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D R A F T

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DATE: May 22, 2007

TO: Ayah Johnson, Ph.D., Chief, CHGME Branch, BHPr, HRSA

FROM: Pete Willson, Vice President for Public Policy, N.A.C.H.

SUBJECT: Recommendations for CHGME Reporting Requirements

Ayah, to help focus our own thinking and to provide suggestions for your consideration as you develop the instrument for the new CHGME reporting requirements under last year's reauthorization, we have developed a set of recommendations.

They include 1) a conceptual framework for the instrument, 2) a description of each data element, and 3) a sample survey instrument – all below. In a nutshell, these recommendations represent our attempt to translate what we understand the intent of the reporting requirements to be – to provide information that illustrates for Congress the benefit of CHGME without placing a reporting burden on the hospitals.

In particular, these recommendations also reflect our very clear understanding from Rep. Nathan Deal (R-GA), the author of the CHGME reauthorization, that the reported data are not to be audited, in the way that HRSA currently audits resident counts, and they are not to be rated in terms of good or bad performance.

We worked with The Lewin Group on the development of these recommendations and would be glad to talk with you or your colleagues about them. *Response: HRSA appreciates the submission by NACH and the opportunity to respond. The thought and effort put into NACH's comments are evident. HRSA particularly appreciates NACH's knowledge of pediatric GME training within children's hospitals. The following detailed responses to NACH's comments are made in a collaborative spirit. Any divergerence from NACH's suggestions are usually the result of HRSA's effort to carefully follow the explicit mandate set forth in the Children's Hospital GME Support Reauthorization Act of 2006 (Public Law 109-307).*

Background and Conceptual Context

The CHGME Payment Program was reauthorized by Congress and signed into law in September 2006. The reauthorization requires the Secretary to specify performance measures and other reporting requirements that must be filed by free standing children's hospitals annually beginning in FFY 2008. This memo presents a summary of measures and questions we recommend be considered for adoption in the first phase of a proposed two phase roll-out of the mandated annual data collection instrument.

Response: P. L. 109-307 (the CHGME reauthorization) does not ask for "performance measures" but rather for an annual report that provides

specific information regarding the previous academic year with the first report addressing all years of CHGME Payment Program funding. P.L. 109 – 307 specifies that this report be filed as an addendum to the children's hospitals application for CHGME funds, but the exact timing that such addendum must be filed is not specified.

The two-phase approach is designed to make the first year's data collection – phase I -- as burden free for hospitals as possible as part of the FY 2008 CHGME applications. Phase II would constitute subsequent years' data collections. This two-phase approach recognizes both the short period of time and the level of effort required for hospitals to collect data and submit a first annual report to HRSA that includes changes in residency training since the initial year each hospital received CHGME payment.

Response: HRSA appreciates the idea of a phased approach, but decided on a more pragmatic solution to the added requirements placed on children hospitals. Since P.L. 109-307 requires the submission of a report that will focus on activities associated with the academic year ending 6/30, and HRSA releases its application for funds on 7/1, requiring that the annual report to be completed in July of each fiscal year makes little sense for any year not just the first year that the report is required. June and July are generally a time of closing an academic year and starting a new one. Hence, rather than phasing the submission of the Annual Report as NACHRI proposes, HRSA is planning to release and require submission of such report during the months of December and January of each Federal fiscal year. It will provide both children's hospitals and HRSA staff time to complete, process, and implement the legislative mandate after the initial application for funds has been completed.

Furthermore, the first year's report does require information since the beginning of CHGME Payment Program funding for certain parts of the annual report. The proposed data collection instrument addresses this requirement by asking for information about changes made since the beginning of CHGME Payment Program funding without reference to the particular year the change was made.

The draft survey instrument at the end of this memo includes specific performance measures designed to comply with the Congressional FFY 2008 reporting requirements. Additional measures and open-ended questions will be proposed for FFY 2009 and beyond, when hospitals will be more familiar with collecting and analyzing the required volume of performance measures and have more time to complete the required report.

Response: HRSA proposed data collection focuses on requirements delineated in the legislative mandate.

In developing these proposed phase one performance measures, we were guided by the requirements of Public Law 109-307 as well as criteria we developed to ensure production of the useful, relevant and feasible program performance measures and reporting requirements. Under these criteria, performance measures must be:

- **Faithful to Congressional intent.** In selecting its reporting requirements, Congress clearly is seeking information regarding how the CHGME payment program helps to: (1) maintain and expand pediatric training programs and positions; (2) support training to enhance quality of care and patient safety; (3) ensure local and statewide availability of pediatric providers; and(4) maintain and expand access for vulnerable pediatric populations. These goals have been instrumental in guiding our selection of proposed performance measures.

