

A Flexible, Part Time Hospitalist Work Schedule: Just What the “Millennial” Doctor Ordered

Exploratory Paper

Submission Date: July 27, 2017

This paper is being submitted in partial fulfillment of the requirements for election to Fellow in the American College of Medical Practice Executives.

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Hospital Medicine developed approximately 30 years ago as a means to provide 24 hour care for hospitalized patients. It has challenged healthcare managers to design staffing schedules that provide continual hospital coverage. With Baby Boomer physicians retiring at an extraordinary rate and Millennials entering the workforce, novel approaches to staffing will be necessary to address their unique concerns and battle physician burnout.

The focus of this Exploratory Paper is to outline a staffing plan that was designed to be flexible and to include part time physician coverage to better address the needs of the millennial generation. It will begin by exploring how the current staffing patterns evolved and how changes in the healthcare environment are challenging healthcare managers to examine novel staffing patterns in an effort to improve the recruitment and retention of hospitalists. A staffing plan will then be modeled, taking into account how the team of providers was created, how the shift length was determined and how part time physician employment was defined.

This paper will challenge the theory that quality of patient care can only be achieved through continuity of care. Instead, quality of care will be accomplished through a redesign of patient handoff procedures as recommended by the Joint Commission, a private, not for profit organization who voluntarily evaluates and accredits health care systems. By adjusting staffing patterns to fit physicians’ lifestyles, inpatient healthcare managers will improve their recruitment and retention of hospitalists without sacrificing patient satisfaction and quality of care. Personal experience, as well as an extensive literature search will be the methodology utilized in support of the text. A case study of a medium sized community hospital will be included and the paper will conclude with an overview of the successes and challenges associated with the implementation of the plan.

Evolution of Hospital Medicine

Since the mid 1980's Hospital Medicine has emerged as a new medical specialty devoted to the needs of acutely ill patients in an inpatient hospital setting. Providing quality patient care 24 hours a day required a clinical work schedule that addressed both the needs of the staff, as well as that of the patient. Continuity of patient care, defined as "a single physician assuming responsibility for the care of an individual patient" (Blecker, 2014) could be achieved with fewer patient handoffs, or transfers of patient care between providers. This quest to improve the continuity of care may have contributed to the development of 12 hour shift work for providers. Additionally, a provider schedule that allowed for a 7 day work week, followed by 7 days off service, would further reduce handoffs between physicians.

This "7 on, 7 off" staffing paradigm has been the "Golden Standard" for hospitalists for decades. However, with the influx of a younger generation of millennial physicians, who have increasingly different work ethics and values than previous generations, will this staffing pattern persist? Furthermore, will the quality of patient care be impacted if that care is more discontinuous between inpatient providers?

Reasons for Hospitalist Program Development

Hospital Medicine is a medical specialty that utilizes hospitalists as the admitting and attending physicians in an inpatient hospital setting. Previously, these responsibilities were primarily held by the patient's Primary Care Provider (PCP.) The main driver of this shift was pressure from the PCPs to practice strictly in an outpatient setting. John Ratelle, MD, et al, believe that it "evolved out of a health care need for increased availability and access to primary care physicians, as well as a goal to improve efficacy and quality of care for increasingly complex hospitalized patients" (Ratelle, 2014.)

The addition of hospitalists not only allowed PCPs to focus on building their outpatient practices, but it also satisfactorily bridged the gap for hospitalized patients who did not have a PCP. Previously, hospitals struggled with assigning providers to admit and care for these “uncovered patients” (Vasilevskis, 2009) without a Primary Care Physician.

The utilization of hospitalists also allowed for greater quality of service with a decrease in overall cost. A large body of historical literature on the subject also shows a correlation between improved quality and the continuity of patient care (Chandra, 2012.) Hence, it is not surprising that a staffing model for hospitalists has developed, such as the “7 on, 7 off” model, which minimizes the number of patient handoffs to physicians across the inpatient length of stay.

