaconess Family Medicine Residency, Evansville	1	6.3	1	11.1
Fort Wayne Medical Education Program, Fort Wayne	2	12.5	1	11.1
Indiana University Health Ball Memorial Hospital, Muncie	3	18.8	2	22.2
Indiana University Methodist Family Medicine Residency, Indianapolis	2	12.5	1	11.1
Memorial Hospital of South Bend	3	18.8	0	0.0
Franciscan Health, Indianapolis	1	6.3	1	11.1
St. Joseph Regional Medical Center, Mishawaka	1	6.3	1	11.1
St. Vincent Family Medicine Residency, Indianapolis	5	31.3	3	33.3
Union Hospital, Terre Haute	1	6.3	1	11.1
Community Westview Osteopathic, Indianapolis	0	0.0	0	0.0
Other	2	12.5	1	11.1

Table 4.9 shows the location at which the male and female survey respondents reported completing their fourth-year elective or externship experience. One-third of the male (31%) and female (33%) respondents indicated they had completed their fourth-year elective or externship experience at St. Vincent Family Medicine Residency in Indianapolis.

Current Individual Educational Debt

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

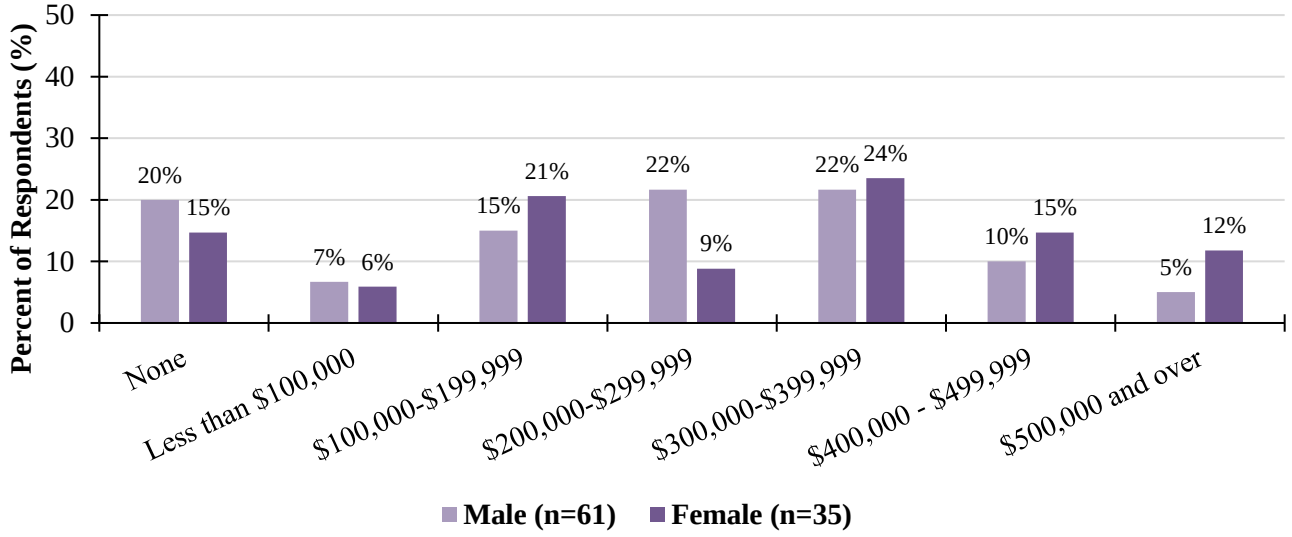


Chi-square *p*-value = 0.884

Figure 4.1 presents the current level of individual educational debt among the male and female survey respondents. One-fourth (25%) of the male respondents indicated having no educational debt, compared to 15 percent of the female respondents. About one-half of the male (48%) and female (53%) respondents indicated they had an educational debt of $200,000 or more. There was no statistically significant difference between the two groups.

Current Total Household Educational Debt

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



Chi-square *p*-value = 0.780

Figure 4.2 presents the current level of total household educational debt among the male and female survey respondents. One-fifth of the male (20%) respondents indicated having no household educational debt, compared to 15 percent of the female respondents. Over one-half of the male (58%) and female (59%) respondents reported having a total household educational debt of $200,000 or more. There was no statistically significant difference between the two groups.

IV. Program Assessment (n=96)

Training Program

Table 4.10	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
The Family Medicine residency program was helpful in the preparation for my board exams.	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	33	54.1	13	37.1
Agree	16	26.2	18	51.4
Neutral	11	18.0	2	5.7
Disagree	1	1.6	2	5.7
Strongly Disagree	0	0.0	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing/ Board Exam in my field does not exist	0		0	

Chi-square p-value = 0.029¥

Table 4.10 shows the male and female survey respondents' assessment of how helpful the training program was in preparing them for their board exams. Over one-half (54%) of the male respondents indicated they "strongly agree" that their training was helpful in preparing them for the board exams, compared to 37 percent of the female respondents. The Chi-square test of association between the two groups was statistically significant. Male respondents appear more likely to "strongly agree" that the training program was helpful in preparing them for their board exam compared to their female counterparts.

ACGME Competency Areas

Table 4.11	All Respondents (n=96)								
	Male (n=61)				Female (n=35)				*p*-value
How competent do you feel in the following ACGME competencies?	Fully		Partially		Fully		Partially		
	#	%	#	%	#	%	#	%	
Patient Care	59	96.7	2	3.3	31	88.6	4	11.4	0.112
Medical Knowledge	54	88.5	7	11.5	28	80.0	7	20.0	0.255
Practice-based learning and improvement	50	82.0	11	18.0	30	85.7	5	14.3	0.635
Interpersonal and communication skills	60	98.4	1	1.6	33	94.3	2	5.7	0.269
Professionalism	58	95.1	3	4.9	32	91.4	3	8.6	0.477
Systems-based practice	54	88.5	7	11.5	27	77.1	8	22.9	0.139

Table 4.11 shows the male and female survey respondents' self-rated competency level in the six Accredited Council for Graduate Medical Education (ACGME) competency areas. Three options were provided in this question: fully, partially or not at all. To maintain clarity and ease of interpretation, the response option "Not at all" has been removed from this table. Almost all male and female respondents indicated they felt "fully" competent in patient care (97%, 89%), interpersonal and communication skills (98%, 94%), and professionalism (95%, 91%) competency areas, respectively. Over four-fifths of the male and female respondents indicated they felt "fully" competent in medical knowledge (89%, 80%) and practice-based learning and improvement (82%, 86%) and competency areas, respectively. About four-fifths of the male and female respondents indicated they felt "fully" competent in the systems-based practice (89%, 77%) competency areas. There was no statistically significant difference between the two groups.

Rural and Underserved Training

Table 4.12	**All Respondents (n=96)**								
	Male (n=61)				**Female (n=35)**				
In your Family Medicine residency program did you <u>receive training</u> to serve the:	**Yes**		**No**		**Yes**		**No**		***p*-value**
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	
Rural Population	42	70.0	18	30.0	25	71.4	10	28.6	0.833
Underserved Population	59	96.7	2	3.3	35	100.0	0	0.0	0.279

Table 4.12 shows whether the male and female survey respondents received training to serve the rural and underserved populations during their training program. Over two-thirds of the male (70%) and female (71%) respondents indicated they had received training to serve the rural populations. There was no statistically significant difference between groups. Almost all male (97%) and female (100%) respondents indicated they had received training to serve the underserved populations. There was no statistically significant difference between the two groups.

Competency in Providing Care to the Rural and Underserved Populations

Table 4.13	All Respondents (n=96)								
	Male (n=61)				Female (n=35)				
How competent do you feel providing care to the:	Fully		Partially		Fully		Partially		*p*-value
	#	%	#	%	#	%	#	%	
Rural Population	38	62.3	22	36.1	20	58.8	13	38.2	0.884
Underserved Population	53	86.9	8	13.1	32	91.4	3	8.6	0.501

Table 4.13 shows the male and female survey respondents' self-rated competency levels in providing care to the rural and underserved populations. Three options were provided in this question: fully, partially or not at all. To maintain clarity and ease of interpretation, the response option "Not at all" has been removed from this table. About three-fifths of the male (62%) and female (59%) respondents indicated they felt "fully" competent providing care to the rural populations. There was no statistically significant difference between groups. A majority of the male (87%) and female (91%) respondents indicated they felt "fully" competent in providing care to the underserved populations. There was no statistically significant difference between the two groups.

Program Opportunities

Table 4.14	All Respondents (n=96)								
	Males (n=61)				Female (n=35)				
In the current academic year, did you:	Yes		No		Yes		No		*p*-value
	#	%	#	%	#	%	#	%	
Have an opportunity to be part of a multi-disciplinary inter-professional team to provide care?	61	100.0	0	0.0	35	100.0	0	0.0	1.000
Participate in a quality improvement project to improve health outcome?	59	96.7	2	3.3	35	100.0	0	0.0	0.279
Participate in patient safety project?	48	78.7	13	21.3	27	77.1	8	22.9	0.860
Have an opportunity to serve on a committee or council?	57	93.4	4	6.6	34	97.1	1	2.9	0.432
Have an opportunity to participate in a cultural competency or diversity training?	55	90.2	6	9.8	31	88.6	4	11.4	0.806

Table 4.14 shows if there were any program opportunities available for the male and female survey respondents to participate in their training program. All (100%) male and female respondents indicated they had the opportunity to be part of a multi-disciplinary inter-professional team. Almost all male and female respondents indicated they had the opportunity to participate in a quality improvement project (97%, 100%), had the opportunity to serve on a committee or council (93%, 97), and had the opportunity to participate in a cultural competency or diversity training (90%, 89%). Over three-fourths of the male (79%) and female (77%) respondents indicated they had participated in a patient safety project. There was no statistically significant difference between the two groups.

Competency in Communicating during the Hand-Off Process

Table 4.15	All Respondents (n=96)			
	Males (n=61)		Female (n=35)	
How competent do you feel in communicating with team members in the hand-off process?	**Number**	**Percent**	**Number**	**Percent**
Very competent	49	80.3	25	71.4
Competent	11	18.0	10	28.6
Neutral	0	0.0	0	0.0
Incompetent	1	1.6	0	0.0
Very incompetent	0	0.0	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.381

Table 4.15 shows the survey respondents' self-rated competency levels in communicating with team members during the hand-off process. Almost all the male (98%) and female (100%) respondents indicated they felt "very competent" or "competent" communicating with team members during the hand-off process. There was no statistically significant difference between the two groups.

Quality of Program

Table 4.16	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I would rate the overall quality of my Family Medicine residency program as:	**Number**	**Percent**	**Number**	**Percent**
Excellent	37	60.7	15	42.9
Above Average	13	21.3	14	40.0
Average	9	14.8	4	11.4
Below Average	2	3.3	2	5.7
Extremely Poor	0	0.0	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.207

Table 4.16 shows the male and female survey respondents' overall rating of the quality of their training program. Over four-fifths of the male (82%) and female (83%) respondents indicated the quality of their training program was "excellent" or "above average." There was no statistically significant difference between the two groups.

Faculty Assessment

Table 4.17	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I would rate the overall performance of the faculty in my Family Medicine residency program to have exceeded my expectations.	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	33	54.1	13	37.1
Agree	12	19.7	15	42.9
Neutral	10	16.4	3	8.6
Disagree	5	8.2	3	8.6
Strongly Disagree	1	1.6	1	2.9
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.150

Table 4.17 shows the male and female survey respondents' overall performance rating of faculty in their training program. Almost three-fourths of the male (74%) and female (80%) respondents indicated they "strongly agree" or "agree" that faculty in their training program exceeded their expectations. There was no statistically significant difference between the two groups.

Assessment of Peer Residents and Fellows

Table 4.18	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I would rate the overall performance of the other residents in my Family Medicine residency program to have exceeded my expectations.	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	34	55.7	13	37.1
Agree	20	32.8	15	42.9
Neutral	5	8.2	5	14.3
Disagree	1	1.6	2	5.7
Strongly Disagree	1	1.6	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square p-value = 0.315

Table 4.18 shows the male and female respondents' overall performance rating of other residents or fellows in their training program. Over four-fifths of the male (89%) and female (80%) respondents indicated they "strongly agree" or "agree" the overall performance of other residents or fellows in their training program had exceeded their expectations. There was no statistically significant difference between the two groups.

Physical Burnout

Table 4.19	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
At this time, I feel…Physically "burnt out" from my work	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	8	13.1	4	11.4
Agree	9	14.8	7	20.0
Neutral	11	18.0	8	22.9
Disagree	21	34.4	13	37.1
Strongly Disagree	12	19.7	3	8.6
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.648

Table 4.19 shows the male and female respondents' overall feeling of physical burnout. Over one-fourth of the male (28%) and female (31%) respondents indicated they "strongly agree" or "agree" they felt physically burnt out from work. There was no statistically significant difference between the two groups.

Emotional Burnout

Table 4.20	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
At this time, I feel…Emotionally "burnt out" from my work	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	10	16.4	5	14.3
Agree	12	19.7	8	22.9
Neutral	10	16.4	13	37.1
Disagree	17	27.9	7	20.0
Strongly Disagree	12	19.7	2	5.7
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.104

Table 4.20 shows the male and female respondents' overall feeling of emotional burnout. Over one-third of the male (36%) and female (37%) respondents indicated they "strongly agree" or "agree" they felt emotionally burnt out from work. There was no statistically significant difference between the two groups.

Resources Available

Table 4.21	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I have resources readily available to maintain my wellness	**Number**	**Percent**	**Number**	**Percent**
Strongly Agree	30	49.2	11	31.4
Agree	18	29.5	14	40.0
Neutral	9	14.8	9	25.7
Disagree	4	6.6	0	0.0
Strongly Disagree	0	0.0	1	2.9
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.098

Table 4.21 shows the male and female respondents' overall ability to use readily available resources to maintain their wellness. About three-fourths of the male (79%) and female (71%) respondents indicated they "strongly agree" or "agree" they had readily available resources to maintain their wellness. There was no statistically significant difference between the two groups.

Personal-Professional Balance

Table 4.22	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I would rate the overall: Balance between my personal and professional life as…	**Number**	**Percent**	**Number**	**Percent**
Very Good	17	27.9	3	8.6
Good	23	37.7	16	45.7
Fair	15	24.6	10	28.6
Poor	5	8.2	6	17.1
Very Poor	1	1.6	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.159

Table 4.22 shows the male and female survey respondents' overall rating of balance between their personal and professional life. Two-thirds (66%) of the male respondents indicated they had a "very good" or "good" balance between their personal and professional life, compared to 54 percent of the female respondents. There was no statistically significant difference between the two groups.

Quality of Life

Table 4.23	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
I would rate the overall: Quality of my life as…	**Number**	**Percent**	**Number**	**Percent**
Very Good	26	42.6	6	17.1
Good	26	42.6	22	62.9
Fair	7	11.5	6	17.1
Poor	2	3.3	1	2.9
Very Poor	0	0.0	0	0.0
Total	**61**	**100.0**	**35**	**100.0**
Missing	0		0	

Chi-square *p*-value = 0.082

Table 4.23 shows the male and female survey respondents' overall rating of their quality of life. Over four-fifths of the male (85%) and female (80%) respondents indicated the overall quality of their life was "very good" or "good". There was no statistically significant difference between the two groups.

Plans after Graduation

Table 4.24	All Respondents (n=96)			
	Male (n=61)		Female (n=35)	
What do you expect to be doing after completion of your current Family Medicine residency program? Please mark only ONE option.	**Number**	**Percent**	**Number**	**Percent**
Patient Care or Clinical Practice (in Non-Training Position)	47	78.3	27	79.4
Fellowship or Additional Subspecialty Training	7	11.7	4	11.8
Military	0	0.0	1	2.9
Non Patient Care-based activities (e.g., research, administration)	0	0.0	0	0.0
Temporarily Out of Medicine	0	0.0	0	0.0
Other	1	1.7	1	2.9
Undecided or Don't know yet	5	8.3	1	2.9
Total	**60**	**100.0**	**34**	**100.0**
Missing	1		1	

Chi-square p-value = 0.656

Table 4.24 shows what the male and female survey respondents expect to do after completing their current training program. Almost four-fifths of the male (78%) and female (79%) respondents indicated they planned to go into patient care or clinical practice after completing their current training. There was no statistically significant difference between the two groups.

NOTE: The following section is only for those respondents who indicated they were going into "patient care or clinical practice" (n=74).

Primary Practice Location

Table 4.25	Clinical Care Respondents (n=74)			
	Male (n=47)		Female (n=27)	
Where is the location of your primary activity after completing your current Family Medicine residency program?	**Number**	**Percent**	**Number**	**Percent**
Same city of country as current training	10	21.3	5	19.2
Same region in Indiana, but different city or county	6	12.8	7	26.9
Other area in Indiana	7	14.9	3	11.5
Other U.S. state (not Indiana)	20	42.6	10	38.5
Outside of U.S.	4	8.5	1	3.8
Total	**47**	**100.0**	**26**	**100.0**
Missing/Undecided	0		1	

Chi-square p-value = 0.494

Table 4.25 shows the location of the male and female survey respondents' primary activity after completing their current training program. About one-half of the male (49%) respondents indicated they planned to practice within Indiana, compared to 58 percent of the female respondents. There was no statistically significant difference between the two groups.

Type of Practice

Table 4.26	Clinical Care Respondents (n=74)			
	Male (n=47)		Female (n=27)	
Which best describes the principal type of Patient Care Practice you will be entering?	**Number**	**Percent**	**Number**	**Percent**
Private practice - Solo	0	0.0	0	0.0
Private Practice - Group or Partnership (2 or more persons)	8	17.8	4	16.7
Hospital or health system owned - inpatient only	4	8.9	1	4.2
Hospital or health system owned - outpatient only	10	22.2	8	33.3
Hospital or health system owned - inpatient and outpatient	19	42.2	9	37.5
Urgent care facility	0	0.0	0	0.0
Managed care organization or insurance company	0	0.0	0	0.0
Free-standing health center or clinic (Federal, state, local government or community board led, etc.)	0	0.0	2	8.3
Nursing home or institutional residential facility	1	2.2	0	0.0
Other	3	6.7	0	0.0
Total	**45**	**100.0**	**24**	**100.0**
Missing	2		3	

Chi-square p-value = 0.279

Table 4.26 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 (17%) respondents indicated they intended to work in a "private practice – group" setting. About three-fourths of the male (73%) and female (75%) respondents indicated they intended to work in a "hospital or health system owned" [inpatient, outpatient, or both inpatient and outpatient] setting. There was no statistically significant difference between the two groups.

Obligation or Visa Requirement

Table 4.27	Clinical Care Respondents (n=74)			
	Male (n=47)		Female (n=27)	
Do you have an obligation or visa requirement to work in a designated HPSA or MUA when you complete your training in the Family Medicine residency program?	**Number**	**Percent**	**Number**	**Percent**
Yes	4	8.7	1	3.7
No	42	91.3	26	96.3
Total	**46**	**100.0**	**27**	**100.0**
Missing	1		0	

Chi-square *p*-value = 0.415

Table 4.27 shows the male and female survey respondents' obligation or visa requirement to work in a designated HPSA or MUA after completing their training. Almost all the male (91%) and female (96%) respondents indicated they had no obligation or visa requirement to work in a designated HPSA or MUA. There was no statistically significant difference between the two groups.