Response: The Department and HRSA concur that the data collection instrument has to be faithful to Congressional intent. As delineated in P.L. 109-307, the data to be collected is descriptive. There is no mention of performance measures in the legislative mandate. The data required by the Congressional mandate focuses on basic information concerning: (1) capacity for training pediatric and pediatric sub-specialists to care children in the US; (2) fill rate of such positions; (3) changes in GME curriculum and training to prepare physicians in caring for underserved populations by virtue of geography, income or disease; (4) curriculum changes that prepares physicians to provide quality and safe care; and, (5) employment choices being made graduate of GME training in freestanding children hospitals.

- **Clearly defined and easily understood by children's hospitals**. It is important that the questions in the data collection instrument be easily understood by hospital staff responsible for completing the instrument. To ensure this is the case, all requested information is commonly defined across teaching hospitals. In addition, definitions for all requested information are included in the attached data collection instrument.

Response: The Department and HRSA concur that the instrument should be clearly defined and easily understood by Children's Hospitals. To that end the data collection instrument is detailed and clear. Furthermore, HRSA will provide technical assistance (1) on completing the questionnaire prior to requiring children's hospital to comply with the legislative mandate; and (2) will be always available to answer questions and queries from hospitals as they complete the data collection instrument. However, given the extensive data collection requirements specified in Pub Law 109-307, and the complexity of providing GME training , the data collection instrument may be lengthy.

- **Comparable across reporting institutions.** Developing appropriate performance measures for CHGME is challenging, in part, because the program includes very different types of eligible institutions. These range from large, short-stay acute care children's hospitals to small, long-stay specialty children's hospitals. As a result, measures appropriate to one may not be for all others. The proposed performance measures included in the attached instrument apply to all free standing children's teaching hospitals and can be compared across hospital types on an equitable basis.

Response: The Department and HRSA concur. The instrument is detailed, covers the same time period and the questions are the same for all children's

hospitals.

- **Directly and meaningfully related to program goals.** CHGME funded activities have a primary goal of strengthening graduate medical education and resident training. The proposed performance measures in the attached instrument are designed to examine the impact of the CHGME payment program in the context of this goal.

Response: The Department and HRSA concur that it is necessary to examine the impact of the CHGME Payment Program on the GME training of pediatricians and pediatric sub-specialists. However, the Department and HRSA wish to caution that: (1) education requirements, quality and extent of training are not controlled and cannot be affected directly by the CHGME Payment Program as those decisions are within the purview of accrediting bodies, state licensing boards; and (2)changes in any education system including GME training in freestanding children's hospitals may not be detected in yearly variations.

- **Not unduly burdensome to children's hospitals.** Children's hospitals may encounter several types of burden in complying with the program's new reporting requirements:

Response: The Department and HRSA concur and have restricted the data collection instrument to include modules and questions that are directly related to the legislative mandate and only to reporting on or about those training programs identified in Part C of the new legislative mandate.

1. The level of effort required to quickly implement new data reporting requirements. As a new reporting requirement, children's hospitals will have about one month to rapidly establish an internal data collection process and complete the initial data collection instrument. The initial data collection instrument will be due to HRSA the beginning of August, 2007, along with the initial annual CHGME PP application**.** Hospitals that fail to meet the deadline may potentially receive a 30 day grace period; after which a 25% payment penalty will be imposed.

This burden can be minimized by collecting quantitative and qualitative data that illustrates the accomplishments and outcomes of the program, rather than an exhaustive compilation of program-specific data. Data at that granular level would be burdensome for hospitals with large teaching programs to collect within a short period of time.

Response: Recognizing the time constraints involved in the development and implementation of the data collection instrument for the CHGME Annual Report, HRSA has tentatively established a deadline of January 15 for hospitals to provide the data required by P. L. 109-307. Forms will be made available to the hospitals by December 1 each year. (Depending on the results of the pre-test, the annual report deadline could be extended as far as February 1.) This time frame for data collection will not change as the

June/July time frame represents the ending of an academic year and the beginning of a new one.