A Need for Continuity of Patient Care Leads to Current Staffing Patterns

In addition to improved quality, Blecker, et al, found that inpatient length of stay could be shortened “if a single physician assumes continued responsibility for the care of an individual patient” (Blecker, 2014, 530.) Their study proved that when additional physicians cross-covered patients, primarily to assist for weekend coverage, that the length of stay increased. This increase was attributed to delays in medical decision-making, diagnoses and treatment, due to the additional doctors involved with the patient care. Increased length of stay also negatively impacts hospital revenue and adversely affects patient satisfaction.

At a time when “payers and policymakers are increasingly holding hospitals accountable for patients’ experiences with their care” (Chen, 2013) it is paramount that hospital systems address patient satisfaction concerns. A study conducted by Dr. Lena Chen found that hospitals that utilize hospitalist programs scored higher on patient satisfaction surveys. Patients were particularly impressed with the round the clock coverage they received from the service, as well as the quality of the discharge planning.

Staffing models were developed as a result of the data confirming that decreasing the number of physicians attending on a hospitalized patient decreases length of stay, increases patient satisfaction and improves quality. Twelve-hour shifts allowed for merely one transfer of care in a 24-hour period and a 7-day workweek meant that most patients would be cared for by one attending physician during their hospitalization. This staffing pattern has steadily remained as a standard since the inception of Hospital Medicine as a specialty.

New Challenges for Hospital Medicine

The modern healthcare environment is facing a new challenge to the accepted staffing paradigm. A physician shortage, coupled with the influx of millennial physicians, has made it more difficult to recruit and retain hospitalists. Millennials, defined as those born in the mid 1980's through the present, currently represent approximately 1/3 of the American workforce and outnumber both the "Generation X" and "Baby Boomer" generations. In contrast to previous generations, Millennials put a greater emphasis on work-family life balance and are more inclined to leave a job if they are dissatisfied. It is clear that healthcare managers will need to address these increasingly common concerns in order to successfully staff their hospitalist programs.

Physician Shortage

The Baby Boomer physicians are beginning to retire at a time when their own generation will begin needing greater medical care. This gap in physician coverage is compounded by the fact that "only 10% of all graduating Internal Medicine residents will go into a career in Hospital Medicine" (Ratelle, 2014, 1029.) This number is getting even smaller due to the larger number of residents pursuing fellowships following residency.

Dr. Eduard Vasilevskis further warns that "policymakers will need to consider the supply of physicians necessary to meet the present and, likely, future demand for hospitalists. This is

especially important in light of recent evidence of continued decreasing interest in general internal medicine, the main pool from which hospitalists are drawn” (Vasilevskis, 2009, 8.)

Those residents who do pursue a career in Hospital Medicine will be challenged with providing 24-hour care for an increasingly more acutely ill population of inpatients. The demands of working 7 twelve-hour shifts in a row may lead to fatigue, decreased quality of sleep and may impact their personal relationships. These deterrents and more may help to explain the high turnover rate seen in Hospital Medicine.

Prolonged fatigue and depression may also lead to physician burnout. Physician burnout is described as an overwhelming feeling of emotional exhaustion leading to a lack of empathy for patients. Physicians, who once felt as though they were making a difference in society, now struggle to see the positive impact of their work. Ironically, many providers react by working longer hours and holding themselves to a level of perfection that can never be attained. This cycle continues in an inevitable downward spiral that ends in a “reduced work effort, leaving their clinical situation, or abandoning direct patient care altogether” (Hinami, 2011.) In a study of the work-life satisfaction amongst hospitalists, burnout symptoms were reported in nearly 30% of those surveyed (Ibid.) It is anticipated that during the physician shortage, hospitalists will be pushed to their limits to provide coverage for the growing inpatient population, putting them at even greater risk of burnout and without relief from new hires.

Millennials Join the Physician Workforce

Jeffrey Bendix, in his online article entitled Millennials in Medicine, “ascribes the interest in work-life balance among Millennials to be a growing awareness of, and a desire to avoid, burnout” (Bendix, 2015.) He goes on to show that they hope to attain this through employment opportunities that support part time employment as well as flexibility in scheduling.