Percentage of Patients Expected to be seen from Underserved Populations

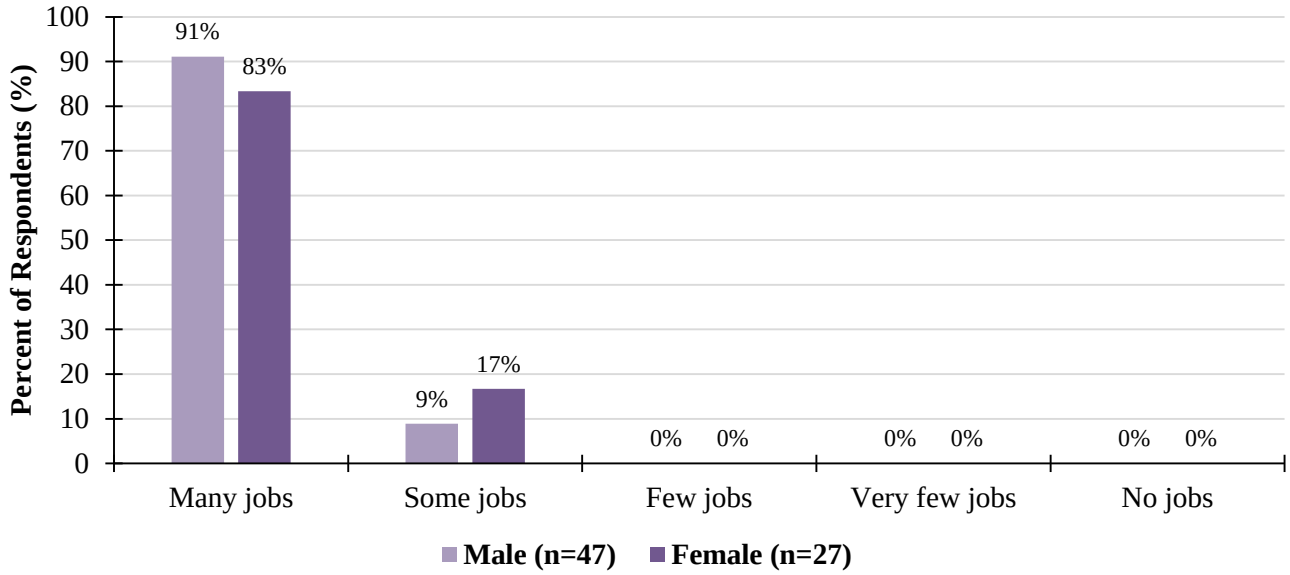
Table 4.28	Clinical Care Respondents (n=74)			
	Male (n=47)		Female (n=27)	
In your new practice, what percentage of the patients do you expect to see from underserved populations? (Medicaid or self-pay, educationally or economically disadvantaged)	**Number**	**Percent**	**Number**	**Percent**
Less than 10 percent	0	0.0	0	0.0
10-24 percent	19	42.2	8	33.3
25-49 percent	17	37.8	7	29.2
50-74 percent	6	13.3	8	33.3
More than 75 percent	3	6.7	1	4.2
Total	**45**	**100.0**	**24**	**100.0**
Missing	2		3	

Chi-square *p*-value = 0.272

Table 4.28 shows the percentage of patients the male and female survey respondents expect to see from underserved populations (Medicaid or self-pay, educationally or economically disadvantaged) in their new practice. About three-fifths of the male (58%) and female (67%) respondents indicated they expect to see 25 percent or more of the underserved populations in their new practice. There was no statistically significant difference between the two groups.

Opportunities in Indiana

Figure 4.3: Overall Assessment of Practice Opportunities (n=74)

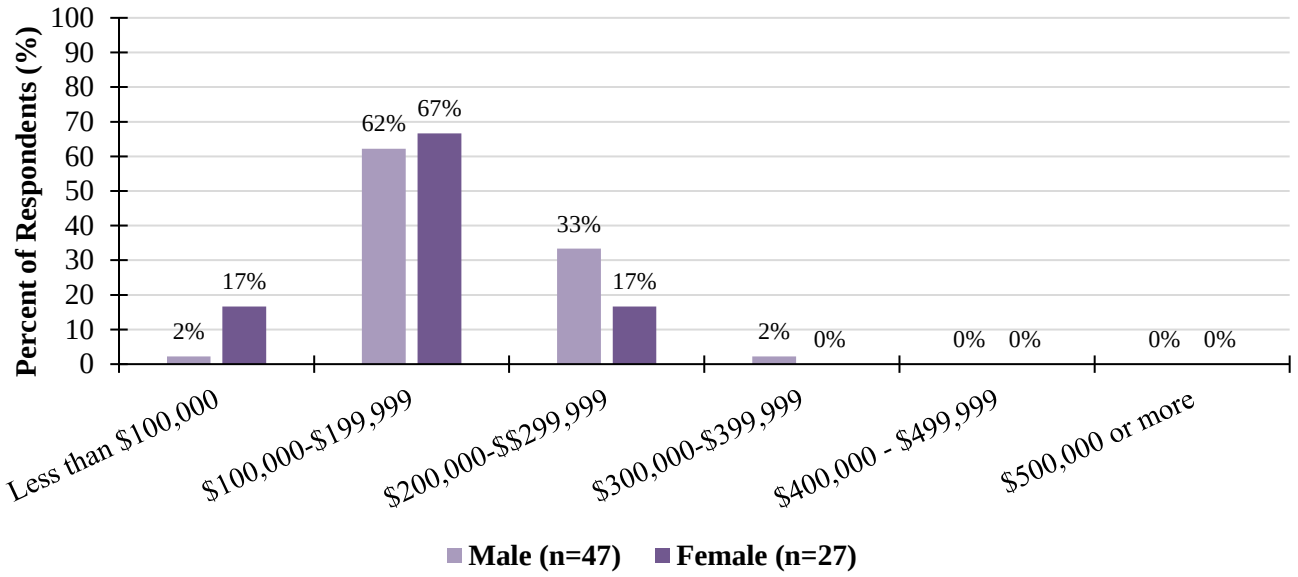


Chi-square *p*-value = 0.336

Figure 4.3 presents the overall assessment of practice opportunities for the male and female survey respondents within their specialty in Indiana. Almost all the male (91%) respondents reported that "many jobs" were available within their specialty in Indiana, compared to 83 percent of the female respondents. There was no statistically significant difference between the two groups.

Expected Gross Income

Figure 4.4: Expected Gross Income (n=74)*



Chi-square *p*-value 0.067

Figure 4.4 presents the gross income (salary plus incentives) that the male and female survey respondents expect to earn during their first year of practice. Over one-third of the male (36%) respondents indicated they expect to earn $200,000 or more during their first year of practice, compared to 17 percent of the female respondents. There was no statistically significant difference between the two groups.

Job Offers All Together

Table 4.29	Clinical Care Respondents (n=74)			
	Male (n=47)		Female (n=27)	
How many offers for employment/practice positions did you receive all together?	**Number**	**Percent**	**Number**	**Percent**
0	0	0.0	0	0.0
1	5	11.1	3	12.5
2	7	15.6	5	20.8
3	10	22.2	6	25.0
4	6	13.3	5	20.8
5 or more	17	37.8	5	20.8
Total	**45**	**100.0**	**24**	**100.0**
Missing/Did not seek employment position at the time	2		3	

Chi-square p-value= 0.537

Table 4.29 shows the total number of offers the male and female survey respondents received for employment or practice positions. Over two-thirds of the male (73%) and female (67%) respondents reported being offered three or more employment or practice positions all together. There was no statistically significant difference between the two groups.

Main Reasons to Practice at this Location

Figure 4.5: Main Reasons to Practice at this Location (n=74)

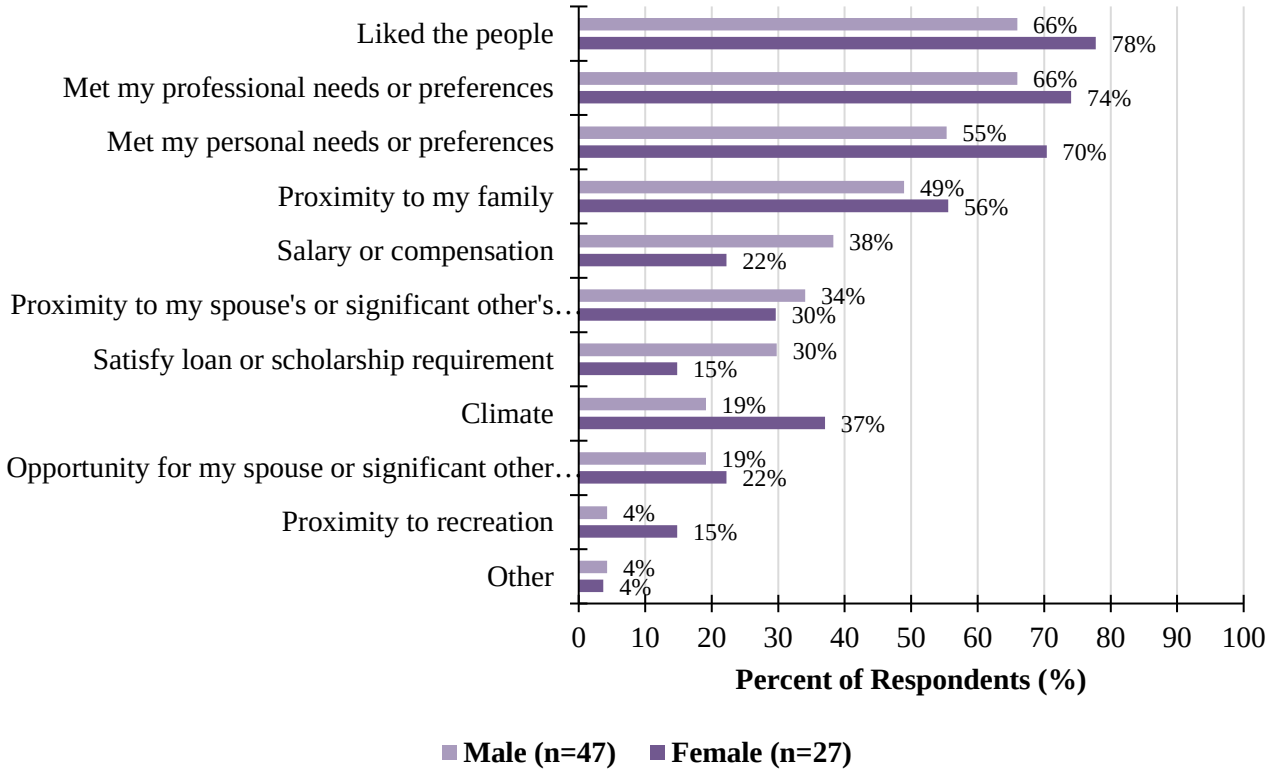


Figure 4.5 presents the main reasons influencing the male and female survey respondents' choice of practice location. The main reasons given by the male respondents to practice at this location were: "liked the people" (66%), "met my professional needs or preferences" (66%), "met my personal needs or preferences" (55%), and "proximity to my family" (49%). The main reasons given by the female respondents to practice at this location were: "liked the people" (78%), "met my professional needs or preferences" (74%), and "met my personal needs or preferences" (70%). There was no statistically significant difference between the two groups.

Job Offers in Indiana

Table 4.30	Clinical Care Respondents (n=38)			
	Male (n=23)		Female (n=15)	
How many offers for employment/practice positions did you receive in Indiana?	**Number**	**Percent**	**Number**	**Percent**
0	0	0.0	0	0.0
1	1	4.8	3	21.4
2	7	33.3	3	21.4
3	4	19.0	4	28.6
4	3	14.3	3	21.4
5 or more	6	28.6	1	7.1
Total	**21**	**100.0**	**14**	**100.0**
Missing/Did not seek employment position at the time	2		1	

Chi-square p-value= 0.339

Table 4.30 shows the number of offers the male and female respondents received for employment or practice positions in Indiana. Only those respondents who indicated their primary practice location was in Indiana were included in the analysis for this table. Of those 38 respondents, about three-fifths of the male (62%) and female (57%) respondents indicated they had received three or more offers for employment or practice positions in Indiana. There was no statistically significant difference between the two groups.

Main Reasons to Practice in Indiana

Figure 4.6: Main Reasons to Practice in Indiana (n=38)

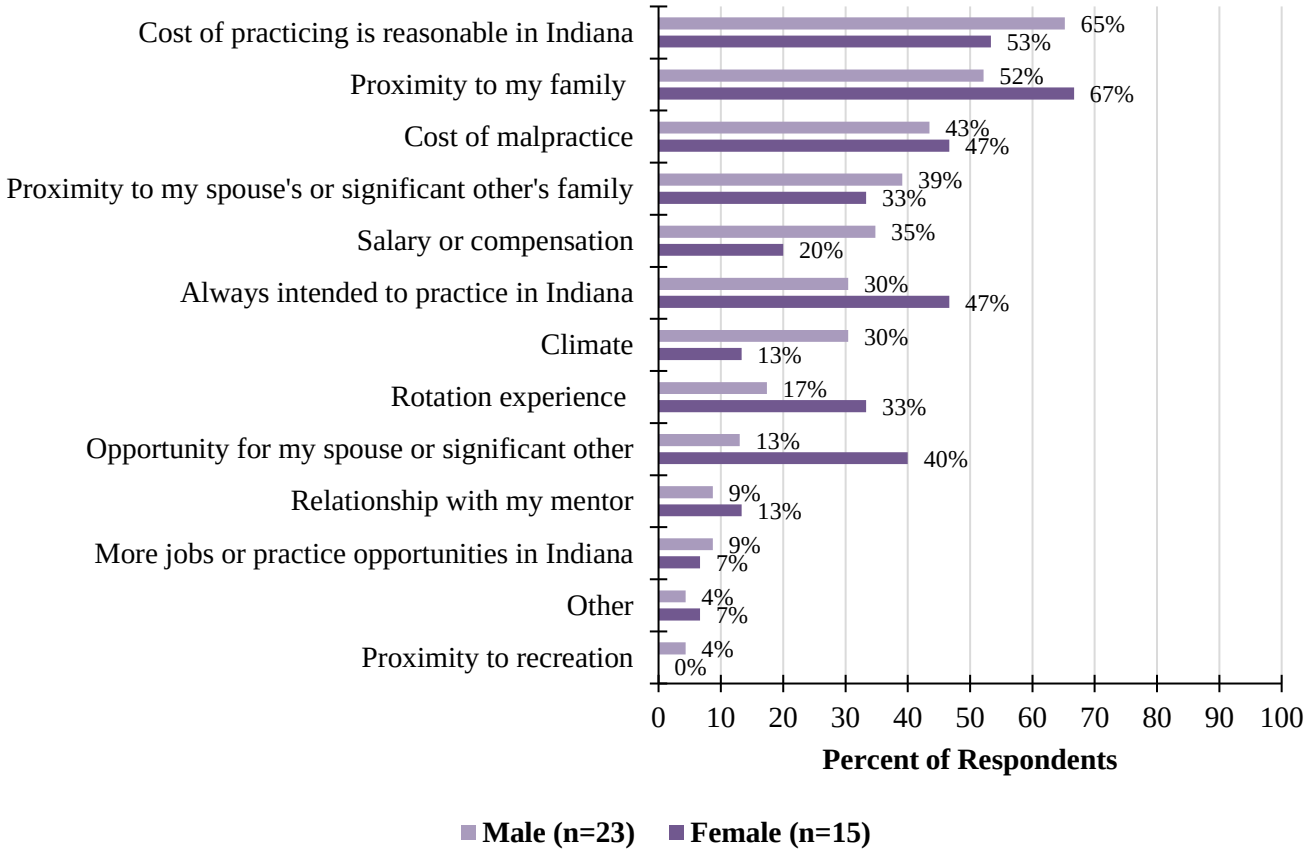


Figure 4.6 presents the main reasons influencing the male and female survey respondents' choice of practice location in Indiana. Only those 38 respondents who indicated their primary practice location was in Indiana were included in the analysis for this graph. The main reasons given by the male respondents to practice in Indiana were: "cost of practicing is reasonable in Indiana" (65%), "proximity to my family" (52%), and "cost of malpractice" (43%). The main reasons given by the female respondents to practice in Indiana were: "proximity to my family" (67%), "cost of practicing is reasonable in Indiana" (53%), "cost of malpractice" (47%), and "always intended to practice in Indiana" (47%). There was no statistically significant difference between the two groups.

Main Reasons not to Practice in Indiana

Figure 4.7: Main Reasons Not to Practice in Indiana (n=35)

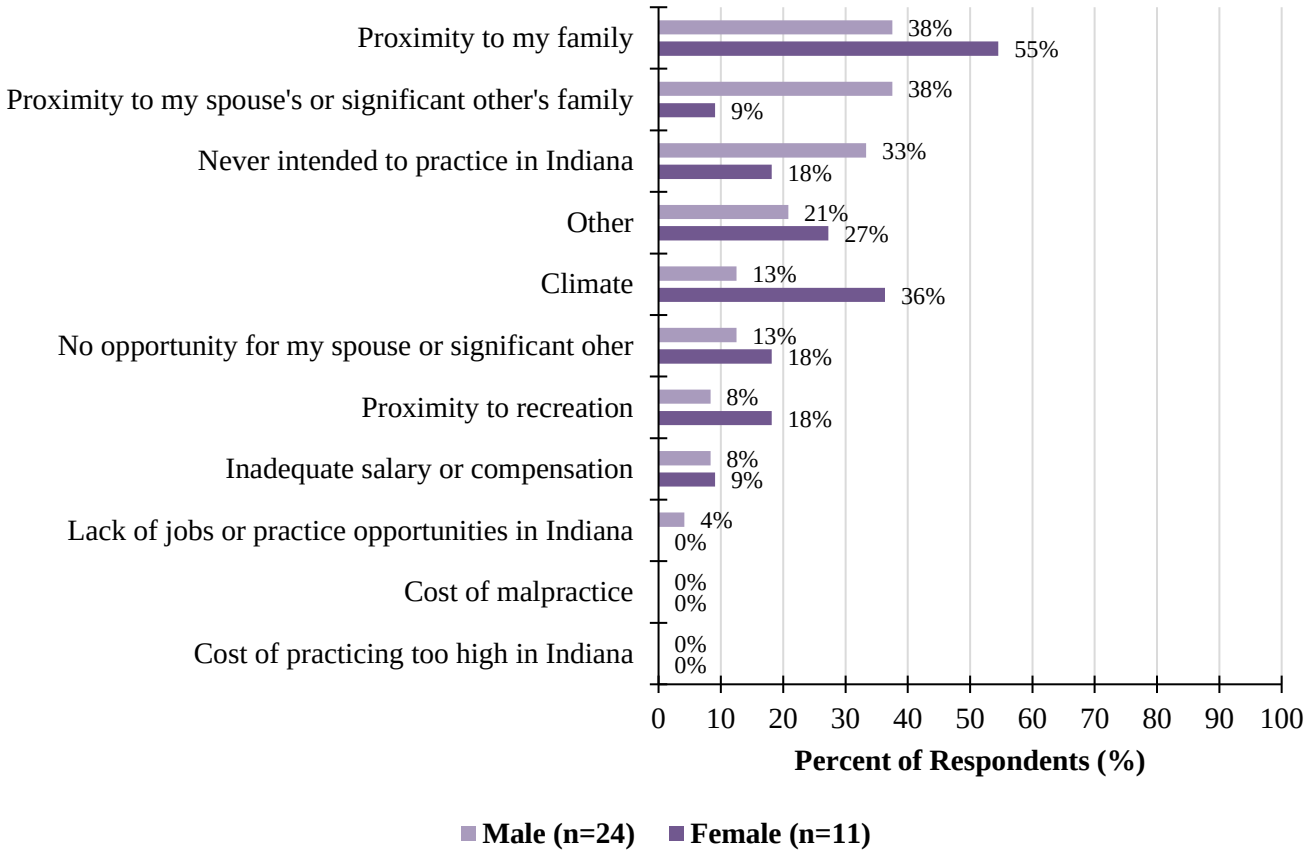
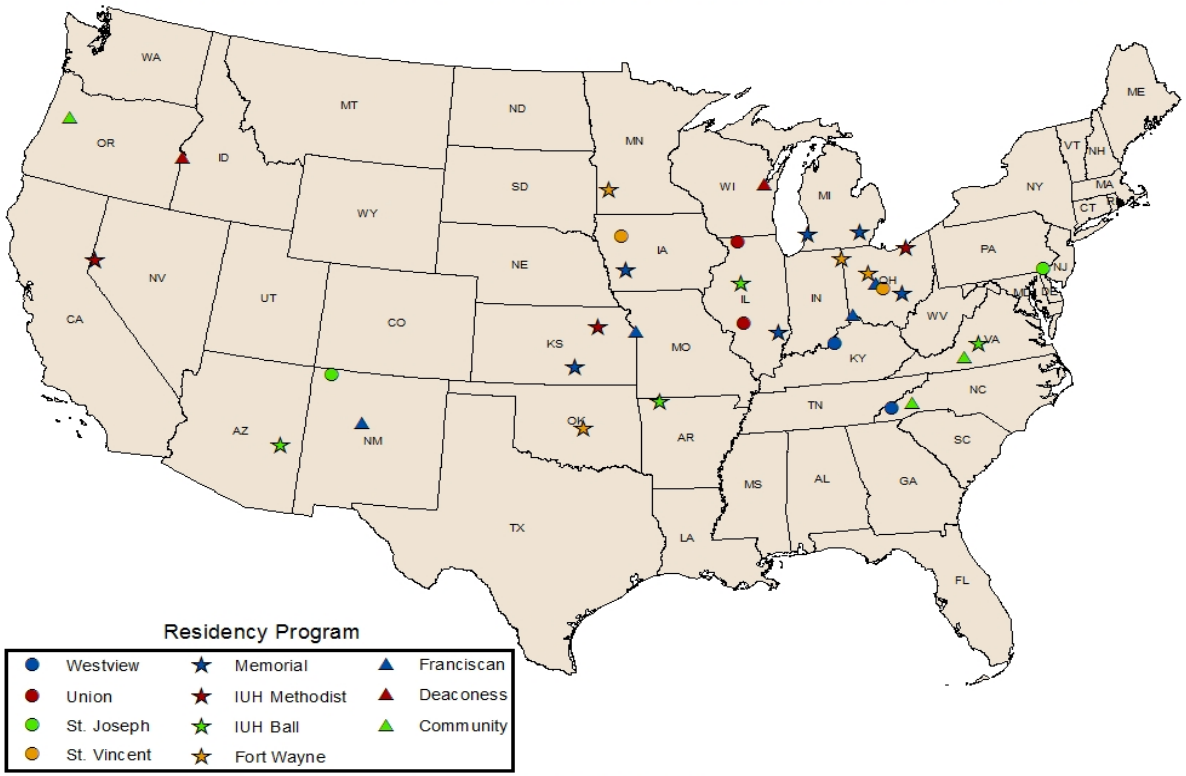


Figure 4.7 presents the main reasons influencing the male and female survey respondents' choice of practice location outside Indiana. Only those 35 respondents who indicated their primary practice location was outside Indiana were included in the analysis for this graph. The main reasons given by the male respondents for not practicing in Indiana were: "proximity to my family" (38%), and "proximity to my spouse's or significant other's family" (38%), and "never intended to practice in Indiana" (33%). The main reasons given by the female respondents for not practicing in Indiana were: "proximity to my family" (55%), "climate" (36%), and "other" (27%). There was no statistically significant difference between the two groups.