2. The benefits versus the level of effort required for hospitals to comply with any new requirements to compile and report a large and detailed amount of new data. We believe the level of reporting detail should be illustrative, consistent with what is required to meet Congressional intent and adequately and accurately capture the information required to describe the results of the program and inform future recommendations for improvement. There would be little value in mandating that hospitals with large numbers of training programs compile voluminous amounts of data on a program-specific basis. For example, Boston Children's Hospital would have to compile at least 35 data collection instruments annually if it had to file reports for each of its' training programs.

Response: Public Law 109-307 specifically requires data for each training program. The legislative mandate is quite explicit with regard to data from each of the training programs: "(i) the types of resident training programs that the hospital provided for residents in subparagraph (C), such as general pediatrics, internal medicine/pediatrics, and pediatric sub-specialties, including medical subspecialties certified by the American Board of Pediatrics (such as pediatric gastroenterology) and non medical subspecialties approved by other medical certification boards (such as pediatric surgery)." Furthermore, illustrative data will not answer the questions raised by Congress regarding the need and the capacity for GME training of pediatricians and pediatric sub-specialists in the U.S.

Data to be collected from the individual programs will be responses to check boxes and drop-down boxes. Completion of these instruments will not be burdensome. There is no requirement that the hospitals aggregate the data from the individual programs. There will be no program data requirements for those children's hospitals that serve as rotation sites and have no residents that spend 75% of their training time in their hospitals. These hospitals still receive CHGME payments but are not required by law to report the detailed information.

As stipulated by Public Law 109-307, the CHGME payment program reporting requirements seek to measure the impact of the program across five domains:

1. The types of residency training programs provided by children's hospitals.

2. The number of residency training positions recruited and filled by children's hospitals.

Response: Rotation sites generally do no recruit residents for training. Sponsoring institutions can report on their recruitment effort. The e legislative mandate also request data on approved slots to possibly measure the capacity to absorb residents for training.

3. Changes in residency training made each academic year since hospital participation in the CHGME PP related to:

    - Training residents in measuring and improving patient care quality and safety
    - Types of training programs, curricula and training experiences, including the benefits that have resulted from such changes

4. The numbers of residents completing their residency training at the end of each residency academic year who care for children within the training hospital's service area or the State within which the hospital is located.

5. The types of residency training provided related to the health care needs of different pediatric populations, such as children who are underserved due to family income, geographic location or other factors.

Response: The proposed instruments cover the same areas. The length will depend on the number of training programs that the children's hospitals will have to report on. Program specific data is required legislatively, but also would have to be collected separately. For example quality of care and safety teaching efforts for residents training in pediatric surgery and for residents training in general pediatrics have to be collected separately. Potential aggregation were considered and the trade –off was between a clearer and simpler instrument to complete and a more complex and shorter instruments. The Department and HRSA chose the first which meets the principles delineated by NACHRI above as being clear, easy to complete, and consistent fro all hospitals.

Proposed Performance Measures

The proposed measures below, although important and required to be reported about by Law are not performance measures. They are descriptive statistics focused on GME in freestanding children's hospitals that receive CHGME payments subject to Part (C) of the legislative mandate. These descriptive measures, in concert with univariate, bivariate, and categorical data analysis will enable the program to prepare theRreport to Congress.

The remainder of this memorandum presents each Congressional reporting requirement, along with proposed performance measures and justifications consistent with the intent of the new CHGME PP reporting requirements and the criteria summarized above.

Types of Pediatric Resident Training Programs

A. **Congressional Reporting Requirement***: "The types of resident training programs that the hospital provided for residents, ……such as general pediatrics, internal medicine/pediatrics and pediatric subspecialties, including both medical subspecialties certified by the American Board of Pediatrics (such as pediatric gastroenterology) and non-medical subspecialties approved by other medical certification boards (such as pediatric surgery)."*

Response: The full text of the section is provide below:

:

`(i) The types of resident training programs that the hospital provided for residents described in subparagraph (C), such as general pediatrics, internal medicine/pediatrics, and pediatric subspecialties, including both medical subspecialties certified by the American Board of Pediatrics (such as pediatric gastroenterology) and non-medical subspecialties approved by other medical certification boards (such as pediatric surgery).

`(C) RESIDENTS- The residents described in this subparagraph are those who--

`(i) are in full-time equivalent resident training positions in any training program sponsored by the hospital; or

`(ii) are in a training program sponsored by an entity other than the hospital, but who spend more than 75 percent of their training time at the hospital.

1. Summary of proposed performance measure: For the most recent academic year (July 2006 – June 2007), report the types and numbers of residency training programs provided, by specialty, including programs added, expanded or contracted.

