**Online Appendix**

**PHM Community Programs Study Questions**

The following questions are intended to gain an understanding of the common practices for staffing pediatric hospitalists in the community. This does not include hospitalists working at University/Children’s Hospital sites, but may include those affiliated with them.

**FTE**

1. What metric do you use to “count” FTE? Weeks? Shifts? Hours? Other
   1. Do you have a way of converting your metric to another (e.g. 1880 hours = 27 weeks)
2. Using that conversion, how many clinical hours are considered 1.0 FTE at your institution? (how many clinical hours would someone working only clinical work in one year)
3. What is a shift or day in that model? (e.g. 7a-5pm, 10h with three shifts, etc)
   1. Total hours per each “shift”
   2. How many total weekends for 1.0 FTE?
   3. Are any shifts weighted differently? (ex. weekends, holidays, acuity,etc..)

**Patient Volume**

1. What do you consider an appropriate upper limit of patient **morning** census for one hospitalist WITHOUT residents, NP/PA’s, or other physician extenders (regardless of the average census at your institution)?
   1. How many newborns per hospitalist (if all newborns)?
   2. How many pediatric patients per hospitalist (if all pediatrics)?
   3. Are there other clinical responsibilities at the same time in the morning per hospitalist?
   4. Do you have residents and/or physician extenders with the hospitalist on these clinical coverages?
2. Which of the following services do you cover?
   1. Pediatric floor patients (inpatient and observation)
   2. General newborn nursery/Level I NICU
   3. Special care nursery/Level II NICU
   4. Level III NICU
   5. Newborn Deliveries
   6. Sedation
   7. Mental health units
   8. ED consults
   9. ED/Urgent care primary coverage
   10. PICU care
   11. Step Down Unit
   12. Circumcision
   13. Other
3. Do you have a patient census cap on your teams? If so, what is it?
   1. If you do not have a patient cap, do you expand staffing in the busier seasons?
      1. How many months do you supply additional staffing?
      2. How did you determine the need for expanded staffing?
4. Do you have a back-up system for unexpected volume increases?
   1. What volume triggers the back-up?
   2. How do you reimburse for back-up?
5. Do your hospitalists take pager call overnight if not in house 24h?
   * 1. If so, how many days in a week and/or weeks per year?
     2. How are “on call” hrs credited (in full, half, partial, etc..)?

**Work Model** [All FTE questions in relation to time covered at COMMUNITY SITE ONLY]

1. What percentage of your hospitalists work the 1.0 clinical FTE you described?
2. What is the TOTAL % “buy-out” for non-clinical work of your whole program? (ex. If 2 staff with 0.5 “buy out” each in a total program of 10 FTE = 10% “buy out” (1.0/10))
   1. What % of staff have time bought out?
   2. Who pays for the non-clinical work (I.e. a university affiliated children's hospital vs adult hospital)
3. Do you or your hospitalists feel that your current full time clinical 1.0 FTE is an appropriate model in regards to minimizing burn out and attrition?
   1. If no, why not?
4. Who is the employer of your hospitalist staff?
   1. Regional/Community Hospital
   2. Children’s/University Hospital
   3. School of Medicine
   4. Independent company contracted by Children’s/University Hospital
   5. Private Organization (ie Pediatrix, Kaiser, etc..)
   6. Other (if more than one and/or not listed)