Chapter 5: Maps Linking Residency Site to Primary Location after Training

In this chapter, all maps and tables include respondents who indicated a "primary location" after completing their training. Data analysis was performed using geographic information mapping software, *ArcGIS 10.5*.

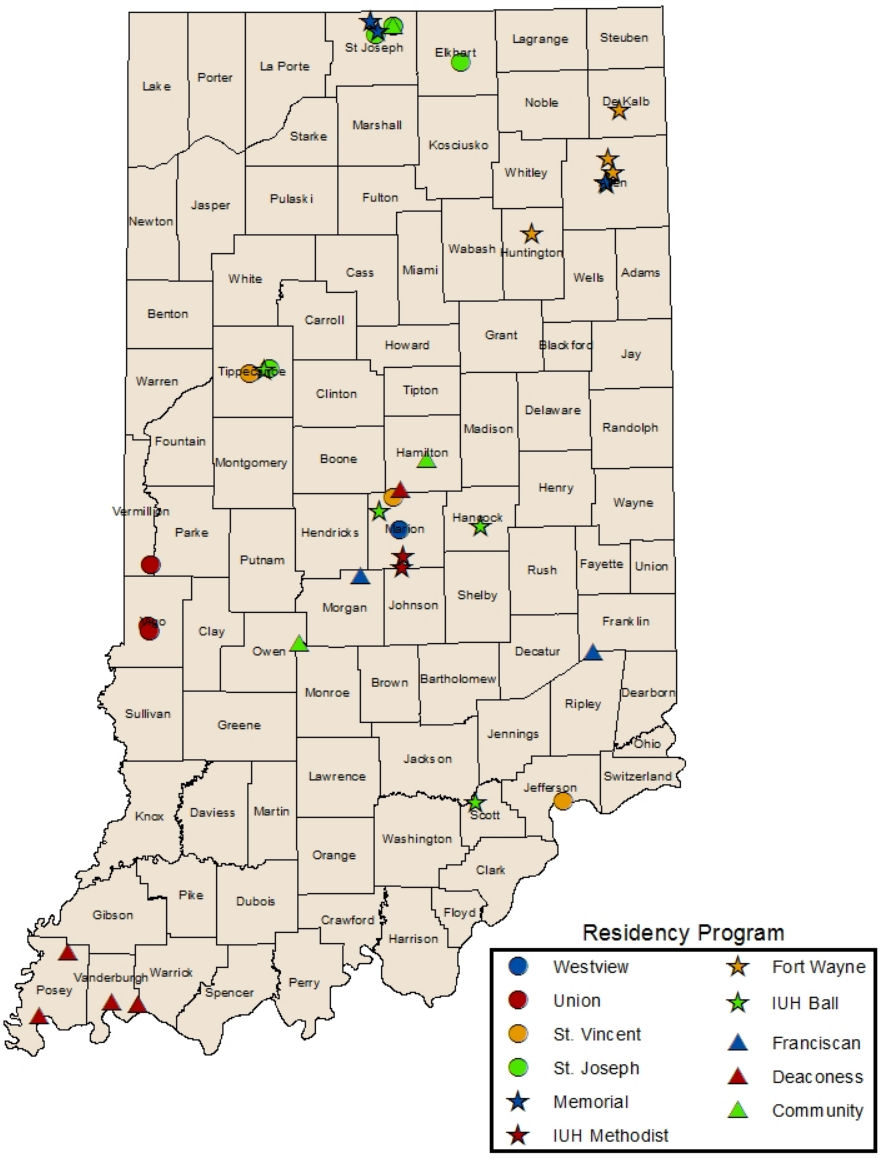
Map 5.1: Primary US* Locations of Indiana FM Residents after Completing Training, 2017



*For ease of interpretation, does not include IN practice locations. These are included on next map.

Map 5.1 depicts the *2017* Indiana family medicine survey respondents' residency site and their primary locations after completing training within United States. In 2017, eighty-four respondents listed *both*, their family medicine residency site as well as their primary location after training. A majority of the respondents planned to choose Indiana as their primary location after training, followed by Ohio (n=8), Illinois (n=4), Kansas (n=3), Michigan (n=3), and Virginia (n=3).

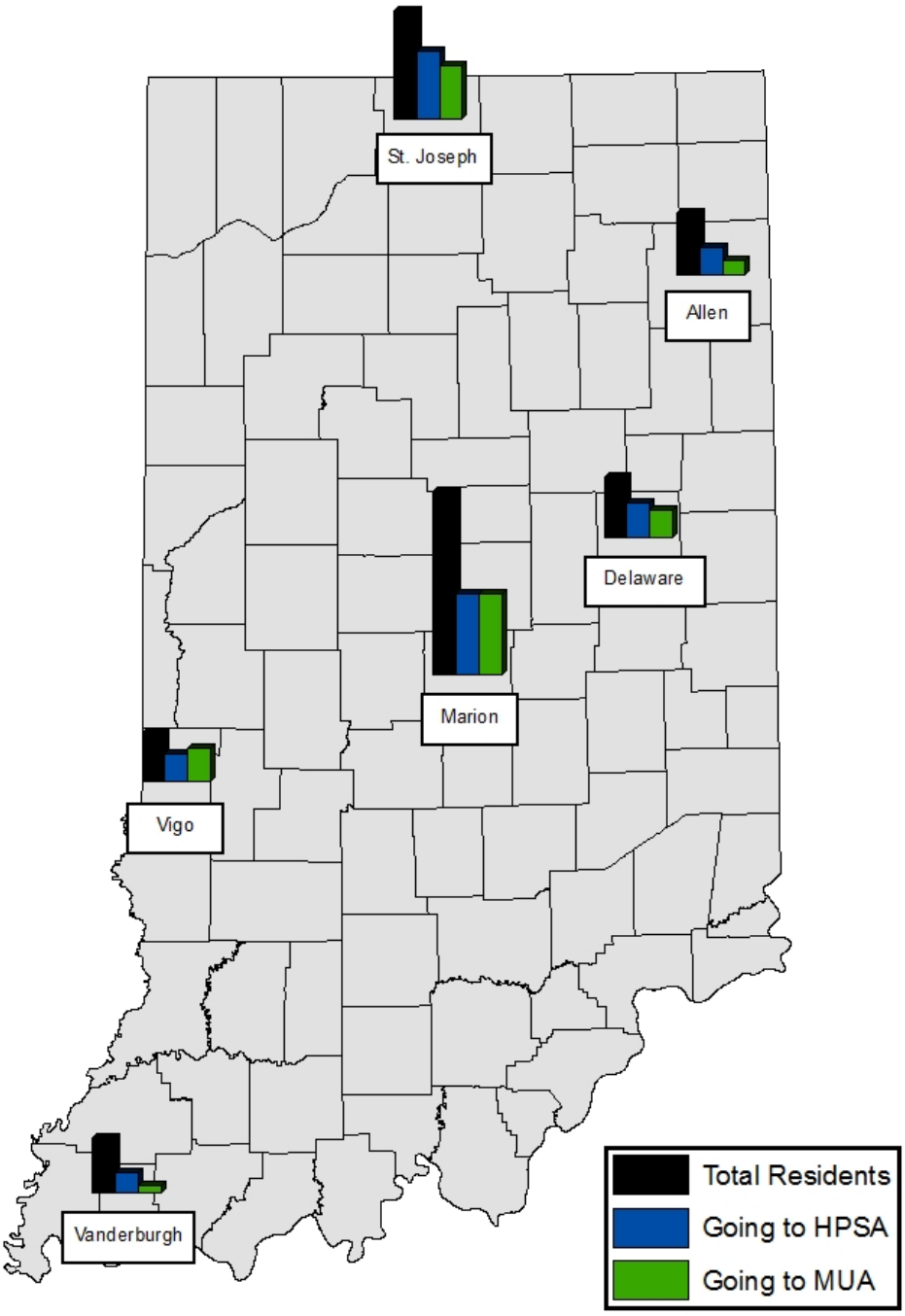
Map 5.2: Primary IN Locations of Indiana FM Residents after Completing Training, 2017



Map 5.2 is an enhanced view of the Indiana map showing the *2017* Indiana family medicine survey respondents' residency site and their primary locations after completing training within Indiana. In 2017, eighty-four respondents listed *both*, their family medicine residency site as well as their primary location after training. A majority of the respondents planned to choose Indiana as their primary location after training. Of those respondents, nine respondents planned to practice or stay in the central Indiana Metropolitan Statistical Area (i.e., Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Putnam, Shelby)[5], followed by St. Joseph county (n=7), Allen (n=5), Tippecanoe (n=3), and Vigo (n=3) counties.

[5] Indiana Core-Based Statistical Area and Maps. Retrieved October 6, 2017, from https://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Feb2013/cbsa2013_IN.pdf

Map 5.3: Indiana FM Residents Going to HPSAs and/or MUAs after Completing Training, 2017



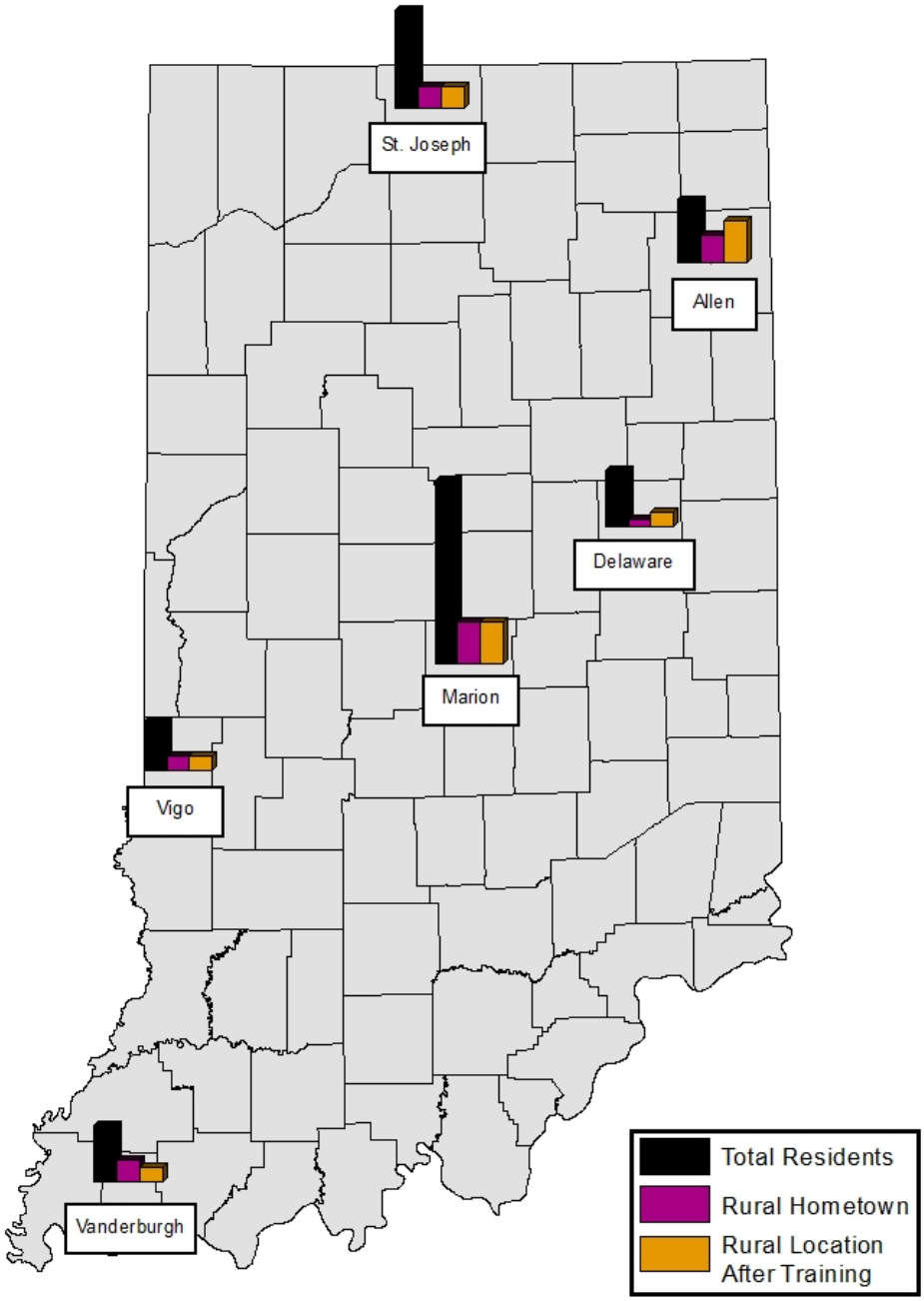
Map 5.3 shows the *2017* Indiana family medicine survey respondents' residency site and those going to a Health Professionals Shortage Area (HPSA) and Medically Underserved Area (MUA) location after completing their training. For ease of interpretation, in this map Marion County includes the five family medicine residency programs (i.e., Community Hospital East, Franciscan Health, IU Health Methodist, St. Vincent, and Community Westview programs).

Table 5.1: Family Medicine Residency Program, IN	HPSA		MUA	
	Number	Percent	Number	Percent
Fort Wayne Medical Education Program	4	44.0	2	22.0
IU Health Ball Memorial Hospital	5	56.0	4	44.0
Community Hospital East	4	67.0	2	33.0
Franciscan Health	2	29.0	2	29.0
IU Health Methodist	2	33.0	3	50.0
St. Vincent	2	40.0	3	60.0
Community Westview	2	67.0	2	67.0
Memorial Hospital of South Bend	5	56.0	4	44.0
St. Joseph Regional Medical Center	5	71.0	4	57.0
Deaconess Hospital	3	38.0	1	13.0
Union Hospital	4	57.0	5	71.0

Table 5.1 shows the *2017* Indiana family medicine survey respondents' residency site and those going to a Health Professionals Shortage Area (HPSA) and Medically Underserved Area (MUA) location after completing their training. This table includes all respondents who indicated a primary location after completing their training. Data analysis was performed using geographic information mapping software, *ArcGIS 10.5*.

In 2017, five respondents *each* from IU Health Ball Memorial in Muncie, Memorial Hospital of South Bend, and St. Joseph Regional Medical Center in Mishawaka indicated they were going to a Health Professionals Shortage Area and five respondents from Union Hospital in Terre Haute indicated they were going to a Medically Underserved Area after completing their training.

Map 5.4: Indiana FM Residents Coming from Rural Hometowns or Going to Rural Areas after Completing Training, 2017



Map 5.4 shows the *2017* Indiana family medicine survey respondents' residency site and those coming from rural hometown and going to a rural area after completing their training. For ease of interpretation, in this map Marion County includes the five family medicine residency programs (i.e., Community Hospital East, Franciscan Health, IU Health Methodist, St. Vincent, and Community Westview programs).

Table 5.2: Family Medicine Residency Program, IN	Rural Hometown		Rural Practice	
	Number	Percent	Number	Percent
Fort Wayne Medical Education Program	4	44.0	6	67.0
IU Health Ball Memorial Hospital	1	13.0	2	25.0
Community Hospital East	2	33.0	1	17.0
Franciscan Health	1	14.0	1	14.0
IU Health Methodist	0	0.0	1	20.0
St Vincent	2	40.0	2	40.0
Community Westview	1	33.0	1	33.0
Memorial Hospital of South Bend	3	43.0	3	43.0
St. Joseph Regional Medical Center	0	0.0	0	0.0
Deaconess Hospital	3	38.0	2	25.0
Union Hospital	2	29.0	2	29.0

Table 5.2 shows the *2017* Indiana family medicine survey respondents' residency site and those coming from a rural hometown and going to a rural area after completing their training. This map includes all respondents who indicated a primary location after completing their training. Data analysis was performed using geographic information mapping software, *ArcGIS 10.5*.

In 2017, four respondents from Fort Wayne Medical Education Program indicated coming from a rural hometown and six respondents from that same program indicated going back to a rural area for practice after completing their training.

Chapter 6: Graphs showing Trend Patterns, 2012-2017

This chapter shows a comparison of Indiana Family Medicine Residencies Exit Survey responses from the time of its inception in 2012 through 2017. Trends for all respondents have been shown in figures 6.1 to 6.10. The remaining figures show responses from only those graduates 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 and all graphs have been zoomed in to improve visualization.

All Respondents, 2008-2017

Demographics

Figure 6.1: Trends showing Age, 2012-2017

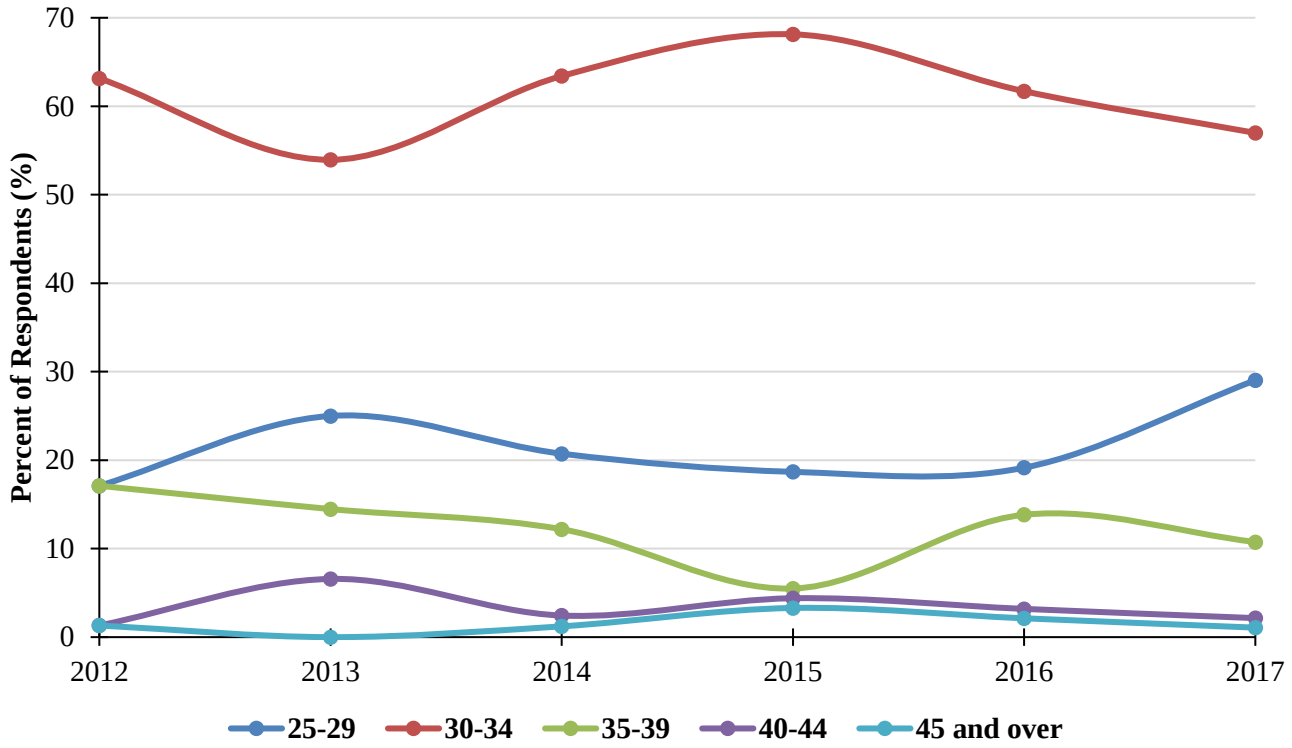


Figure 6.1 shows trends among the Indiana family medicine survey respondents' and their age distributions from 2012 to 2017. The graph has been zoomed in to improve visualization.

An increasing trend has been noted for those between 25 and 29 years of age (17% in 2012 to 29% in 2017). The 6-year average was 22 percent.

For the remaining age categories, trends have remained fairly constant.