Justification: Collecting data on the types and number of resident training programs directly responds to Congressional intent of better understanding the extent to which teaching hospitals that participate in this program continue to maintain robust training programs that meet the needs of the nation's pediatric population. This performance measure also aligns well with each of the four additional selection criteria outlined above.

Response: The summary provided above will only address part of the question. It will provide Congress with measures of GME capacity of training by training program as well as the fill rates, i.e. the market interest in such a profession. It will not quantify the "need" for pediatric care.

Number of Pediatric Training Positions

A. **Congressional reporting requirement***: "The number of training positions for residents…… the number of such positions recruited to fill, and the number of such positions filled."*

Response: Again the full text of the section reads as follows:

`(ii) The number of training positions for residents described in subparagraph (C), the number of such positions recruited to fill, and the number of such positions filled.

`(C) RESIDENTS- The residents described in this subparagraph are those who--

`(i) are in full-time equivalent resident training positions in any training program sponsored by the hospital; or

`(ii) are in a training program sponsored by an entity other than the hospital, but who spend more than 75 percent of their training time at the hospital.

1. Summary of proposed performance measure: For the most recent academic year (July 2006 – June 2007), report the number of offered residency training slots, and filled positions by specialty. This should include both residents in their initial training period and residents who already have completed an initial residency training period, including subspecialty fellows.

Justification: Tracking changes in the number of pediatric trainees in children's hospitals may be an early indicator of the impact of the CHGME PP on the educational mission of these teaching hospitals. It is also consistent with better understanding the current and future availability of the pediatric physician workforce needed to ensure access for the growing pediatric population. In addition, this performance measure also aligns well with each of the selection criteria outlined above.

Response: See response above.

Changes in Residency Training Curricula, Experiences and Programs and Resulting Benefits

A. **Congressional Reporting Requirement** *: "Changes in residency training which the hospital has made during such residency academic year (except that the first report submitted by the hospital under this subparagraph shall be for such changes since the first year in which the hospital received payment under this section), including—*

I. Changes in curricula, training experiences, and types of training programs, and benefits that have resulted from such changes; and

1. Summary of Proposed Performance Measures: 1) Annual changes by residency training program in training curricula and training experiences, since participating in the CHGME PP; and 2) a summary of the three most important changes in training curricula and experiences and resulting benefits.

Response: In an effort to reduce reporting time and to increase the accuracy of data, the proposed data collection instrument does ask for change since the hospital first received CHGME funding, but does not ask for each individual year. The proposed instrument also asks for benefits of the changes. It is unlikely that substantial or significant changes in curricula occur on a "yearly" cycle. If significant and/or substantial changes in training residents occurs, the accredited bodies and the state boards will have to review , approved and/or change their evaluation instruments.

Changes in Curricula and Types of Training Programs Related to Measuring and Improving Patient Care Quality and Safety

A. **Congressional Reporting Requirement** *: "Changes in residency training which the hospital has made during such residency academic year (except that the first report submitted by the hospital under this subparagraph shall be for such changes since the first year in which the hospital received payment under this section), including—*

I. Changes for purposes of training the residents in the measurement and improvement of the quality and safety of patient care.

1. **Summary of Proposed Performance Measures:** 1) Annual changes in residency training for purposes of measurement and improvement of quality and safety of patient care since participating in the CHGME Payment Program; and 2) examples of changes in quality and safety related residency training and the resulting benefits

Justification: Proposed data to be collected responds to Congressional intent, is not overly burdensome and is directly related to CHGME activities.

Ensure Local/State-Wide Availability of Pediatric Providers

A. **Congressional reporting requirement:** *"The number of residents who completed their residency training at the end of such residency academic year and care for children within the borders of the service area of the hospital or within the borders of the state in which the hospital is located. Such numbers shall be disaggregated with respect to residents who completed residencies in general pediatrics or internal medicine/pediatrics, subspecialty residencies and dental residencies."*

1. Summary of proposed performance measure: For the academic year July 2006 to July 2007, and for primary care, subspecialty, and dental residencies, report: 1) the numbers of residents and fellows completing their training; 2) the number and percent of residents and fellows completing their training and practicing within the hospitals service area, defined as primary and secondary service areas; and 3) the number and percent of residents and fellows completing their training and practicing within the state in which the children's hospital is located. This would include residents who have completed their initial training period and taken a fellowship for further

training. It includes only those residents and fellows who took a position in the service area or region immediately upon completion of training. It doesn't not include residents who have moved after their first position following completion of training.