In addition to avoiding burnout, a study that followed physicians' satisfaction levels seven years post-graduation, found that Millennials were not willing to sacrifice family life for a career. "These findings reflect the change in lifestyle aspired to by the younger generation of physicians: they want medical careers and working practices organized in such a way as to enable them to lead a 'normal' life" (Buddeberg-Fischer, 2010.) They define a "normal life" as having a spouse or life partner, as well as children, and having personal time to enjoy a variety of hobbies. Unlike previous generations who sacrificed family life for a career in medicine, Millennials strive to blend career success with a satisfying home life. While "92% of Millennials say that it is important to strike a balance between work and personal and family responsibilities, only 65% felt that they have achieved it at this point in their careers" (Miller, 2017.)

Despite a higher debt burden, due to the rising costs of a medical education, Hinami, et al, found that Millennials find "current hospitalist work models to be less flexible in work hours than desired and that compensation has a relatively weak influence over global satisfaction" (Hinami, 2011, 33.) This provides a unique opportunity for healthcare managers to meet the Millennials' need for scheduling changes, with the potential to also positively impact their bottom line.

In sum, the new generation of American physicians entering the workforce is looking for a way to battle burnout by prioritizing outside interests and family life. They are interested in flexible, part time scheduling options despite the reduction in compensation that may result from these choices.

Hospital administrators and managers are also battling the effects that the physician shortage and burnout are having on their ability to adequately staff their hospitalist programs. Furthermore, a study conducted by Dr. Brian Drolet that studied patient's perceptions of physician fatigue, hours worked and continuity of care found that "patients may be less concerned

with transfers of care and loss of continuity than with (physician) fatigue” (Drolet, 2014.) By allowing a more flexible work schedule for hospitalists, physician burnout may be reduced and recruitment efforts may improve without sacrificing patient satisfaction.

Designing a Staffing Plan

In order to design a staffing plan that will allow a mixture of part time and full time employees, several components will need to be addressed. First, the pros and cons to including Nurse Practitioners and Physician Assistants as members of the Hospital Medicine team must be assessed. Secondly, the length of shifts and of part time workweeks must be defined. Finally, team communication should be addressed and patient care handoffs should be standardized to ensure success.

Creating the team

Some hospital systems primarily use physicians as hospitalists as opposed to complementing them with Nurse Practitioners or Physician Assistants, known as midlevel providers or advanced practitioners. The benefits to exclusively utilizing physicians include higher reimbursement from third party payers and less clinical restrictions. However, midlevel providers are allowed to practice medicine semi-autonomously with physician oversight in most states in America. While their reimbursement rates are lower than that of physicians, so is the cost of their compensation package, which may lead to a cost savings for some hospital systems.

Another benefit of adding midlevel providers to the Hospital Medicine team is that they often see the patient on a more continual basis and for longer periods of time than the physician hospitalists. A survey conducted by Dr. Charlie Wray in 2016 showed that the use of midlevels “improved patients’ rating of their overall care, and influenced their ability to understand their physicians’ role” (Wray, 2016.) This is of particular interest to hospital systems that struggle with patient satisfaction due to the community’s lack of knowledge or understanding on the benefits of

a Hospital Medicine program. In this case, the midlevel provider can provide information and answer questions regarding the importance of having a team of acute care specialists caring for a patient during their hospital stay.

The community hospital used as a case study for this paper chose to use midlevel providers to round on patients during the day shift. They care for patients, with physician oversight, and the charges are billed under their names. Press Ganey survey results show that both patient and associate satisfaction scores are high with both physicians and advanced practitioners working as hospitalists.