Figure 6.2: Trends showing Gender, 2012-2017

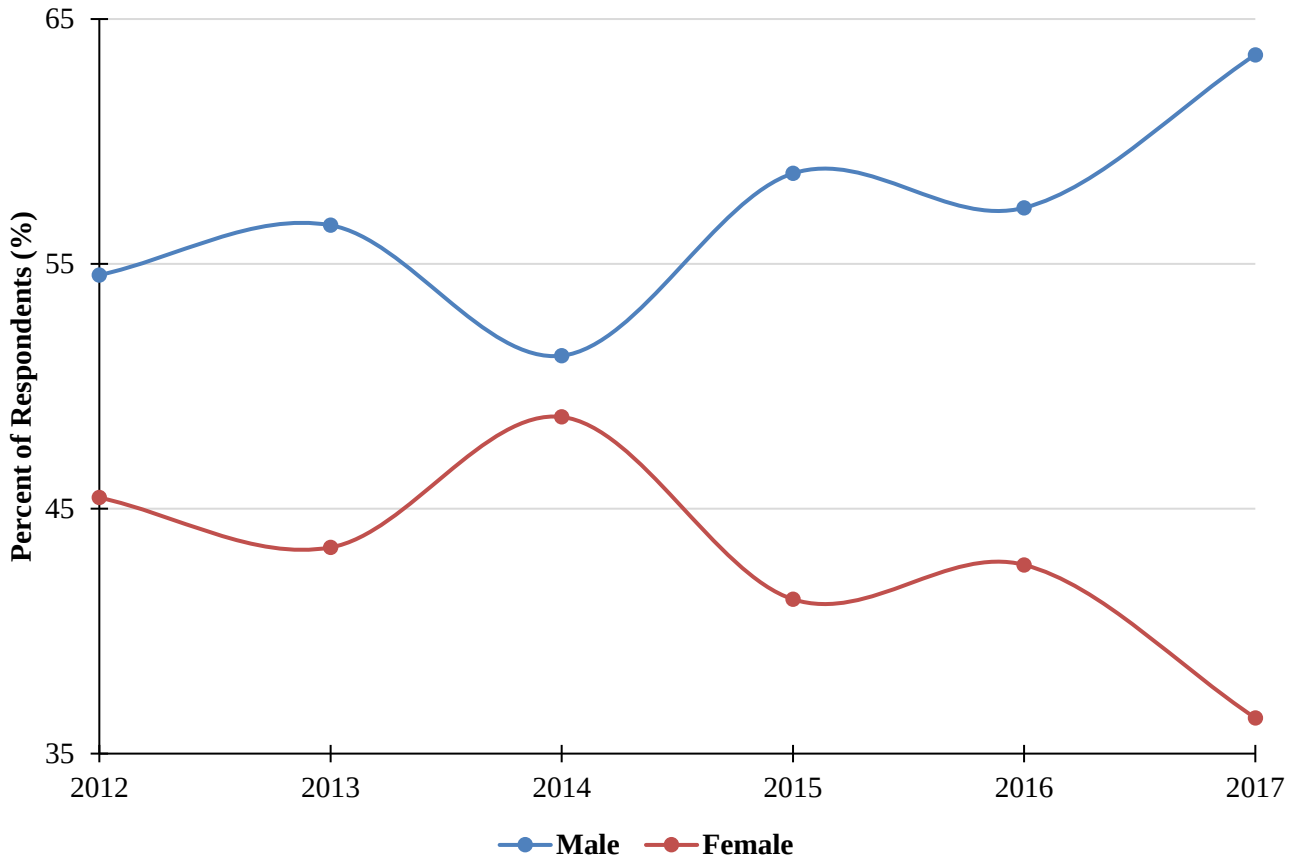


Figure 6.2 shows trends among the Indiana family medicine survey respondents' and their in gender distribution from 2012 to 2017. The graph has been zoomed in to improve visualization.

A slight increase was noted among the male respondents (55% in 2012 to 64% in 2017). The 6-year average was 57 percent.

A noticeable drop was noted among the female respondents (46% in 2012 to 37% in 2017). The 6-year average was 43 percent.

Figure 6.3: Trends showing Race and Ethnicity, 2012-2017

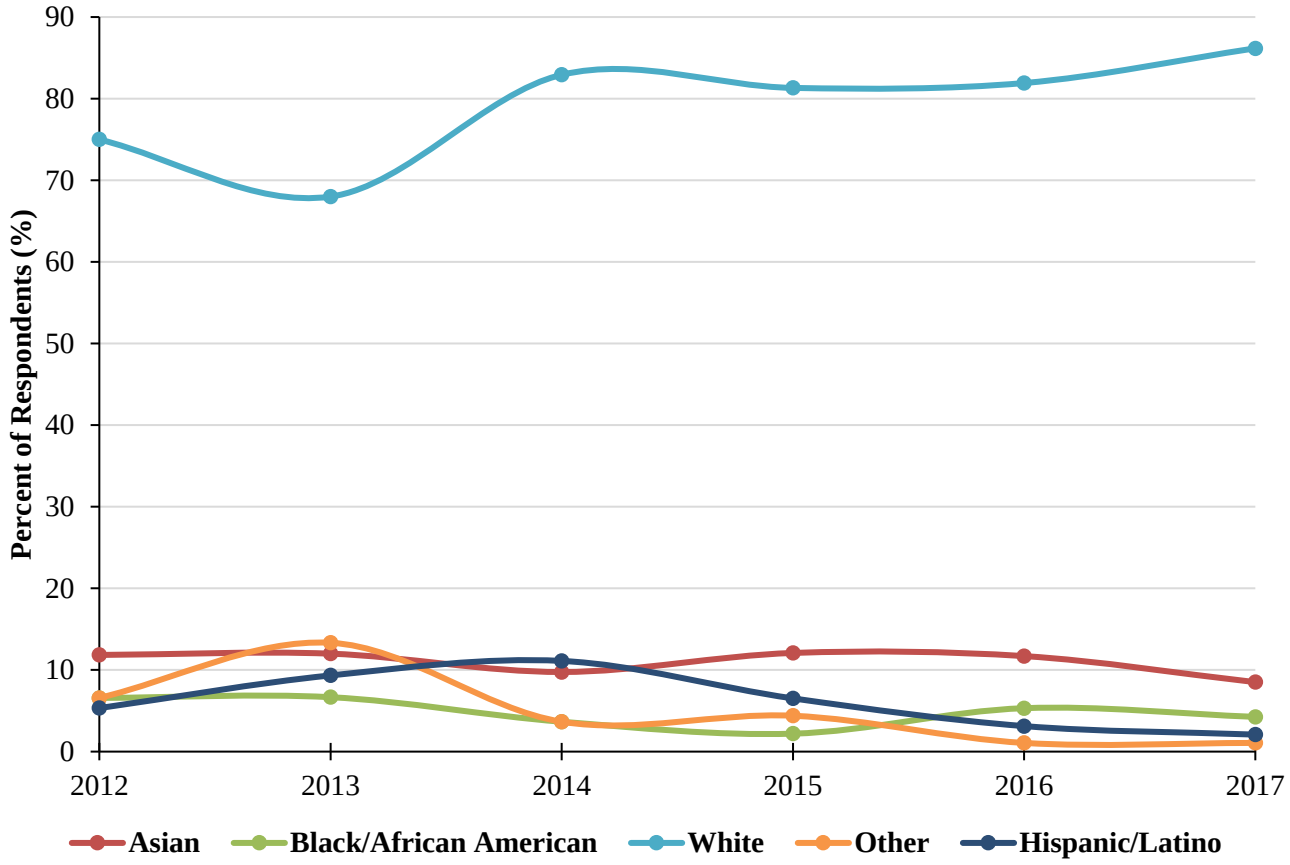


Figure 6.3 shows trends among the Indiana family medicine survey respondents' and their racial and ethnic distributions from 2012 to 2017. The graph has been zoomed in to improve visualization.

An increasing trend was noted for respondents who identified themselves as white (75% in 2012 to 86% in 2017). The 6-year average was 79 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.4: Trends showing Where the Respondents are Coming From, 2012-2017

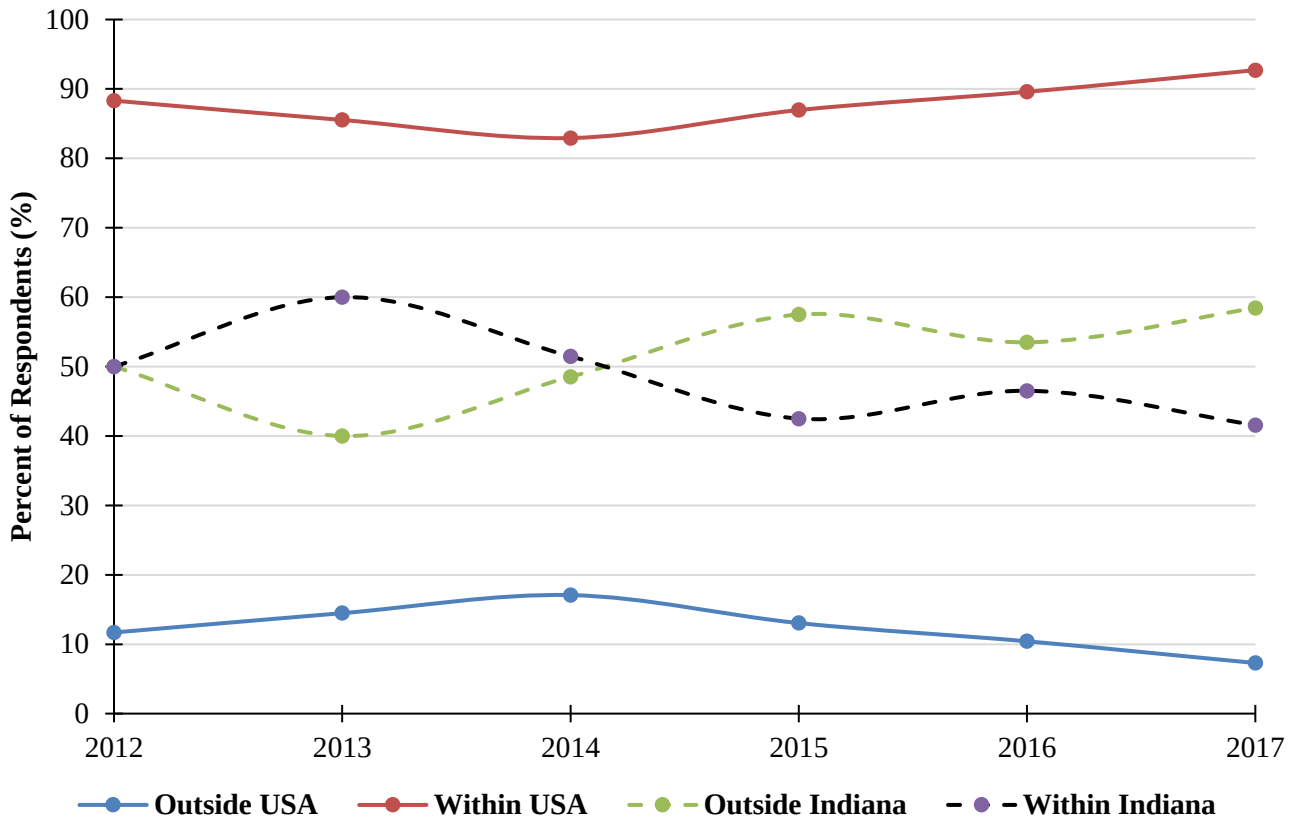


Figure 6.4 shows trends among the Indiana family medicine survey respondents' and where they came from between 2012 and 2017.

Of the respondents who indicated they were from within the United States:

- A slight increase was noted among those coming from *outside* of Indiana (50% in 2012 to 58% in 2017). The 6-year average was 51 percent.
- A declining trend was noted among those coming from *within* Indiana (50% in 2012 to 42% in 2017). The 6-year average was 49 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.5: Trends showing Individual Educational Debt, 2012-2017

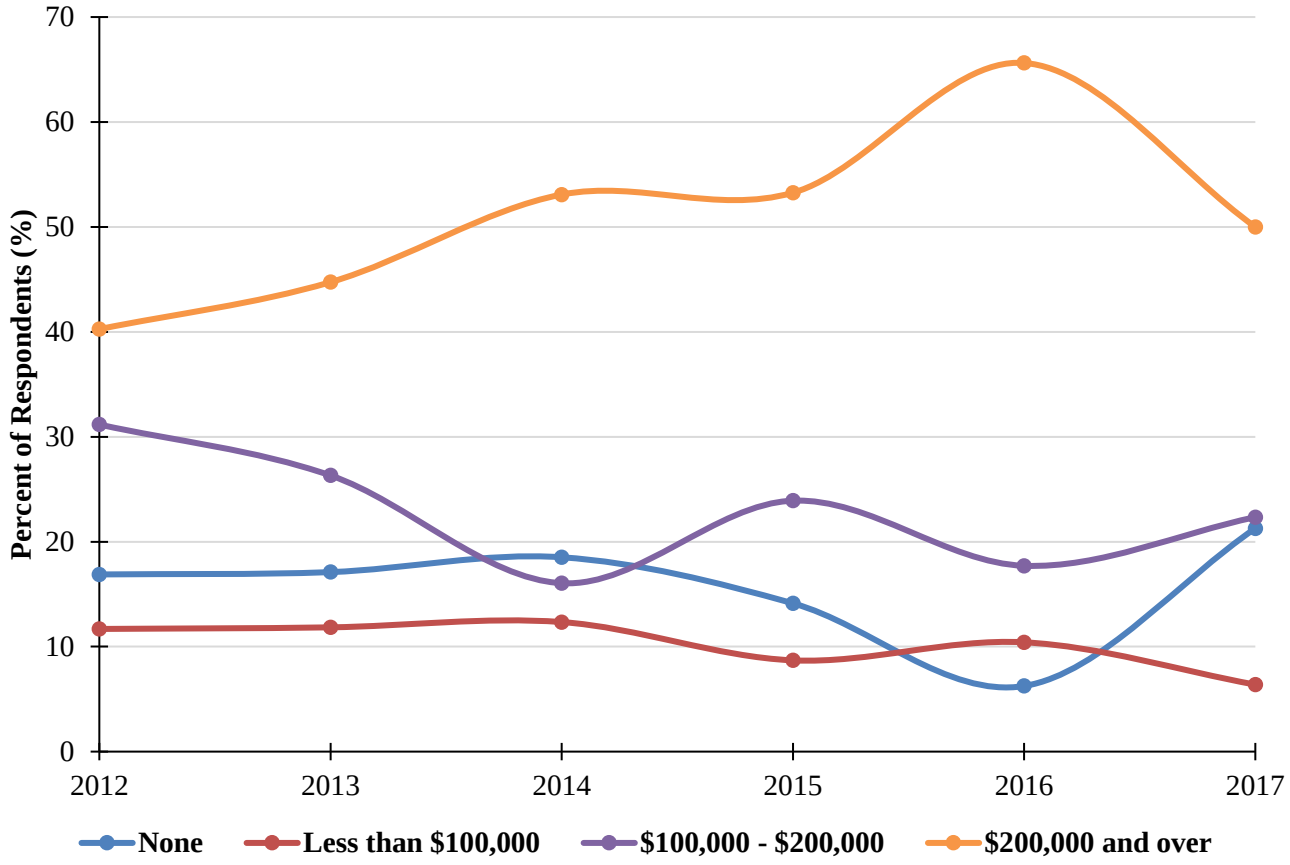


Figure 6.5 shows trends among the Indiana family medicine survey respondents' and their current level of educational debt from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents with an individual educational debt load of "$200,000 or more" (40% in 2012 to 50% in 2017). The 6-year average was 51 percent.

A noticeable drop was noted among respondents with an individual educational debt load "between $100,000 and $200,000" (31% in 2012 to 22% in 2017). The 6-year average was 23 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.6: Trends showing Program Helpfulness in Board Exam Preparation, 2012-2017

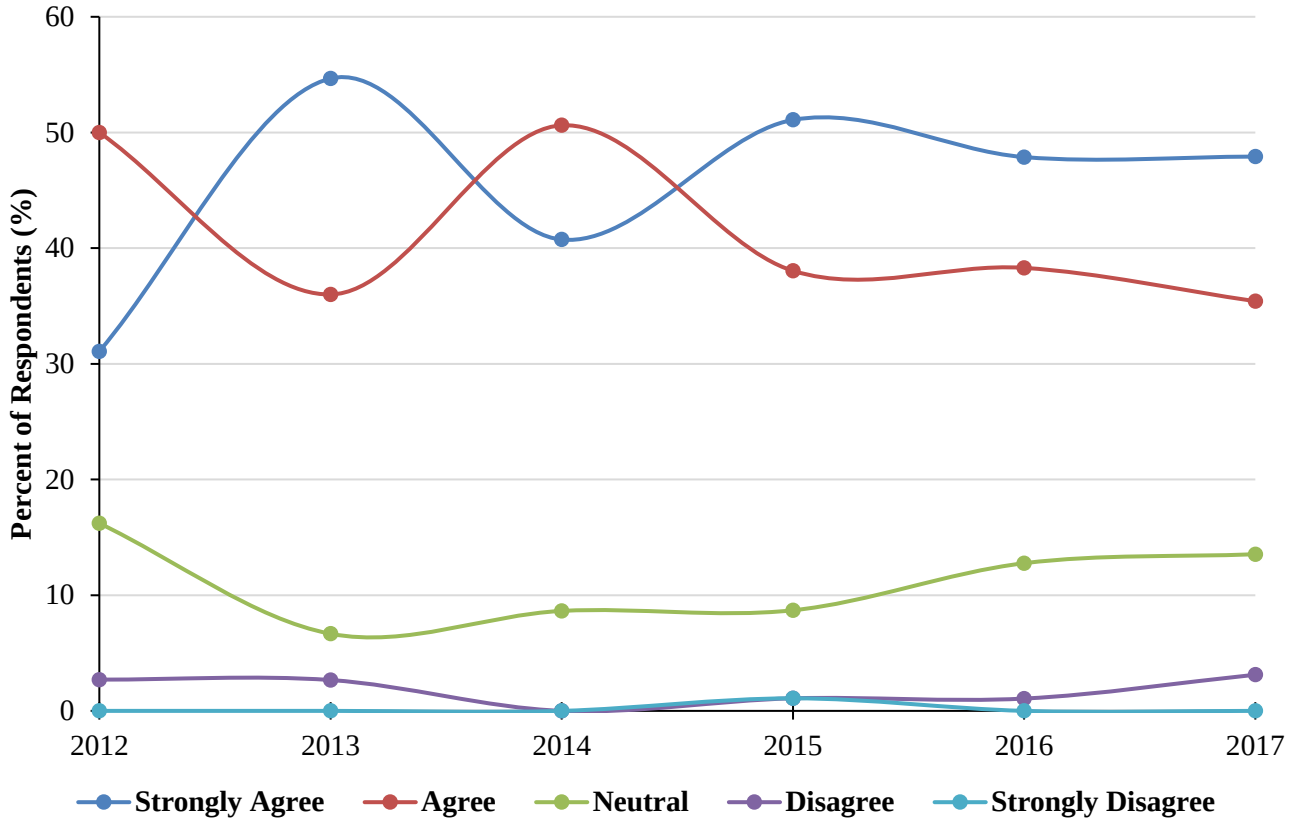


Figure 6.6 shows trends among the Indiana family medicine survey respondents' and how helpful the residency training program was in preparing them for their board exams from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who indicated they "strongly agree" their training program was helpful in preparation for their board exams (31% in 2012 to 48% in 2017). The 6-year average was 46 percent.

A declining trend was noted among respondents who indicated they "agree" their training program was helpful in in preparation for their board exams (50% in 2012 to 35% in 2017). The 6-year average was 41 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.7: Trends showing Training Received and Level of Competency in Providing Care, 2012-2017

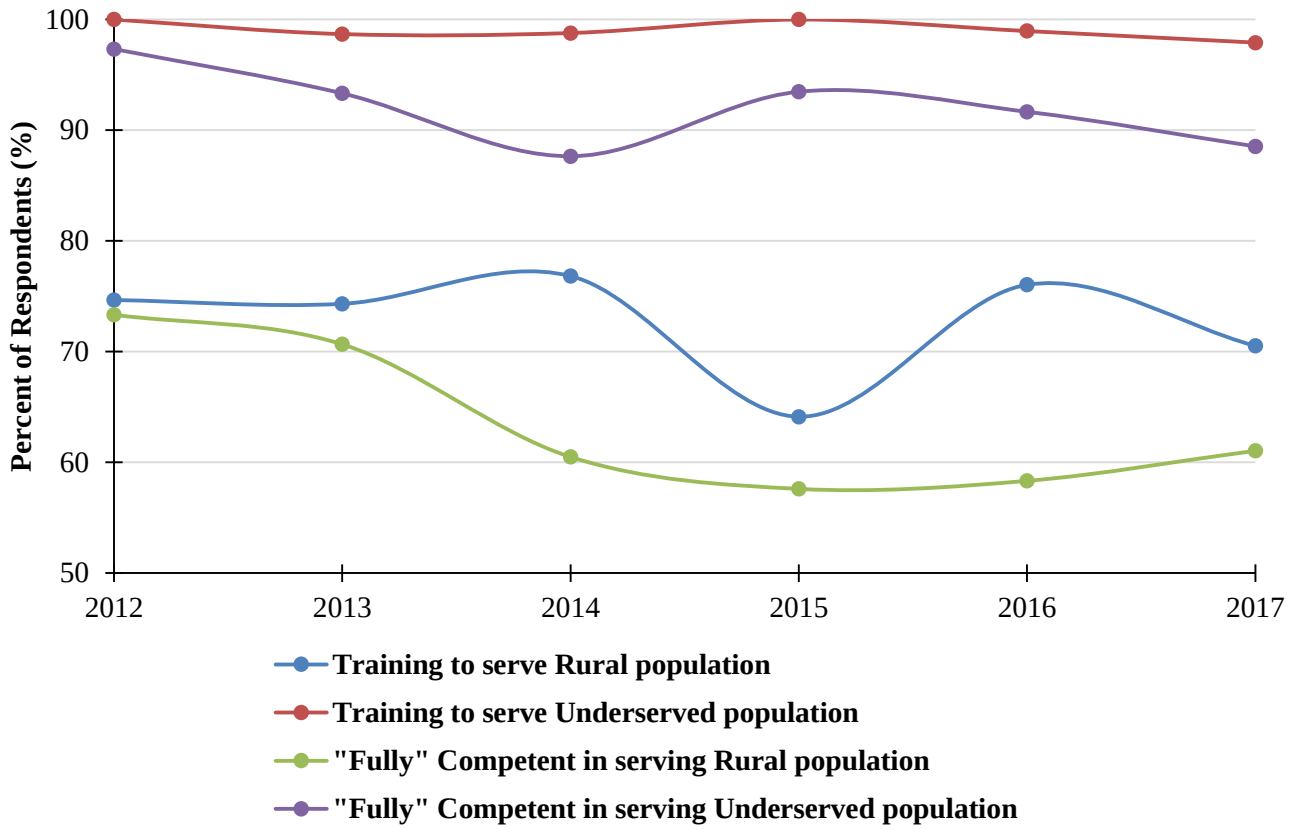


Figure 6.7 shows trends among the Indiana family medicine survey respondents' training received to serve the rural and underserved populations *and* their self-rated level of competency in providing care to those rural and underserved populations from 2012 to 2017. This graph has been zoomed in to improve visualization.

A declining trend was noted among respondents who indicated they felt "fully" competent in providing care to the *rural* populations (73% in 2012 to 61% in 2017) and *underserved* populations (97% in 2012 to 89% in 2017). The 6-year average was 64 percent and 92 percent, respectively.

For the remaining categories, trends have remained fairly constant.

Figure 6.8: Trends showing Quality of Program, 2012-2017

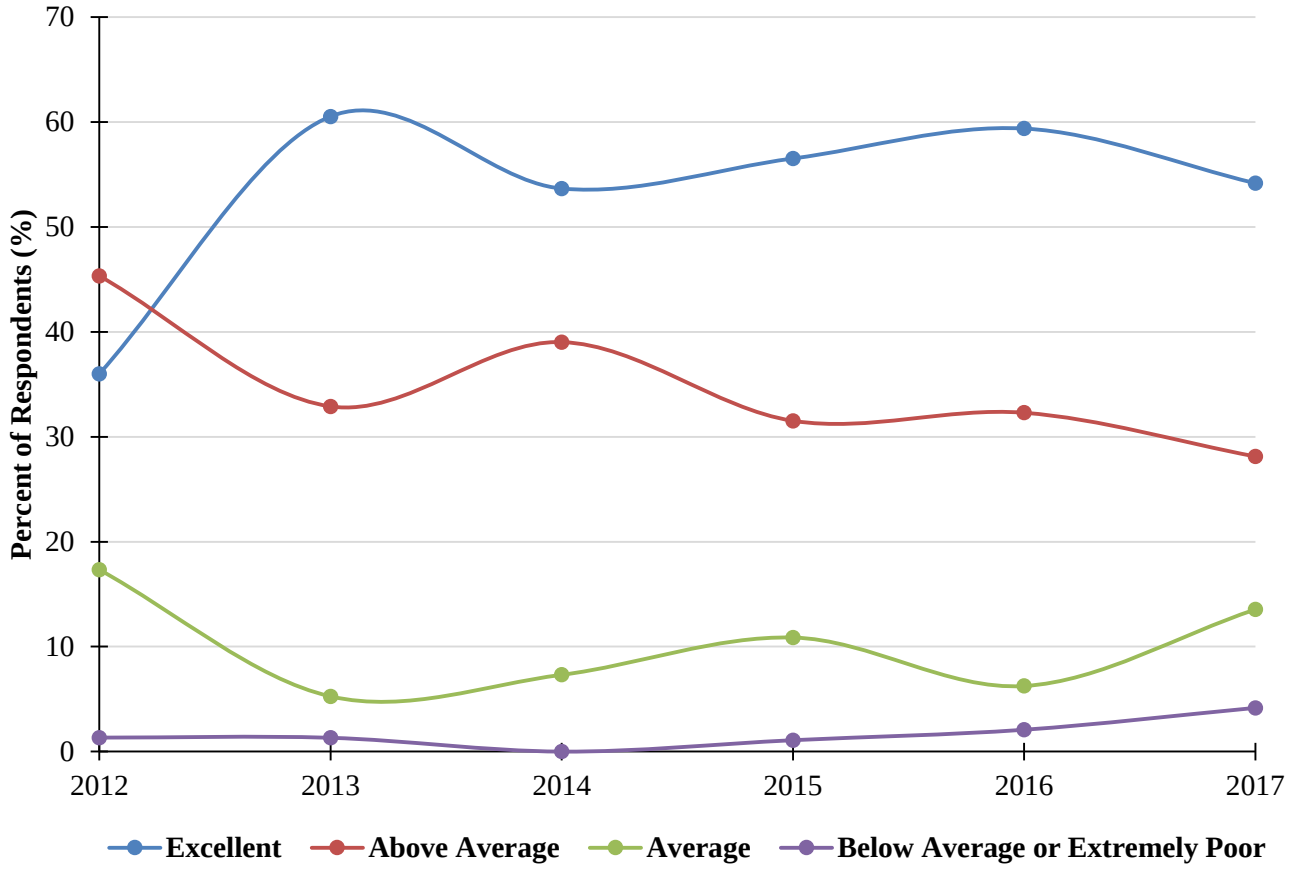


Figure 6.8 shows trends among the Indiana family medicine survey respondents' overall rating of the quality of their training program from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who rated the quality of their program as "excellent" (36% in 2012 to 54% in 2017). The 6-year average was 53 percent.

A declining trend was noted among respondents who rated the quality of the program as "above average" (45% in 2012 to 28% in 2017). The 6-year average was 35 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.9: Trends showing Overall Faculty Performance, 2012-2017

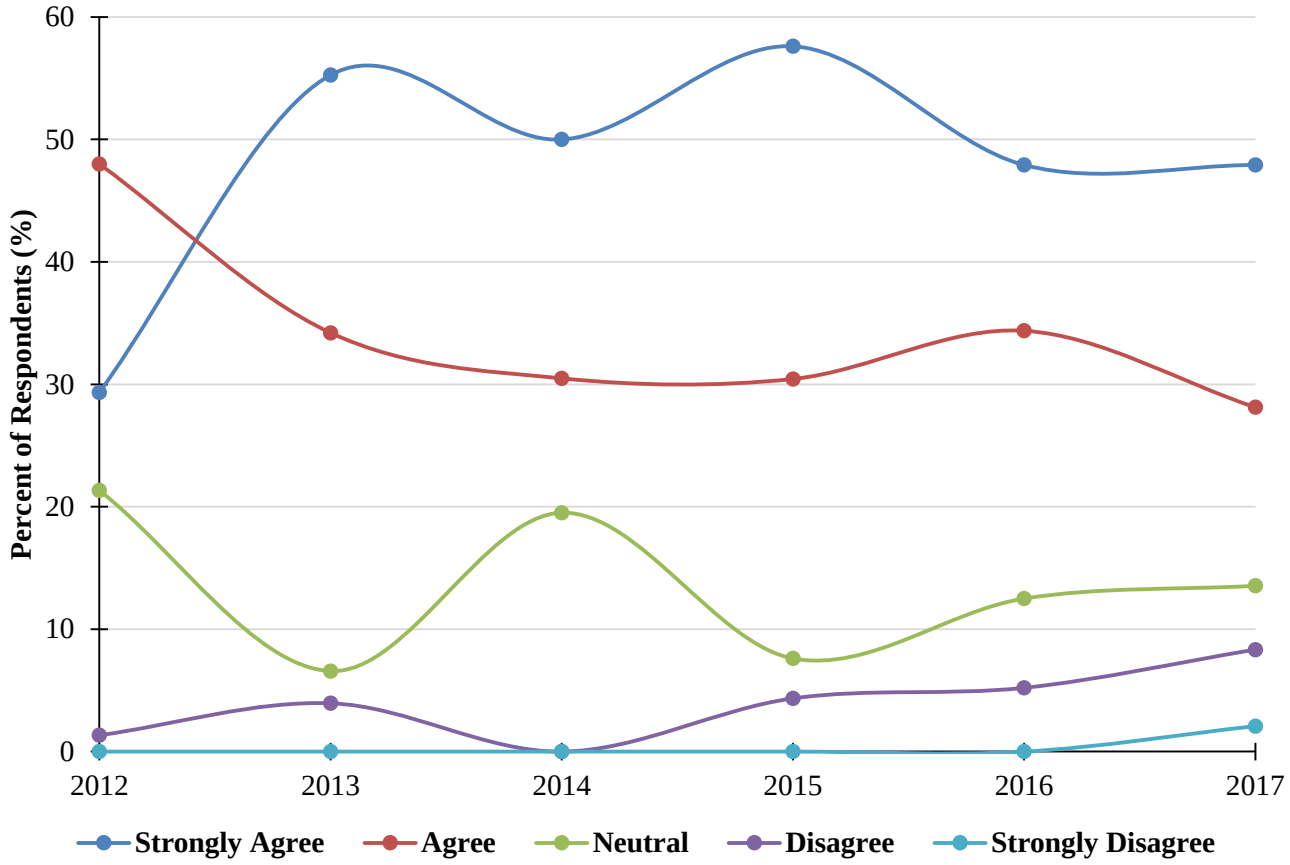


Figure 6.9 shows trends among the Indiana family medicine survey respondents' overall assessment of performance of faculty in their training program from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who indicated they "strongly agree" that the performance of faculty in their training program had exceeded their expectations (29% in 2012 to 48% in 2017). The 6-year average was 48 percent.

A declining trend was noted among respondents who "agree" that the performance of faculty in their training program had exceeded their expectations (48% in 2012 to 28% in 2017). The 6-year average was 34 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.10: Trends showing Overall Peer Performance, 2012-2017

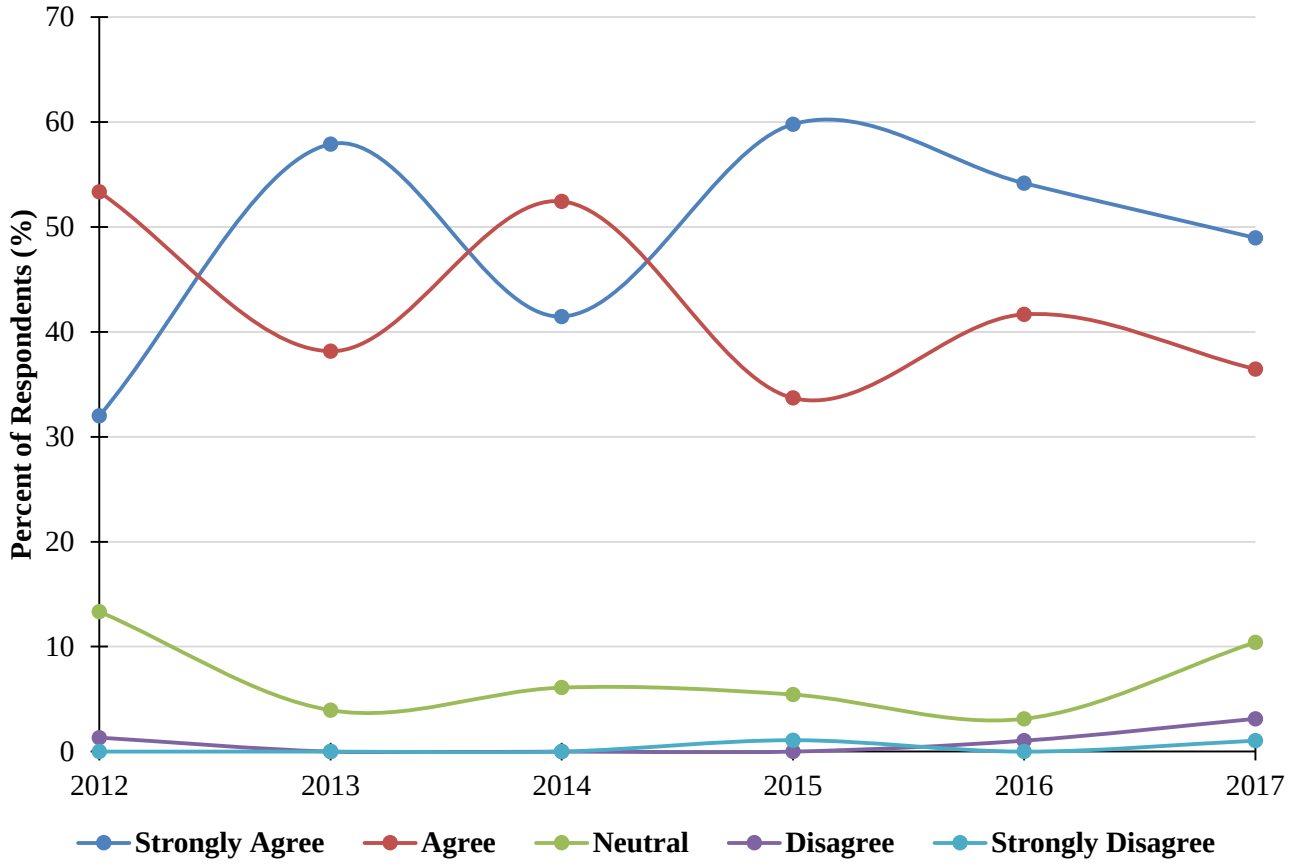


Figure 6.10 shows trends among the Indiana family medicine survey respondents' overall assessment of performance of other residents or fellows in their training program from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who "strongly agree" that the performance of other residents or fellows in their program had exceeded their expectations (32% in 2012 to 49% in 2017). The 6-year average was 49 percent.

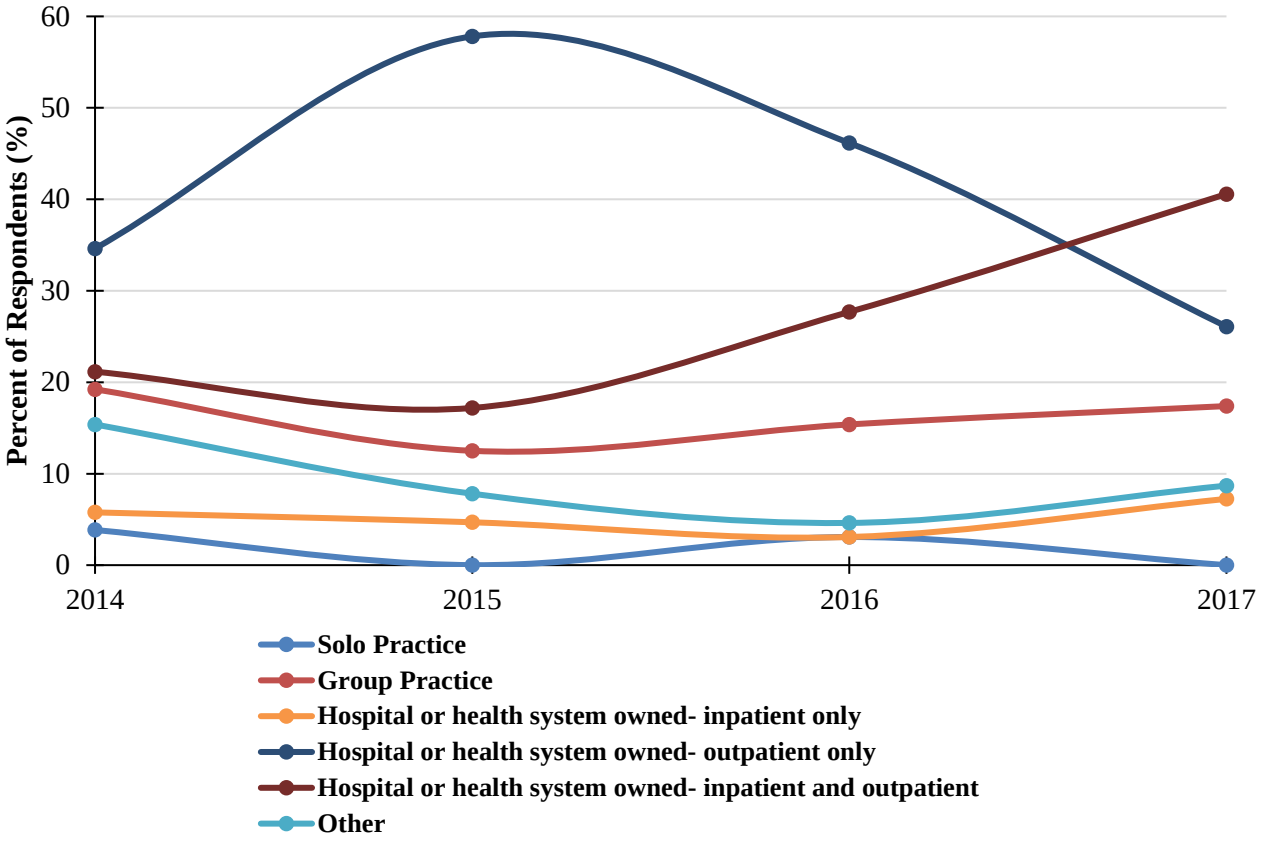
A declining trend was noted among respondents who "agree" that the performance of other residents or fellows in their training program had exceeded their expectations (53% in 2012 to 37% in 2017). The 6-year average was 43 percent.

For the remaining categories, trends have remained fairly constant.

NOTE- The following section is only for those who indicated they were going into "patient care or clinical practice.

Practice Characteristics

Figure 6.11: Trends showing Principal Type of Patient Care Practice, 2014-2017*



**Response categories differed in the 2012 and 2013 Indiana Family Medicine Residencies Exit Survey and were thus excluded from analysis.*

Figure 6.11 shows trends among the Indiana family medicine survey respondents' and the principal type of patient care practice setting they will be entering after completing their training program from 2014 to 2017. Response categories differed in the *2012 and 2013 Indiana Family Medicine Residencies Exit Survey*© and were thus excluded from this graph. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents going into a "hospital or health system owned – inpatient and outpatient" facility (21% in 2014 to 41% in 2017). The 6-year average was 41 percent.