Looking at the length of shifts

While physician schedules have evolved to 12-hour shifts to ensure continual coverage with reduced patient handoffs, midlevel schedules have remained flexible. Many hospital systems allow midlevel shifts that are 8, 10 or 12 hours. This flexibility is likely due to the fact that the physician overseeing the coverage of a patient remains on service until later in the evening while the midlevel leaves earlier in the day, thus maintaining daily continuity of coverage between the two providers. Arora, et al, emphasizes “*team continuity must be prioritized over personal continuity between individual physicians and patients. One way to achieve this is to design a schedule that maximizes the amount of time during which someone from the primary team is present*” (Arora, 2011.)

Team continuity can be established by designing a provider schedule with midlevels working shorter days than their physician counterparts. This would allow them to work more days in a pay period. For example, a 40-hour midlevel workweek may consist of five 8-hour shifts or four 10-hour shifts, allowing them to work every week instead of every other week. Thus, in a hospital system that staffs physicians on a “7 on, 7 off” rotation, the midlevels would work with both physician teams. This is important for continuity of patient care because it means that while

a patient's physician may change during the week, they will likely see the same midlevel during the course of their stay and be more at ease with the consistency of staff. This will help to diminish the discontinuity of inpatient care that will result from adding part time physician coverage.

The case study hospital employs midlevels for 10-hour shifts. The providers are scheduled for eight 10-hour shifts per bi-weekly pay period and are expected to work one weekend per month. This allows more flexibility than requiring four 10-hour shifts per week and has been well received by staff.

The addition of midlevel providers to a Hospital Medicine team may also help to reduce the length of patient stay by improving the continuity of patient care. "Whereas a new hospitalist may feel uncomfortable discharging a patient that he/she is meeting for the first time, the hospitalist who has cared for a patient from admission onward can appreciate the progress and may have more confidence in discharging the patient as soon as it is appropriate to do so" (Chandra, 2012, 369.) Thus, while a physician hospitalist may be coming on service for the first day and apprehensive to discharge a patient that is new to them, a midlevel hospitalist will most likely be familiar with the patient, and thus more comfortable with the discharge.

Defining part time

The ideal adaptation for part time physician coverage, in a hospitalist program where "7 on, 7 off" physician coverage currently exists, is to have two physicians share a monthly rotation equally. This may be achieved by having one physician complete a 7-day rotation, followed by 7 days off, and then by having the second physician complete the same pattern. This would allow each physician to work only one 7-day rotation per month. Alternatively, two physicians may split a 7-day rotation in blocks of 3 or 4 shifts. These scheduling variations accommodate those physicians who find seven 12-hour shifts in a row to be too grueling.

Either pattern of part time staffing will seamlessly blend into the current “7 on, 7 off” scheduling pattern and both have proven successful in the case study’s hospitalist program. These changes to the staffing pattern will allow the healthcare manager the flexibility to offer both full time and part time options, thus improving their recruitment and retention capability.

Making it successful

Adding part time hospitalists to the staff does require adding additional patient care handoffs. In order to ensure that the quality of patient care is not compromised, it is imperative that the procedure for the handoff of patient care be well orchestrated. In 2006 the Joint Commission recommended that improving the effectiveness of communication among caregivers must be made a national patient safety goal (Arora, 2006.) Since that time, a great deal of research has surrounded the improvement of care transitions in the inpatient setting. A search of the current literature reveals several options for handoff design. Those healthcare systems seeking accreditation by the Joint Commission should consider implementing their SHARE handoff process and can benefit from the plethora of information found on their Transitions of Care (ToC) Portal (Joint Commission, 2017.)

Anytime a provider is transferring the care of a patient to another provider, a handoff of critical patient care information is required. In Hospital Medicine, handoffs occur when a provider has completed their daily shift or when a provider has completed their shift rotation and is going off service. These handoffs may be written, verbal, or have components of both. Many hospitals have Electronic Medical Records (EMRs) that assist in the transfer of patient care by allowing pertinent information to be accessed or printed for the incoming provider’s use. While this is not required, it proves to be a beneficial and effective handoff tool.