A slight drop was noted among respondents going into a "hospital or health system owned – outpatient only" facility (35% in 2014 to 26% in 2017). The 6-year average was 41 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.12: Trends showing Expected Percent of Patients to be seen from Underserved Populations, 2012-2017

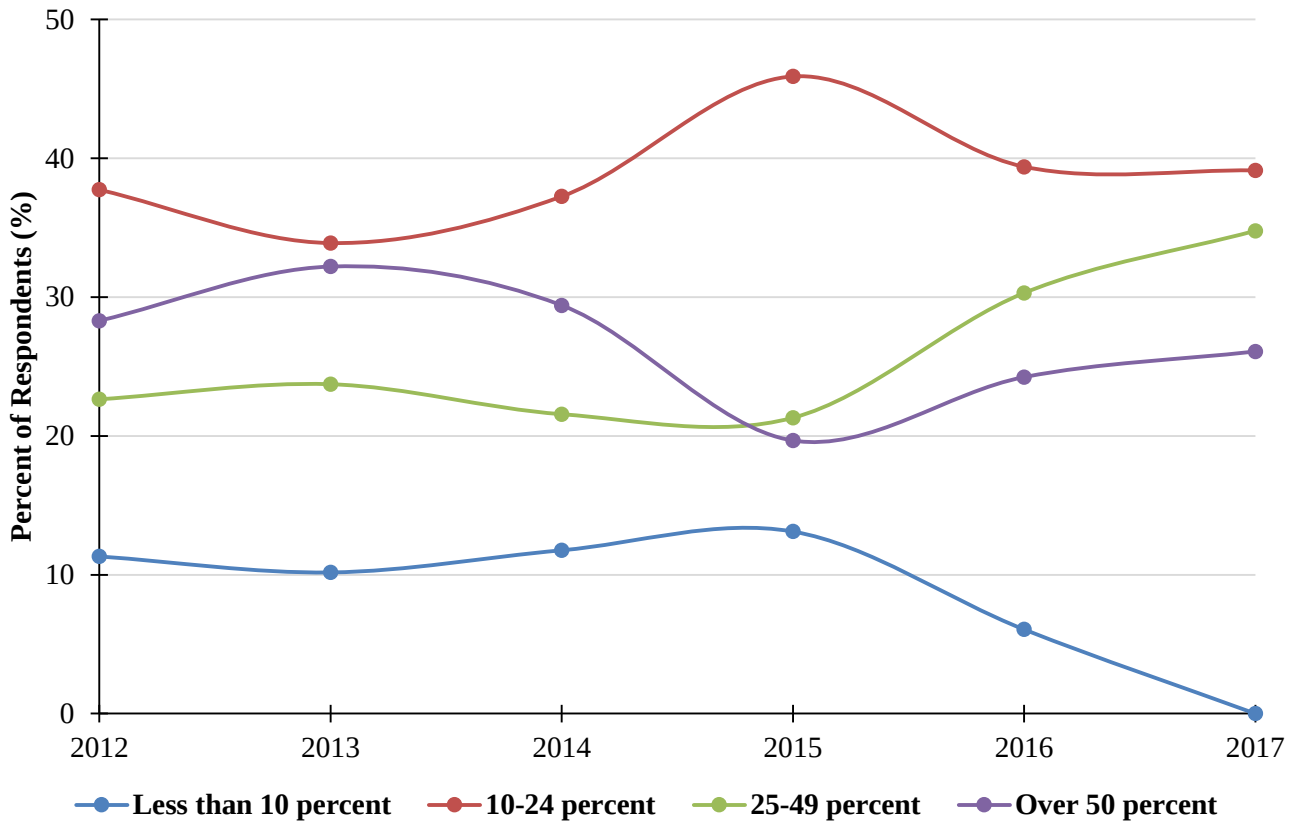


Figure 6.12 shows trends among the Indiana family medicine survey respondents' and the percentage of patients they expect to see from underserved populations from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who expect to see "between 25 and 49 percent" of their patients from underserved populations (23% in 2012 to 35% in 2017). The 6-year average was 26 percent.

A declining trend was noted among respondents who expect to see "less than 10 percent" of their patients from underserved populations (11% in 2012 to 0% in 2017). The 6-year average was 9 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.13: Trends showing Expected Gross Income in 1st Year of Practice, 2012-2017

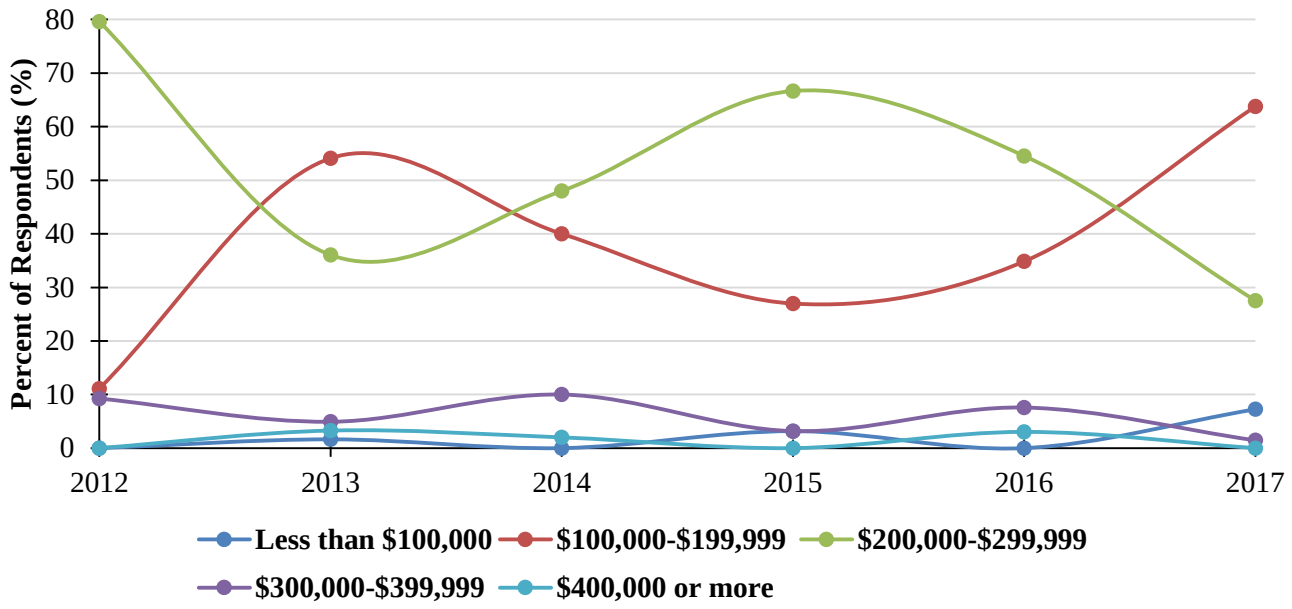


Figure 6.13 shows trends among the Indiana family medicine survey respondents' and their expected gross income (salary plus incentives) during their first year of practice from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who expect to earn between $100,000 and $199,999 during their first year of practice (11% in 2012 to 64% in 2017). The 6-year average was 39 percent.

A declining trend was noted among respondents who expect to earn between $200,000 and $299,999 during their first year of practice (80% in 2012 to 28% in 2017). The 6-year average was 52 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.14: Trends showing Employment Offers Received <u>All Together</u>, 2012-2017

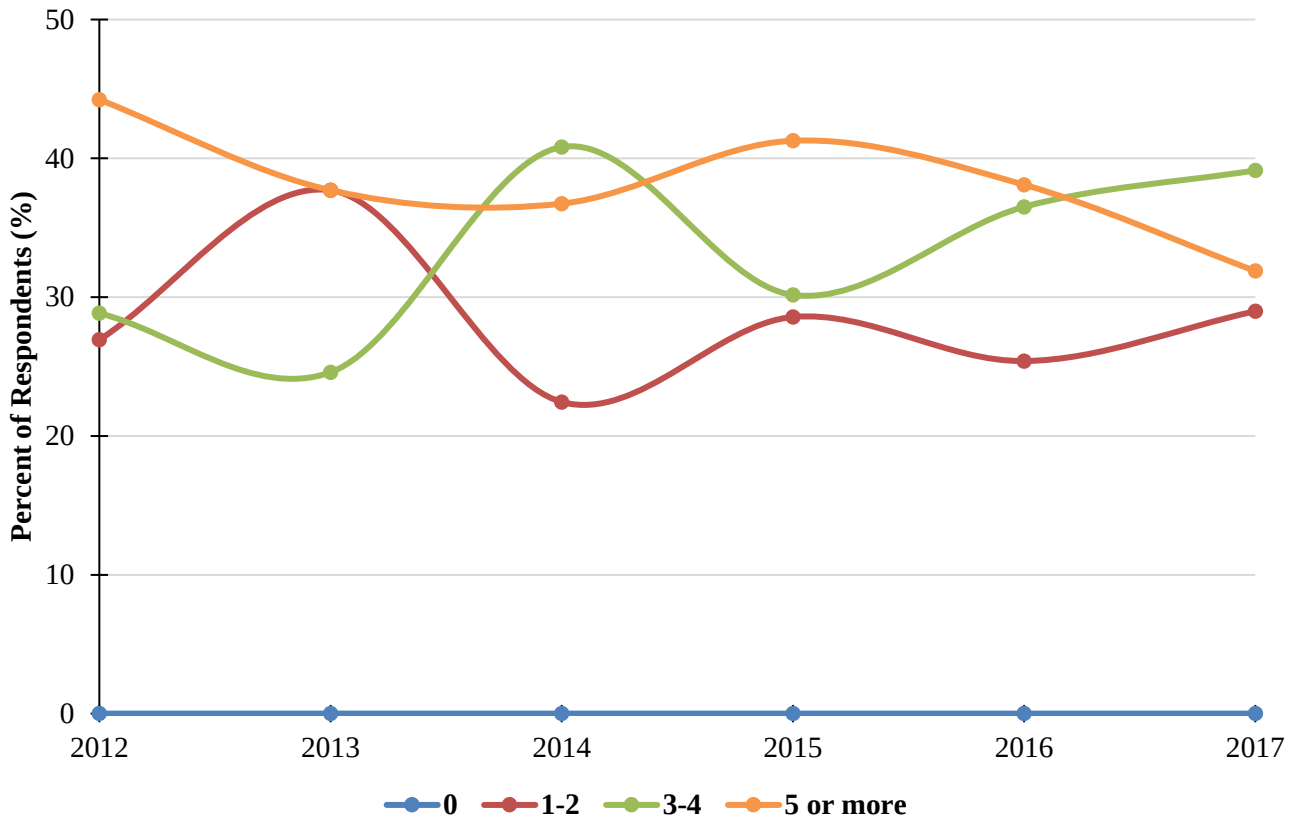


Figure 6.14 shows trends among the Indiana family medicine survey respondents' and the number of offers they received <u>all together</u> for employment or practice positions from 2012 to 2017. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who received "3 to 4" employment or practice positions all together (29% in 2012 to 39% in 2017). The 6-year average was 33 percent.

A slight drop was noted among respondents who received "5 or more" employment or practice positions all together (44% in 2012 to 32% in 2017). The 6-year average was 38 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.15: Trends showing Main Reasons to Practice <u>at this Location</u>, 2012-2017

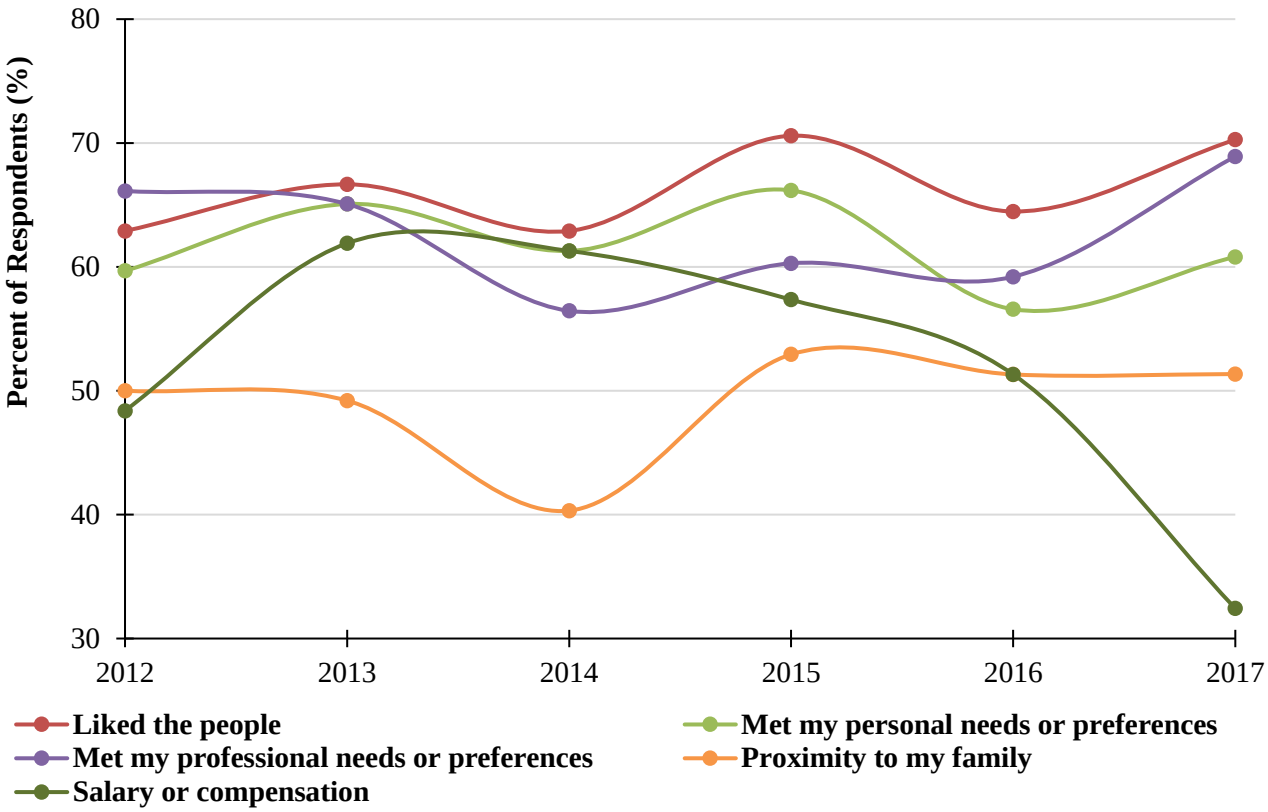


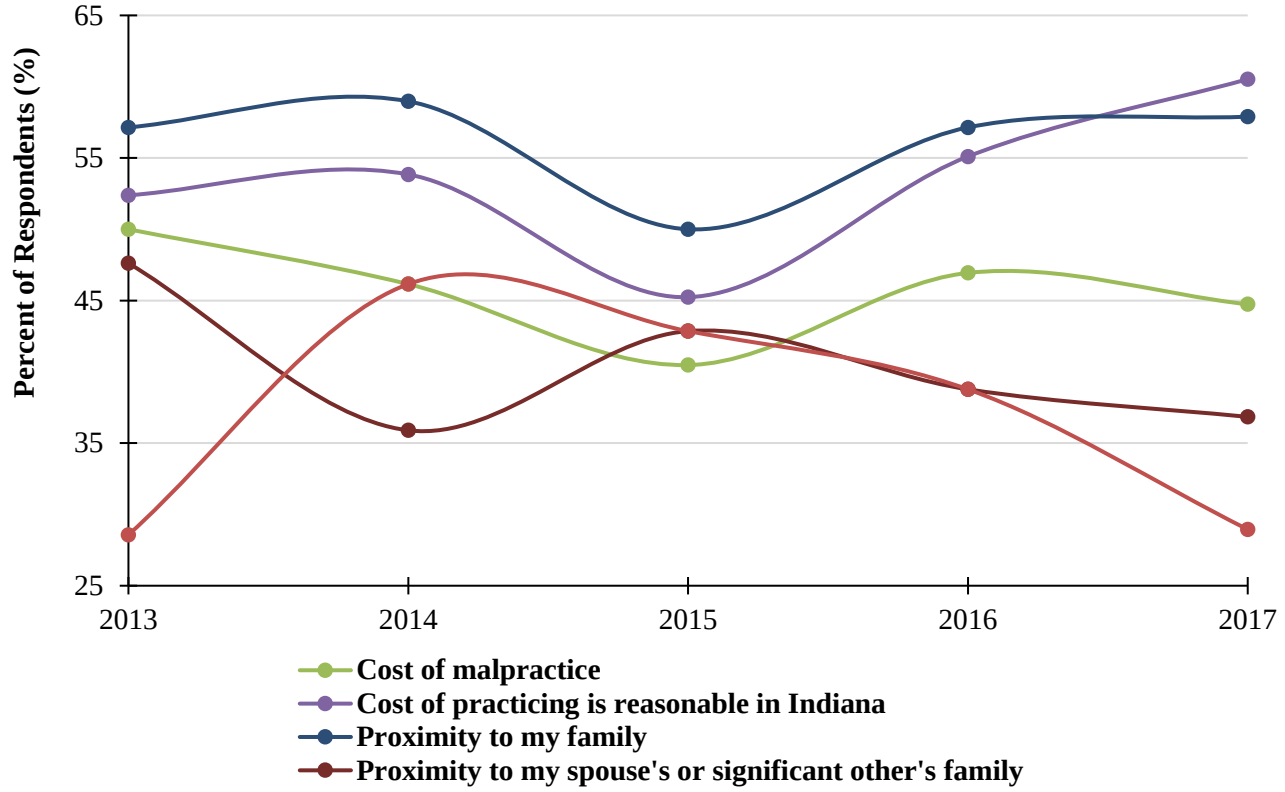
Figure 6.15 shows trends among the Indiana family medicine survey respondents' and the top 5 reasons they decided to practice <u>at this location</u> from 2012 to 2017. This graph has been zoomed in to improve visualization.

A slight increase was noted among respondents who indicated the main reason they chose to practice at location was because they "liked the people" (63% in 2012 to 70% in 2017). The 6-year average was 66 percent.

A declining trend was noted among respondents who indicated the main reason they chose to practice at this location was because of "salary or compensation" (48% in 2012 to 32% in 2017). The 6-year average was 52 percent.

For the remaining categories, trends have remained fairly constant.

Figure 6.16: Trends showing Main Reasons to Practice in Indiana, 2013-2017*



**Response categories differed in the 2012 Indiana Family Medicine Residencies Exit Survey and were thus excluded from analysis.*

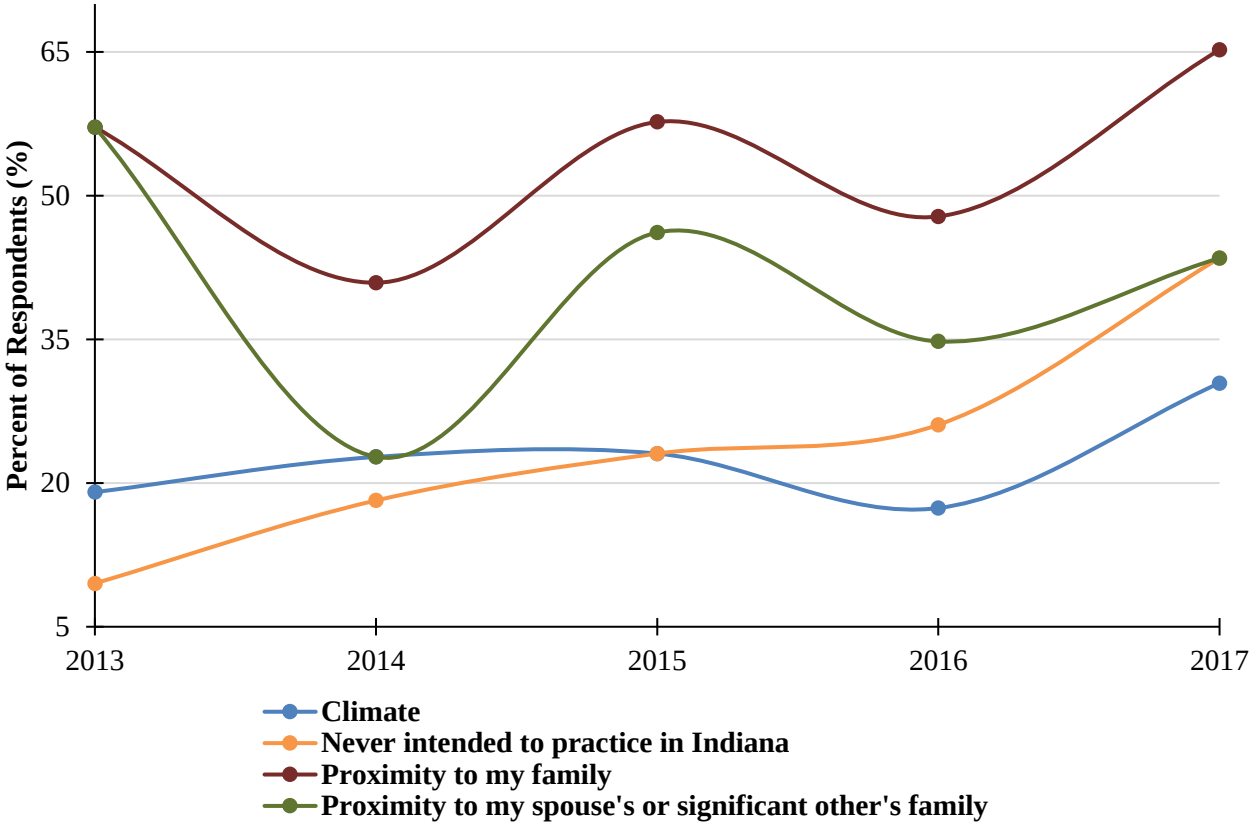
Figure 6.16 shows trends among respondents and the top five reasons they decided to practice in Indiana from 2013 to 2017. Response categories differed in the *2012 Indiana Family Medicine Residencies Exit Survey*© and were thus excluded from this graph. Only those respondents who indicated they were intending to practice in Indiana after completing their training were included in this analysis. This graph has been zoomed in to improve visualization.

A slight increase was noted among respondents who indicated the main reason they chose to practice in Indiana was because the "cost of practicing was reasonable in Indiana" (52% in 2013 and 61% in 2017). The 5-year average was 53 percent.

A declining trend was noted among respondents who indicated the main reason they chose to practice in Indiana was because of "proximity to their spouse or significant other's family" (48% in 2013 and 37% in 2017). The 5-year average was 46 percent and 40 percent, respectively.

For the remaining categories, trends have remained fairly constant.