Vineet Arora, in her paper “A Model for Building a Standardized Hand-off Protocol,” urges healthcare managers to begin evaluating the effectiveness of their handoff process by first

creating a process map. To incorporate standardization, she also encourages managers to create a checklist for providers to follow. To ensure success, she suggests getting buy-in from leadership as well as from the providers, and then monitoring the process to confirm that the protocol is in place.

The previously referenced Joint Commission's SHARE handoff process, similarly to Arora's method, requires healthcare management to standardize and monitor the process. It expands upon that premise by adding additional categories. SHARE stands for "Standardize Critical Content," "Hardwire within Your System," "Allow Opportunity to ask Questions," "Reinforce Quality and Measurement" and "Educate and Coach."

"Standardizing Critical Content" includes stressing key information and critical elements of the patient care, synthesizing patient information from disparate sources and the development of key phrases for use during the handoff process. "Hardwiring within the System" not only includes the development and use of a standardized checklist, but also addressing the culture within the system. A successful handoff of patient care cannot be achieved in an environment where there are barriers to communication. Hence, providers are encouraged to clearly express their expectations and to focus on system issues as opposed to personal issues. Healthcare managers are called upon to provide their staff with a quiet setting that is conducive to information sharing amongst caregivers. Access to patient medical records and other data should be supplied as well, to keep all parties well informed and current.

Another important aspect of the team culture is the ability to freely ask questions and give input in a non-punitive environment. This is of particular concern when introducing midlevel providers to the team. It is vital that healthcare management impress upon the team that each member's input is valuable and makes the signoff successful. Physicians must be able to give, as well as take, advice from midlevel providers when appropriate. It is also beneficial to have all

providers include their contact information during the handoff so that the incoming provider can address questions to them directly.

“Reinforcing Quality and Measurement” includes demonstrating leadership’s commitment to a safe and successful handoff and instilling accountability for its success within the group. To ensure sustained success, metrics must be chosen and monitored, and education and coaching must occur to keep staff fully engaged.

The case study hospital system utilizes the Joint Commission’s SHARE handoff program. Verbal handoff is given between providers at the beginning and end of each shift. Midlevel providers attend the morning “signoff huddle” with the physicians and give a verbal handoff directly to their collaborating physician prior to going off shift. Written handoff is required of all providers and physicians prior to going off service and contact information for each provider must be included. These documents are distributed to the entire Hospital Medicine team electronically and a hard copy of the document is left in the hospitalist breakroom, where the “signoff huddle” is located.

Making successful staffing changes of this magnitude requires open and transparent communication with the team. It is best to have their input when designing the new staffing schedule and to give ample opportunities for them to give feedback throughout the process. Having a physician champion, such as the medical director of the program, may prove beneficial if there is resistance within the group. This buy-in can be a difficult process and inclusion is a key element for any group.

Expectations must be made clear and accountability must be established when onboarding part time physician candidates. For example, if physicians are allowed to work one week per month, it must be clear what the expectations are for the timely addressing of medical record queries during their absence. If there are questions pertaining to a patient’s medical record

or to billing, is the expectation that the physician address these queries from home? Will the medical director take responsibility for these questions for the off service physician? Processes to handle situations such as this must be established in order to ensure the success of the part time provider program.

The Mayo Clinic, recognizing midlevel providers as capable of filling the gap created by the physician shortage, designed a protocol driven onboarding program to address these needs. Their study has found that the use of midlevel providers requires “a structured orientation program, didactic support, hands-on learning, and professional growth opportunities” (Spychalla, 2014.) A standardized program, such as this one, that is designed to educate and support midlevels is pivotal to their success in a Hospital Medicine program and its design should be a priority of healthcare management.

To ensure that the introduction of a part time schedule has benefited both the program and the physician, it is imperative that follow up meetings are set up to monitor success. At a minimum, 30, 60 and 90-day post-onboarding assessments should be conducted by the administration or by human resources personnel, as appropriate in the healthcare system.