Figure 6.17: Trends showing Main Reasons Not to Practice in Indiana, 2013-2017*

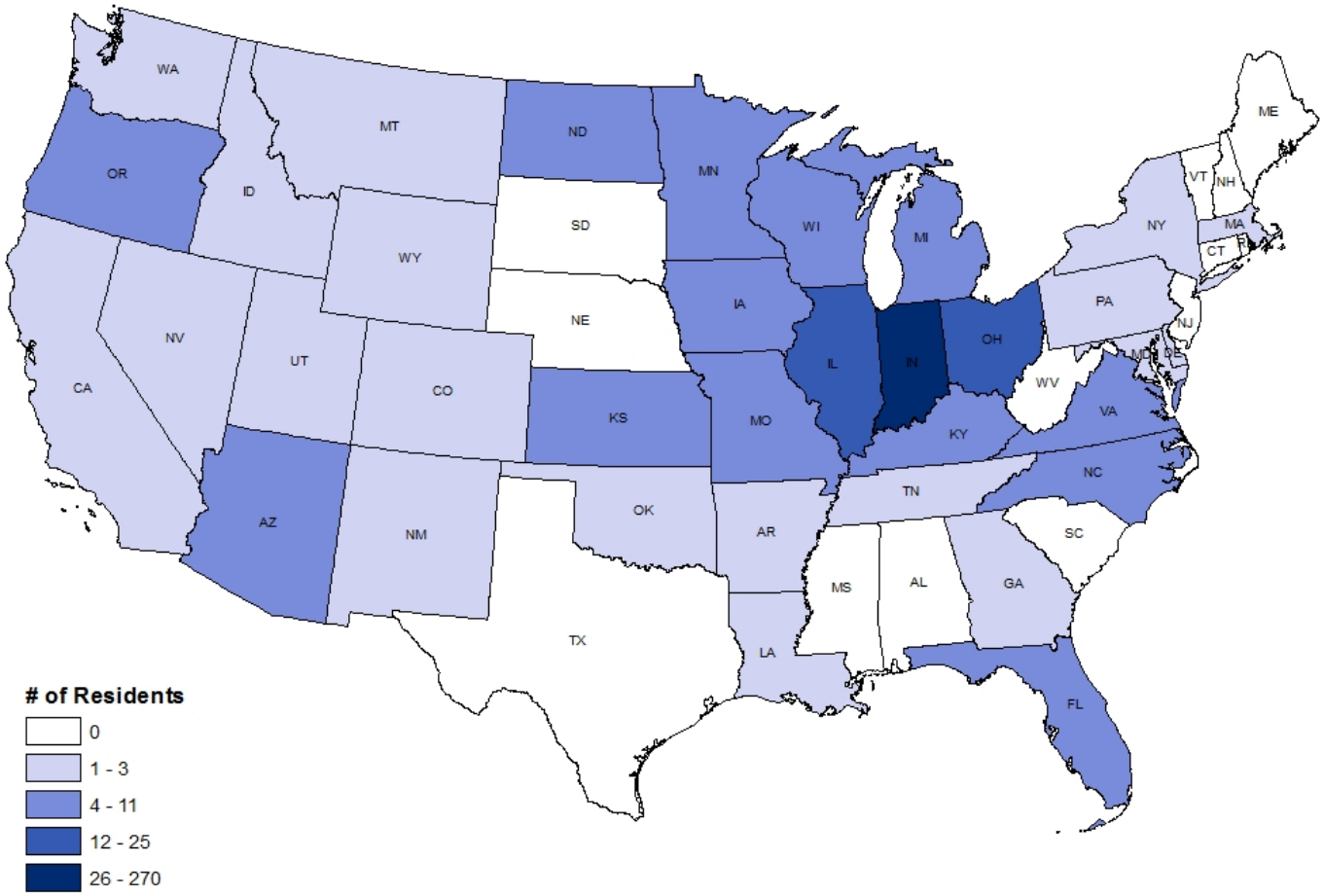


**Response categories differed in the 2012 Indiana Family Medicine Residencies Exit Survey and were thus excluded from analysis.*

Figure 6.17 shows trends among the Indiana family medicine survey respondents' and the top four reasons they decided not to practice in Indiana from 2013 to 2017. Response categories differed in the *2012 Indiana Family Medicine Residencies Exit Survey*© and were thus excluded from this graph. Only those respondents who intended to practice outside Indiana were included in the analysis. This graph has been zoomed in to improve visualization.

An increasing trend was noted among respondents who indicated the main reasons they chose to practice outside Indiana were because of "climate" (19% in 2013 to 30% in 2017), "never intended to practice in Indiana" (10% in 2013 to 44% in 2017), and "proximity to their family" (57% in 2013 to 65% in 2017). The 5-year average was 23 percent, 24 percent, and 54 percent, respectively.

Map 6.1: Primary US Locations of Indiana Family Medicine Residents after Completing Training
2012-2017



Map 6.1 depicts the *2012 to 2017 trends* showing Indiana family medicine survey respondents' residency site and their primary locations after completing training within United States. This map includes all respondents who indicated a primary location after completing their training. Data analysis was performed using geographic information mapping software, *ArcGIS 10.5*

Table 6.1: Primary Location in the U.S. after Completing Training									
County	**Family Medicine Residency Program**	**Location after Training**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**
Allen	Fort Wayne Medical Education Program, Fort Wayne	Florida	1	0	0	0	0	0	**1**
		Iowa	1	0	0	0	1	0	**2**
		Indiana	4	9	6	8	7	5	**39**
		Kansas	1	0	0	1	0	0	**2**
		Minnesota	0	0	0	0	0	1	**1**
		Nevada	1	0	0	0	0	0	**1**
		North Carolina	0	0	0	0	1	0	**1**
		Ohio	0	0	0	0	0	2	**2**
		Oklahoma	0	0	0	0	0	1	**1**
		Wyoming	1	0	0	0	0	0	**1**

County	**Family Medicine Residency Program**	**Location after Training**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**
Delaware	IU Health Ball Memorial Hospital, Muncie	Arizona	0	0	0	1	0	1	**2**
		Arkansas	0	0	0	0	0	1	**1**
		Idaho	0	0	1	0	0	0	**1**
		Illinois	1	0	0	0	0	1	**2**
		Indiana	1	5	2	5	6	5	**24**
		Kentucky	2	0	0	0	0	0	**2**
		Michigan	0	0	0	1	0	0	**1**
		Minnesota	0	0	1	0	0	0	**1**
		Missouri	1	0	1	0	0	0	**2**
		New Mexico	0	0	1	0	0	0	**1**
		Utah	1	0	0	0	1	0	**2**
		Virginia	0	0	0	0	0	1	**1**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Marion	Community Hospital East FM Residency at CHN, Indianapolis	Florida	0	1	0	0	0	0	**1**
		Georgia	0	1	0	0	0	0	**1**
		Idaho	0	1	0	0	0	0	**1**
		Illinois	0	2	0	0	0	0	**2**
		Indiana	5	0	6	5	7	3	**26**
		Minnesota	0	0	1	0	0	0	**1**
		Missouri	0	0	0	0	1	0	**1**
		North Carolina	0	0	0	0	0	1	**1**
		Oregon	0	0	0	0	0	1	**1**
		Virginia	0	0	0	0	0	1	**1**
		Wisconsin	0	0	1	0	0	0	**1**
	Franciscan Health Indianapolis Family Medicine Residency, Indianapolis	Arizona	0	0	0	1	0	0	**1**
		Illinois	1	0	0	0	0	0	**1**
		Indiana	4	6	7	5	5	2	**29**
		Kansas	1	0	0	0	0	1	**2**
		Minnesota	0	0	0	0	1	0	**1**
		New Mexico	0	0	0	0	0	1	**1**
		Ohio	0	0	0	0	0	3	**3**
		Utah	0	0	0	0	1	0	**1**
	IU Methodist Family Medicine Residency, Indianapolis	Colorado	0	0	0	1	0	0	**1**
		Florida	0	0	0	0	0	1	**1**
		Illinois	1	0	0	1	0	0	**2**
		Indiana	4	7	7	5	6	2	**31**
		Kansas	0	0	0	0	0	1	**1**
		Kentucky	0	0	0	1	0	0	**1**
		Maryland	1	0	0	0	0	0	**1**
		Nevada	0	0	0	0	0	2	**2**
		New York	1	0	0	0	0	0	**1**
		Ohio	0	0	0	0	1	1	**2**
		Oregon	0	0	1	0	0	0	**1**
		Tennessee	0	0	1	0	1	0	**2**
		Washington	0	0	0	1	0	0	**1**
		Canada	1	0	0	0	0	4	**5**
	St. Vincent Family Medicine Residency, Indianapolis	Georgia	0	0	0	1	1	0	**2**
		Illinois	0	0	0	0	1	0	**1**
		Indiana	6	0	4	6	6	3	**25**
		Iowa	0	0	0	0	0	1	**1**
		Kentucky	0	0	0	0	1	0	**1**
		Michigan	0	2	0	0	0	0	**2**
		Minnesota	0	1	0	0	0	0	**1**
		Missouri	0	1	0	0	0	0	**1**
		North Carolina	0	0	0	0	1	0	**1**
		Ohio	0	1	1	1	0	1	**4**
		Tennessee	0	0	1	0	0	0	**1**
	Community Westview Osteopathic FM Residency at CHN, Speedway	Indiana	1	1	3	3	2	1	**11**
		Kentucky	0	0	0	0	1	1	**2**
		Michigan	0	0	0	0	0	1	**1**
		North Carolina	0	0	0	0	0	1	**1**
		Washington	0	1	0	0	0	0	**1**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Saint Joseph	Memorial Hospital of South Bend	Delaware	0	0	0	0	1	0	**1**
		Florida	0	0	0	2	0	0	**2**
		Illinois	1	0	0	0	0	1	**2**
		Indiana	6	4	5	6	5	3	**29**
		Iowa	0	0	0	0	1	1	**2**
		Kansas	0	0	0	0	0	1	**1**
		Michigan	0	0	0	1	0	2	**3**
		Missouri	0	0	0	0	1	0	**1**
		Montana	0	0	0	1	0	0	**1**
		North Dakota	0	0	1	0	0	0	**1**
		Ohio	0	0	0	0	0	1	**1**
	St. Joseph Regional Medical Center, South Bend	Arizona	0	0	0	0	1	0	**1**
		California	0	0	1	0	0	0	**1**
		Delaware	0	0	0	0	0	1	**1**
		Illinois	0	0	0	0	2	0	**2**
		Indiana	3	2	3	4	3	6	**21**
		Iowa	0	0	0	0	1	0	**1**
		Kentucky	0	1	0	1	0	0	**2**
		Massachusetts	0	0	0	1	0	0	**1**
		Michigan	0	1	0	0	0	0	**1**
		New Mexico	0	0	0	0	0	1	**1**
		North Dakota	0	0	0	2	0	0	**2**
		Ohio	1	0	2	0	1	0	**4**
		Oregon	1	0	0	0	0	0	**1**
		Pennsylvania	0	0	0	1	0	0	**1**
		Virginia	0	0	1	0	0	1	**2**

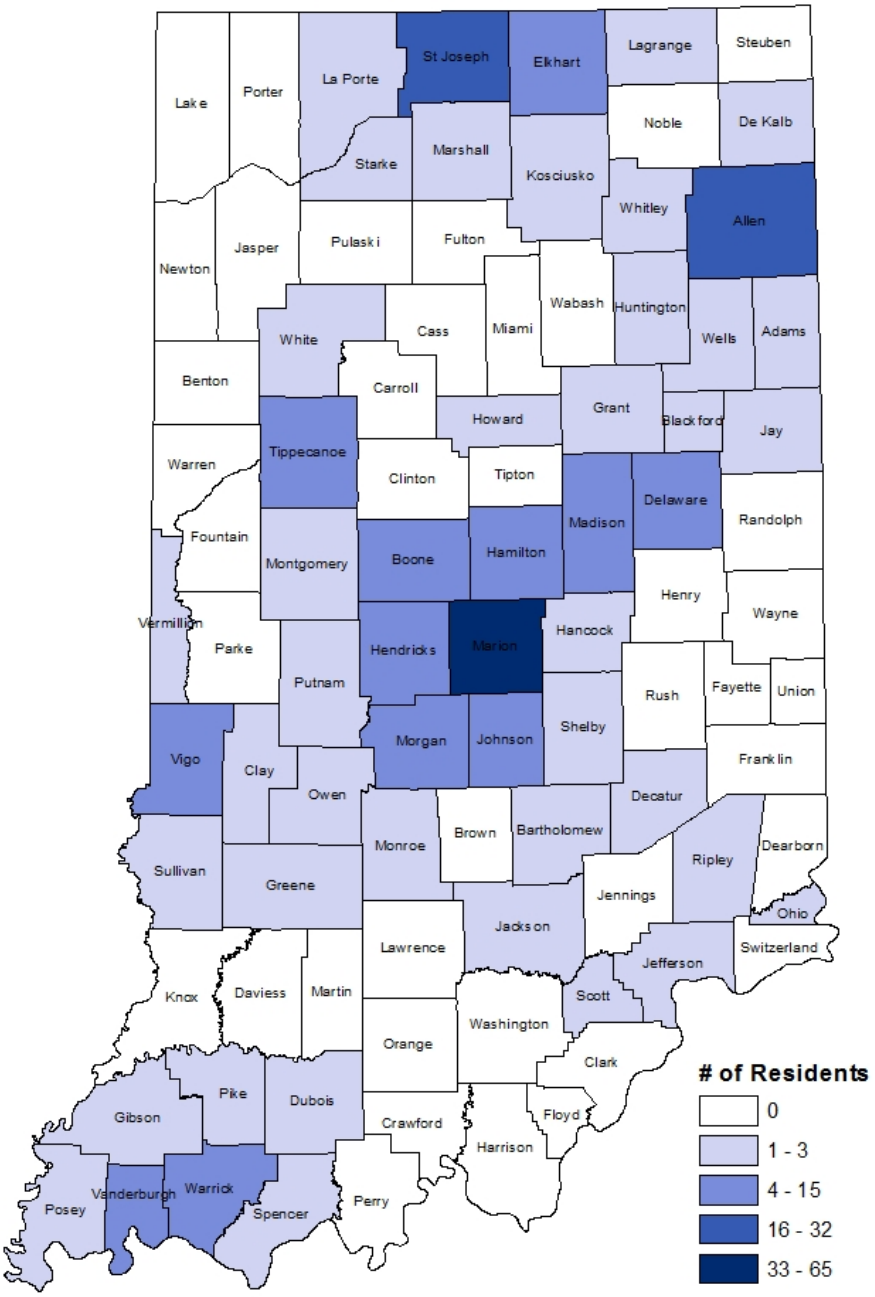
County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Vanderburgh	Deaconess Family Medicine Residency, Evansville	Illinois	0	1	2	1	1	0	**5**
		Indiana	1	4	3	4	5	6	**23**
		Kentucky	2	0	0	0	0	0	**2**
		Louisiana	0	0	1	0	0	0	**1**
		Missouri	0	0	0	1	0	0	**1**
		North Carolina	1	0	0	0	0	0	**1**
		Oregon	0	0	0	0	0	1	**1**
		Wisconsin	1	0	0	0	0	1	**2**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Vigo	Union Hospital Family Medicine Residency, Terre Haute	California	0	0	0	0	1	0	**1**
		Florida	0	0	0	1	0	0	**1**
		Illinois	1	0	4	1	0	2	**8**
		Indiana	2	0	2	0	3	5	**12**
		Kentucky	0	0	0	0	1	0	**1**
		Massachusetts	0	0	0	1	0	0	**1**
		North Dakota	1	0	0	0	0	0	**1**
		Ohio	0	1	1	0	1	0	**3**
		Oklahoma	0	2	0	0	0	0	**2**
		Pennsylvania	0	0	0	1	0	0	**1**
		Wisconsin	0	0	0	0	1	0	**1**

Table 6.1 shows the Indiana family medicine survey respondents' residency site and their primary locations after completing training within United States. The table shows a breakdown by state of where the respondents were going after completing their training from 2012 to 2017.

In 2017, eighty-four respondents listed *both*, their family medicine residency site as well as their primary location after training. A majority of the respondents planned to choose Indiana as their primary location after training, followed by Ohio (n=8), Illinois (n=4), Kansas (n=3), Michigan (n=3), and Virginia (n=3).

Map 6.2: Primary IN Locations of Indiana Family Medicine Residents after Completing Training, 2012-2017



Map 6.2 depicts the *2012 to 2017 trends* showing Indiana family medicine survey respondents' residency site and their primary locations after completing training within Indiana. This map includes all respondents who indicated a primary location after completing their training. Data analysis was performed using geographic information mapping software, *ArcGIS 10.5*.

Table 6.2: Primary Location in Indiana after Completing Training									
County	**Family Medicine Residency Program**	**Location after Training**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**
Allen	Fort Wayne Medical Education Program, Fort Wayne	Adams	1	0	0	0	0	0	**1**
		Allen	2	0	1	6	1	3	**13**
		DeKalb	0	0	0	0	0	1	**1**
		Huntington	0	0	0	0	1	1	**2**
		Marion	0	3	0	0	0	0	**3**
		Putnam	0	0	0	0	1	0	**1**
		Shelby	0	0	0	1	0	0	**1**
		Vanderburgh	0	0	0	0	2	0	**2**
		Wells	0	0	0	1	2	0	**3**
		Whitley	1	0	1	0	0	0	**2**

County	**Family Medicine Residency Program**	**Location after Training**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**Total**
Delaware	IU Health Ball Memorial Hospital, Muncie	Allen	0	0	0	0	0	1	**1**
		Delaware	1	0	1	2	0	0	**4**
		Grant	0	0	0	0	1	0	**1**
		Hamilton	0	0	0	0	1	0	**1**
		Hancock	0	0	0	0	0	1	**1**
		Hendricks	0	1	0	0	0	0	**1**
		Howard	0	0	0	0	1	0	**1**
		Jay	0	0	0	0	2	0	**2**
		Johnson	0	2	0	0	0	0	**2**
		Madison	0	0	0	0	1	0	**1**
		Marion	0	0	0	1	0	1	**2**
		Morgan	0	1	0	0	0	0	**1**
		Putnam	0	0	0	1	0	0	**1**
		Scott	0	0	0	0	0	1	**1**
		Spencer	0	0	0	1	0	0	**1**
		Tippecanoe	0	0	0	0	0	1	**1**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Marion	Community Hospital East FM Residency at CHN, Indianapolis	Hamilton	1	0	0	0	1	1	**3**
		Johnson	0	0	1	1	1	0	**3**
		Madison	0	0	0	1	1	0	**2**
		Marion	2	0	1	3	4	0	**10**
		Ohio	0	0	1	0	0	0	**1**
		Owen	0	0	0	0	0	1	**1**
		Saint Joseph	0	0	1	0	0	1	**2**
	Franciscan Health Indianapolis Family Medicine Residency, Indianapolis	Allen	0	0	1	0	0	0	**1**
		Bartholomew	0	0	0	0	1	0	**1**
		Boone	0	0	0	0	1	0	**1**
		Hamilton	0	1	0	0	0	0	**1**
		Hendricks	0	0	1	0	0	0	**1**
		Howard	0	1	0	0	0	0	**1**
		Johnson	1	0	1	0	1	0	**3**
		Marion	2	3	2	3	2	0	**12**
		Morgan	0	0	0	2	0	1	**3**
		Putnam	0	1	0	0	0	0	**1**
		Ripley	0	0	1	0	0	1	**2**
		White	1	0	0	0	0	0	**1**
	IU Methodist Family Medicine Residency, Indianapolis	Bartholomew	0	1	0	0	0	0	**1**
		Blackford	0	1	0	0	0	0	**1**
		Boone	0	1	0	0	0	0	**1**
		Delaware	0	2	0	0	0	0	**2**
		Hamilton	0	0	0	0	1	0	**1**
		Howard	0	0	1	0	0	0	**1**
		Marion	4	1	1	5	2	2	**15**
		Monroe	0	1	0	0	0	0	**1**
		Montgomery	0	0	1	0	1	0	**2**
		Starke	0	0	1	0	0	0	**1**
		Tippecanoe	0	0	0	0	2	0	**2**
	St. Vincent Family Medicine Residency, Indianapolis	Boone	0	0	0	0	1	0	**1**
		Hamilton	0	0	0	2	1	0	**3**
		Hendricks	1	0	0	0	1	0	**2**
		Jefferson	0	0	0	0	0	1	**1**
		Kosciusko	0	0	1	0	0	0	**1**
		Madison	1	0	0	1	0	0	**2**
		Marion	4	0	3	3	3	1	**14**
		Tippecanoe	0	0	0	0	0	1	**1**
	Community Westview Osteopathic FM Residency at CHN, Speedway	Decatur	1	0	0	0	0	0	**1**
		Hamilton	0	0	0	0	1	0	**1**
		Jackson	0	0	0	1	0	0	**1**
		Jefferson	0	0	1	0	0	0	**1**
		Madison	0	0	1	0	0	0	**1**
		Marion	0	0	0	2	1	1	**4**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Saint Joseph	Memorial Hospital of South Bend	Allen	0	0	0	0	0	1	**1**
		Boone	0	1	0	0	0	0	**1**
		Elkhart	0	0	0	1	2	0	**3**
		LaGrange	1	0	0	0	0	0	**1**
		Marion	0	1	0	0	0	0	**1**
		Marshall	0	1	0	0	0	0	**1**
		Saint Joseph	5	1	1	4	3	2	**16**
		Sullivan	0	0	0	1	0	0	**1**
	St. Joseph Regional Medical Center, South Bend	Boone	0	0	1	0	0	0	**1**
		Elkhart	0	0	0	0	1	1	**2**
		Greene	1	0	0	0	0	0	**1**
		Huntington	0	0	1	0	0	0	**1**
		LaPorte	0	0	0	1	0	0	**1**
		Marion	0	2	0	0	0	0	**2**
		Saint Joseph	2	0	2	3	2	4	**13**
		Tippecanoe	0	0	0	0	0	1	**1**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Vanderburgh	Deaconess Family Medicine Residency, Evansville	Dubois	0	0	0	1	0	0	**1**
		Gibson	1	0	0	0	0	0	**1**
		Hancock	0	0	0	1	1	0	**2**
		Marion	0	2	0	0	0	1	**3**
		Pike	0	0	1	0	0	0	**1**
		Posey	0	0	0	0	0	2	**2**
		Saint Joseph	0	1	0	0	0	0	**1**
		Vanderburgh	0	0	1	1	3	1	**6**
		Vigo	0	0	1	0	0	0	**1**
		Warrick	0	0	0	1	1	2	**4**
		White	0	1	0	0	0	0	**1**

County	Family Medicine Residency Program	Location after Training	2012	2013	2014	2015	2016	2017	Total
Vigo	Union Hospital Family Medicine Residency, Terre Haute	Allen	0	0	0	0	1	0	**1**
		Clay	1	0	0	0	0	0	**1**
		Greene	0	0	1	0	0	0	**1**
		Montgomery	1	0	0	0	0	0	**1**
		Vermillion	0	0	0	0	0	2	**2**
		Vigo	0	0	1	0	2	3	**6**

Table 6.2 shows the Indiana family medicine survey respondents' residency site and their primary locations after completing training within Indiana. The table shows a breakdown by county of where the respondents were going after completing their training from 2012 to 2017.