Analysis and Conclusion

“To further improve the overall value of in-patient care, many programs are testing new models of care delivery, such as adjusting provider schedules and incorporating advanced practitioners” (Bastian, 2014.) This is of particular importance given that fewer physicians are going into Hospital Medicine, physician burnout is on the rise and Baby Boomer physicians are retiring at record numbers. Millennial physicians, the largest section of the current employment pool, have verbalized their need for more personal time and a desire for part time hospitalist employment.

Successes of part time, flexible staffing

The introduction of part time hospitalist physicians improves physician recruitment by appealing to millennial providers. Furthermore, it reduces the risk for physician burnout by decreasing the number of shifts a provider is obligated to work. When coupled with the use of midlevel providers working shorter daily shifts, patient satisfaction increases and length of stay decreases. This is accomplished by having the midlevels cross-cover patients with whom they are familiar. Under these conditions, discharges will not be postponed due to delays in medical decision-making.

Improved recruitment reduces the Hospital Medicine division's usage of temporary staff, known as locum tenens providers, to fill open shifts. It is beneficial to reduce the usage of locum tenens staff because it reduces cost, improves employee engagement and has been shown to reduce the patient's length of stay.

This staffing plan was successfully implemented in a medium sized community hospital system. The quality of patient care was not compromised, despite increasing the number of patient handoffs between providers. This was made possible through the use of the Joint Commission's standardized handoff procedure known as the SHARE program.

Physician retention also improved with the addition of part time employment. Female physicians, who may have otherwise left after the birth of their children, have remained on staff. Male physicians have also chosen to work part time while caring for their young children. These providers are more energetic, engaged and bounce back more quickly than their peers following similar challenges. They are more inclined to attend educational seminars, sit on committees and volunteer for improvement projects. These unexpected benefits add value to the Hospital Medicine program, which, in turn, improves patient care.

Challenges of part time, flexible staffing

To successfully incorporate part time employment into an existing full time program, communication is vital. Differences in generational values are prevalent in Hospital Medicine. Physicians from previous generations idealize the embodiment of a “Super Doctor” who works long hours, ceaselessly caring for others. They may question the integrity of their millennial peers who do not outwardly “live and breathe” medicine. It is incumbent upon the healthcare management staff to bridge this gap by echoing the importance of “taking care of the care-taker.” For example, it may be beneficial to send physicians on a “Mindfulness Retreat”, where they can learn self-care techniques designed to reduce stress.

The management team should also communicate the importance of physicians holding positions on hospital committees and boards. Hospital Administration benefits tremendously from continuous input from the medical staff. While many part time physicians are more apt to attend these meetings, those physicians from the Baby Boomer generation and Generation X may not readily see their value. In their opinion, the physician’s time may be better spent taking care of patients. As such, they may regard their millennial peers as lazy, or shirking their clinical responsibilities for their committee participation.

Another concern that is introduced when increasing the number of physicians attending on a patient during a hospital stay is provider recognition. This is an issue because “patients who cannot identify their inpatient physicians may be more likely to suffer harm and may be unable to obtain answers to questions about their recent hospitalization after discharge” (Arora, 2009.) Several options to address this include the use of patient-centered business cards with photos and in-room white boards to improve physician identification. While these methods have been shown to have varying success, due mainly to noncompliance, Dr. Broderick-Forsgren believes that “making these tools available and providing low-cost physician training should increase

utilization of these tools, and through that, improve patients' identification of their physician" (Broderick-Forsgren, 2016.) This is an area where further study may be warranted.

In conclusion, through the development of Hospital Medicine as a medical specialty, staffing patterns were born that supported minimal handoffs of patient care between physicians. These staffing schedules have persisted for decades. However, recent changes have challenged healthcare management staff to examine novel ways of recruiting and retaining hospitalists. To appeal to a greater number of providers, a part time physician work schedule was developed and successfully implemented in a community hospital's Hospital Medicine program. With the addition of midlevel providers and a standardized handoff process, the program improved recruitment and retention without sacrificing patient satisfaction, quality of patient care or length of inpatient stay.

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