In 2017, eighty-four respondents listed *both*, their family medicine residency site as well as their primary location after training. A majority of the respondents planned to choose Indiana as their primary location after training. Of those respondents, nine planned to practice or stay in the central Indiana Metropolitan Statistical Area (Boone, Brown, Hamilton, Hancock, Hendricks, Johnson, Madison, Marion, Morgan, Putnam, Shelby)[6], followed by St. Joseph county (n=7), Allen county (n=5), Tippecanoe (n=3), and Vigo (n=3) counties.

[6] Indiana Core-Based Statistical Area and Maps. Retrieved October 6, 2017, from https://www2.census.gov/geo/maps/metroarea/stcbsa_pg/Feb2013/cbsa2013_IN.pdf

Chapter 7: Open-Ended Comments from Survey Respondents, 2012-2017

Since 2012, two-open ended questions have been asked on the *Indiana Family Medicine Residencies Exit Survey*©. These 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 as shown below.

Respondents' suggestions for improving the program

Didactics

2017

- Increased effort on part of the faculty to prepare formal didactic sessions. More focus on population health/PCMH.
- Re-organize curriculum for increasing residents.

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

2017

- More training on burn out.
- Eliminate OB required delivery number + continuity number's.
- Increase opportunity for office-based procedures, specifically getting us capabilities in the office for injections, prenatal office visits.

- Centering for prenatal care seemed to interfere with educational opportunities more than improve the overall educational experience so removing this would be beneficial.
- Centering pregnancy has been a disaster resulting in worse OB training for new residents and has left us uninformed about our complicated patients.
- Most family physicians could not incorporate centering into their practice so we need experience see prenatal PTs in our clinics. I am disappointed that I have missed these experiences.
- Add a FMC rotation (5 days/week of continuity clinic).
- More thorough EMR direct training, as opposed to learning from doing.
- Don't teach to the lowest common denominator - challenge bright residents.
- More diversity in the interest within family medicine for new faculty. We are too OB/women's health heavy.
- The longitudinal curriculum we have changes every year and many rotations feel diluted going intermittent half days. I feel because of this when I am with specialists that it is shadowing (like med school).
- Better or any diversity training - I've worked w/ residents that told me to stop acting like an angry black woman.
- We should de-emphasize OB as the majority of us will not be doing OB once we graduate.
- I would have wanted more autonomy on OB and experience being able to primary on C-sections as a resident.
- Area needs more specialists to work with.
- Improve relationships with specialists to improve opportunities for rotations.
- More opportunities to practice office based procedures and in clinic store often in first year residency.
- Keep it full spectrum!
- Keep full spectrum training as this is essential for rural medical care.
- More clinical work as interns.
- Division between in- and outpatient pediatric experiences.
- Would be nice to have interaction with other residents or faculty from other programs to better diversify our exposure to new ideas.
- More EMR access on electives.
- More outpatient procedural training.
- Increase availability of procedures.
- Have a book of electives to choose from.

- Adding US training.
- Would like more inpatient ICU focus. I feel adequately trained, but my interest is in ER medicine, and have primarily done my own thing to prepare, and have only had moderate input from our faculty. But clinic-wise, they've done a decent job teaching and I feel well prepared in that area.
- Need to help residents check out from electronic medical record.
- Residents are trained in clinic but not well trained in clinic procedures and are not well trained in OB, inpatient, casting, ER or urgent care. We don't have enough independence.
- We need more US experience, procedure inpatient and outpatient training.
- More OB and rural opportunities.
- More funding for procedural fairs (ie skin bx fair).
- Emphasis seems to be placed on learning by doing- we work hard and work often. Could shift this to a bit less of the 'learn by doing' model and a bit more structured education.
- Improve potential for continuity of care in the OP setting, decrease focus on IP and OB and strengthen basic OP care.

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, derm.
- 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 declining 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.
- Declining 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

2017

- Faculty need to teach more about practice and how they run.
- Diversity training for faculty is greater than hiring diverse faculty members.
- Diversity mainly amongst faculty.
- Faculty training - hiring faculty fresh out of residency w/ minimal preparation/clinical experience to teach.
- Diversity among staff - we have no minority attendings; in expressing concern, I have seen white attending express no concern or empathy.
- We MUST make hiring minority faculty our number one priority.
- Need faculty who are actually engaged. Director is not a natural leader and is a poor communicator. This has led to innumerable problems.
- Faculty needs to do more didactics, & more noon conference.
- Increase upper level and faculty involvement.
- At some point hiring a DO faculty member would be great as we start to have more DO students from Marian apply.
- We need more stability from staff but a lot of staff has left due to contracts with ascension health.
- More faculty presence on campus, more engaged program director.

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.
- More faculty
- Improve efficiency of the family medicine clinic.

General

2017

- Pay preceptors for rotations.
- Listen to the residents and do something when there are issues e.g. staff in office not doing jobs.
- More time off.
- Less concern/time spent on subjective dress/professionalism.
- More positive reinforcement.
- More community doctors willing to take residents on as learners.
- Skip centering.
- Stop centering as it is too disruptive to other resident clinical activities.
- I like centering for what PT's get out of it, but I thought it took away from resident's experience.
- Better train front office: Check-in + check-out.
- Stricter clinic scheduling protocols to get patients into more appropriate clinics and minimize chronic issues being seen in acute clinics.
- Current hospitalist rotations should be addressed.
- Due to needing additional inpatient encounters, there was "note churning" with many notes on the same patient in a day sometimes with minimal or no staffing with faculty or hospitalist attending.
- If our clinic is considered part of the hospital (but is physically across the street) does that count as "on-site" supervision of 1st years?
- Improving clinic stuff and improving the flow in clinic.
- More staff in the clinic. More trained nurses and better work flow. Although this is always being worked on. Continued improvement.

- Happy customer.
- Very good program.
- This program is amazing. I am blessed to be a part of it.
- Reduce hours, more supportive approach to resident evaluations.
- Better communication between faculty + residents.
- I feel like often resident suggestions for changes are not taken seriously.
- There have been way too many changes recently.
- We are in grave need of professionalism. Residents are rude, and distinctly inappropriate for a physician. I truly felt like I was in grade school again and couldn't leave secondary to contract.
- Expectations should be equal for all residents.
- Strong retention program for hired/struggling residents is better than firing only in extreme circumstances.
- Faculty + residents treating each other with respect.
- Fairness of the rules + regulations for all residents. We all should be held to the same standards + expectations.
- Feedback - staff will talk terrible about you to your advisor and cohort and then not say a word to your face.
- Feedback needs to be given at the time, not weeks/after.
- Continue growing and changing with input from the residents.
- Exercise program/gym at or assoc. w/ hospital.
- Add an 8th resident.
- Our program grows around the residents and has always adapted to my goals.
- Our monthly rotation evals and program improvement committee actives work to make any good adjustments we suggest.
- Very happy with the program.
- Better communication between residents and directors.
- Better constructive criticism from advisors-- need more positive feedback along with areas for improvements. Meetings often left me depressed, tearful, and dreading future encounters.
- Less red tape.
- Increase community medicine staffing doctors.
- Need better inpatient relationship w/IIMC.
- OD efficiency needs to be addressed.

- RN/MA work ethic & how they treat the residents/staff (Rieser and E. Billington) needs to be addressed as that was unacceptable.
- More frequent check in to have residents on track for licensure, boards, etc.
- Increased mentoring of interns- Have seen in other years that they need more hand-holding.
- Have the attendings listen to residents more without trying to fix everything.
- Have pediatrics attendings not treat us like kids.
- Burn-out could be better addressed/prevented- for example, increasing support/resources so that resident involvement in clinical tasks is minimal and we can focus on patient care and education.
- The clinic workflow could be streamlined somewhat.
- Need more help balancing the work/life balance.
- Medical students and high school students make learning very difficult when Marion came to St Vincent. It's hard to get rotations that you need for training when attending has so many learners.
- Assistance with paperwork, RAF sheets should be completed by ancillary staff.

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.

Residents' areas for the new curriculum

Didactics

2017

- Improved, evidence based learning.
- Improved lectures from specialists.
- More conferences from primary care physicians.
- Would like noon conferences to be given by more family physicians and less specialists.
- More formal didactics on inpatient service.
- DOs teaching OMT and musculoskeletal exam to MDs.
- Need better didactics.
- More inpatient medicine topics a priority during didactics. Less focus on insurance consultants.
- Doesn't need to be 'new' just tightened up- more organized didactic sessions, could certainly use more education emphasis during rotations like pain medicine, OB clinic, etc.
- More emphasis on didactics curriculum for OP management.
- Organized didactics with known schedules.
- Faculty involvement in didactics along with outside speakers.

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

2017

- Rural track for CHS. Outdoor/wilderness medicine.
- OB for the CHS residents (continuity patients).
- Adolescent health.
- Improvement in coding and billing on both the inpatient and outpatient side to help more after graduation.
- Increase billing/reimbursement education.
- It would be nice if specific tracks could be made to allow residents to obtain more experiences they would like to focus their future practice. For example, allowing for more inpatient experience or OB experience or peds.
- Continue to offer OB and osteopathic training - but find ways to enhance them (ie hospital w/ greater OB exposure- more hands-on OMT practical experience).
- More structured ultrasound and procedures curriculum.
- Ultrasound training (already in process).
- I think palliative medicine, something we can fellow in, should become a more required/prevalent topic/rotation.
- Endocrinology - more exposure to diabetes/insulin management in addition to other disorders (PWS, adrenal dysfunction, etc).
- More ICU time, more OB inpatient time, more ED time. But overall a well-balanced curriculum.
- Full spectrum contraceptive training.
- Sports med v/s
- Population health.
- PCMH training.
- Diversity training.
- Cultural competency.
- Rural medicine.
- Use of US in clinic for MSK, RUQ exams, OB.
- Dedicated, annual diversity training.
- Wound care - we get no training in this.
- Wound care.
- Would like additional training with suburban/wealthy patient population.

- Opportunities for care of intellectual/developmental disability.
- Disability education for residents.
- Nursing home management, Palliative/Hospice Care.
- Wilderness Med.
- Please continue global health!
- Stronger global health track.
- More inpatient experience.
- Ultrasound POC in outpatient and inpatient settings.
- Neonatal resuscitation experience- newborn nursery experience in 1st year. Working at deliveries to assess infants.
- Perhaps continue to increase underserved/rural training.
- Add an elective or make some ambulatory numbers at an FQHC or a rural health clinic.
- Procedure rotation to increase procedures.
- Better inpatient.
- Hands-on procedural workshops in our clinic.
- More case presentations by residents and faculty.
- More rural opportunities.
- Integrative medicine.
- More OB procedure training and supplies.
- Need more OB training- hands on maybe at rural location.
- More US training for injections and OB US (ultrasound).
- Too much OB care allow residents to decide.

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

2017

- Direct primary care.
- Concierge.
- Advocacy opportunities.
- Practice mgmt.
- Sports medicine track vs Fellowship. Though we claim to have a sports med track, we truly do NOT!
- More ways to help improve competent residents + continue to make team better as they continuously meet expectations
- Consistency with rotation set up.
- Improved health/wellness.
- True dedicated time for retreat. We are required on our day off to go and then go back to work the next day on high week work hrs.
- New faculty from other areas.
- New leadership.
- Better advisor/advisee relationship.
- Would like more responsibility in some rotations (writing more notes and doing less shadowing).
- Have more suggested electives to choose from based on tracks.
- I struggle with standardized tests. My program referred me to someone to help but it was too expensive. I feel I was on my own to study for boards.
- Have faculty that have greater clinical skills in OB, inpatient care, colonoscopies, casting, procedural care.
- The clinic needs to be efficient.
- Residents need staff to be more empathetic.
- More autonomy with schedule and care rotation/ more flexibility with "tracts".
- Can't think of any.

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: *2017 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
   - ☐ Other (please specify): _____

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. What do you consider your hometown? (e.g., Indianapolis, IN 46202)
   - ☐ City _____ State _____ Zip code _____
   - ☐ Outside of US

6a. Where was the high school located from which you graduated? (e.g., Indianapolis, IN)
   - ☐ City _____ State _____
   - ☐ Outside of U.S.

6b. Where was the college located from which you graduated? (e.g., Indianapolis, IN)
   - ☐ City _____ 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.

If you ATTENDED Indiana University School of Medicine:

7a. In which campus did you begin your first year?

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

7b. At which Family Medicine residency program did you complete your 3rd year required Family Medicine rotation?

- ☐ Community Hospital East, Indianapolis
- ☐ Deaconess Family Medicine Residency, Evansville
- ☐ Fort Wayne Medical Education Program, Fort Wayne
- ☐ Indiana University Health Ball Memorial Hospital, Muncie
- ☐ Indiana University Methodist Family Medicine Residency, Indianapolis
- ☐ Memorial Hospital of South Bend
- ☐ Franciscan Health, Indianapolis
- ☐ St. Joseph Regional Medical Center, Mishawaka
- ☐ St. Vincent Family Medicine Residency, Indianapolis
- ☐ Union Hospital, Terre Haute
- ☐ Community Westview Osteopathic, Indianapolis
- ☐ Other (please specify): _____

7c. Did you experience a 4th year elective or student externship experience at any of the following sites?

- ☐ Community Hospital East, Indianapolis
- ☐ Deaconess Family Medicine Residency, Evansville
- ☐ Fort Wayne Medical Education Program, Fort Wayne
- ☐ Indiana University Health Ball Memorial Hospital, Muncie
- ☐ Indiana University Methodist Family Medicine Residency, Indianapolis
- ☐ Memorial Hospital of South Bend
- ☐ Franciscan Health, Indianapolis
- ☐ St. Joseph Regional Medical Center, Mishawaka
- ☐ St. Vincent Family Medicine Residency, Indianapolis
- ☐ Union Hospital, Terre Haute
- ☐ Community Westview Osteopathic, Indianapolis
- ☐ Other (please specify): _____

8a. What is <u>your</u> 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 - $499,999
- ☐ $500,000 and over

8b. Considering others in your household, what is the current <u>total</u> 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 - $499,999
- ☐ $500,000 and over

9. What do you consider yourself? **Please mark ALL that apply.**

- ☐ First generation learner (e.g., first to go to college)
- ☐ Learner from a rural area (e.g., area located outside a Metropolitan Statistical Area)
- ☐ Economically or educationally disadvantaged (e.g., someone who is placed at special risk by socioeconomic and educational background)
- ☐ None of the above

10. What do you expect to be doing <u>after</u> completion of your current residency or fellowship program? **Please mark only ONE option.**

- ☐ Patient Care or Clinical Practice (in Non-Training position)
- ☐ Fellowship or Additional Subspecialty Training (please specify): _____
- ☐ Military
- ☐ Non Patient Care-based activities (e.g., research, administration)
- ☐ Temporarily Out of Medicine
- ☐ Other (please specify): _____
- ☐ Undecided or Don't know yet

11. 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

12a. 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

12b. What is the name and address of your principal work location after completing your current residency or fellowship 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 21.

PRACTICE CHARACTERISTICS:

13. 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): _____

14. 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

15. 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): _____

16. 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): _____

17. 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): _____

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

☐ Less than $100,000
☐ $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 - $499,999
☐ $500,000 or more

19a. 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

19b. 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

20. 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:

21. 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

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

23a. In your residency or fellowship program, did you receive training to serve the:	Yes	No
i. Rural population	☐	☐
ii. Underserved population	☐	☐

23b. How competent do you feel providing care to the:	Fully	Partially	Not at all
i. Rural population	☐	☐	☐
ii. Underserved population	☐	☐	☐

CLINICAL LEARNING ENVIRONMENT:

24. In your residency program, did you:	Yes	No
a. Provide care as part of a multi-disciplinary inter-professional team?	☐	☐
b. Participate in a quality improvement project to improve health outcome?	☐	☐
c. Participate in a patient safety project?	☐	☐
d. Have an opportunity to serve on a hospital-based committee or council?	☐	☐
e. Have an opportunity to participate in a cultural competency or diversity training?	☐	☐

25. How competent do you feel in communicating with team members in the hand-off process?

- ☐ Very competent
- ☐ Competent
- ☐ Neutral
- ☐ Incompetent
- ☐ Very incompetent

PROGRAM QUALITY:

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

- ☐ Excellent
- ☐ Above average
- ☐ Average
- ☐ Below average
- ☐ Extremely poor

27a. 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

27b. 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

***QUALITY OF LIFE*:**

28. At this time, I feel…	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a. Physically "burnt out" from my work	☐	☐	☐	☐	☐
b. Emotionally "burnt out" from my work	☐	☐	☐	☐	☐

29. I have resources readily available to maintain my wellness

- ☐ Strongly agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

30. I would rate the overall:	Very good	Good	Fair	Poor	Very poor
a. Balance between my personal and professional life as…	☐	☐	☐	☐	☐
b. Quality of my life as…	☐	☐	☐	☐	☐

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 2017 Indiana Family Medicine Residencies Exit Survey!

Appendix B: Survey Response Rates, 2012-2017

Residency Program	IMEB Surveys Distributed and Completed											
	2012		2013		2014		2015		2016		2017	
	Distributed	Completed	Distributed	Completed	Distributed	Completed	Distributed	Completed	Distributed	Completed	Distributed	Completed
Community Hospital East	7	7	6	6	8	8	8	8	10	10	9	9
Deaconess Family Medicine Residency	5	5	6	6	6	6	6	6	6	6	8	8
Franciscan Health	6	6	6	6	7	7	7	7	7	7	8	8
Ft Wayne Medical Education Program	10	9	10	10	10	10	10	10	10	10	10	10
IU Methodist Family Medicine Residency	10	10	10	10	11	11	14	14	10	10	10	10
IU Health Ball Memorial Hospital	8	8	7	7	8	8	8	8	14	14	13	13
Memorial Hospital of South Bend	8	8	8	8	6	6	10	10	9	9	9	9
St. Joseph Regional Medical Center	7	7	8	8	8	8	9	9	9	9	9	9
St. Vincent Family Medicine Residency	10	10	8	8	7	7	9	9	10	10	9	9
Union Hospital	6	6	5	5	7	7	7	7	7	7	7	7
Community Westview Osteopathic	1	1	2	2	4	4	4	4	4	4	4	4
Total	**78**	**77**	**76**	**76**	**82**	**82**	**92**	**92**	**96**	**96**	**96**	**96**
Response Rate	**98.7%**		**100.0%**		**100.0%**		**100.0%**		**100.0%**		**100.0%**	