Justification: The proposed performance measures are designed to help assess the extent to which graduating residents and fellows from freestanding children's teaching hospitals apply their skills and experience to meet the medical needs of children, both locally and statewide. Proposed data to be collected is responsive to Congressional intent and is routinely collected by residency program departments.

Response: The proposed data collection instrument simply asks for the zip code of the first practice site of each resident completing the training program for the immediate past academic year. The location of the zip code in the state, service area, and various categories of underserved areas can be determined in the analysis of the data.

Ensure Access to Care for Financially Vulnerable Pediatric Populations

A. **Congressional** r**eporting requirement***: "The types of training that the hospital provided for residents…. related to the health care needs of different populations, such as children who are underserved for reasons of family income, or geographic location, including rural or urban areas."*

1. **Summary of proposed performance measures:** Proposed data elements include: 1) the extent to which hospitals offer training programs designed to expose residents to financially vulnerable pediatric populations; 2) the proportion of residents rotating into or otherwise spending time in community-based clinics or other settings serving low-income children; and 3) whether access to care is provided to children from low-income families. For the purposes of this data collection instrument, low-income families are defined as families with children who are covered by Medicaid, a State Children's Health Insurance Program, or are uninsured.

Justification: The Congressional intent of the CHGME payment program includes ensuring access to care for socio-economically underserved children. By identifying the types of training programs and services across levels of care children from low income families receive at CHGME participating hospitals; this proposed measure is consistent with the selection criteria described above. This data is also routinely collected and reported and is comparable across children's hospitals.

Response: The proposed data collection instrument will obtain some of the information based on hospital discharge records. The discharge data will be provided at the hospital level rather than the program level. Program level data will be provided by responses to particular questions about the curricula, primarily in check-off boxes.

Ensure Access to Care for Geographically Vulnerable Pediatric Populations

A. **Congressional** r**eporting requirement***: "The types of training that the hospital provided for residents…. related to the health care needs of different populations, such as children who are underserved for reasons of family income, or geographic location, including rural or urban areas."*

1. **Summary of proposed performance measures:** Identifies whether children's hospitals provide access to care for children underserved by virtue of their geographic location, and to what extent residents rotate into or otherwise spend time in community-based clinics or other settings. Geographic locations include both underserved urban and all rural settings. Underserved urban locations are defined to include areas designated by HRSA as medically underserved areas (MUA) or medically underserved populations (MUP). Rural areas are designated as defined by the Bureau of the Census.

Justification: The Congressional intent of the CHGME payment program includes ensuring that residency training programs enhance access to care for geographically underserved children and offer residents training opportunities in urban and rural areas. These proposed measures target Congressional intent, and urban and rural geographic areas are defined using generally accepted and accessible definitions.

Proposed CHGME Payment Program
Annual Data Collection Instrument
Application Period: FFY 2008
Reporting Period: Academic Year July 2006 – June 2007

1: Numbers of Pediatric Resident Training Programs

In the table below, please indicate the number of residency training programs provided in Academic Year 2006-2007, by specialty, that are ACGME or AOA accredited, or ABMS or ABP approved.

Response: Question 1 and 2 as proposed here are similar to the questions asked in HRSA's proposed data collection instrument. However, the commenter's questions do not provide information on whether the children's hospital is a sponsor of the program or if not a sponsor, whether residents spend 75 percent of training time at the hospital. The statutory language is quite clear in requesting this information:

> *`(C) RESIDENTS- The residents described in this subparagraph are those who--*
>
> *`(i) are in full-time equivalent resident training positions in any training program sponsored by the hospital; or*
>
> *`(ii) are in a training program sponsored by an entity other than the hospital, but who spend more than 75 percent of their training time at the hospital.*

Table 1(a)	
Number of Residency Training Programs by Specialty	
General Pediatrics	
Internal Medicine/Pediatrics	
Subtotal	
Pediatric Subspecialties	
Adolescent Medicine	
Allergy	
Anesthesiology	
Cardiology	
Cardiovascular Surgery	
Critical Care	
Dentistry	
Dermatology	
Developmental Medicine	
Endocrinology	

Genetics	
Gynecology	
Hematology	
Infectious Diseases	
Nephrology	
Neurology	
Neurosurgery	
Newborn Medicine	
Nuclear Medicine	
Ophthalmology	
Orthopedic Surgery	
Otolaryngology	
Pathology	
Pediatric Surgery	
Plastic Surgery	
Psychiatry	
Pulmonology	
Radiation Oncology	
Radiology	
Rehabilitation Medicine	
Rheumatology	
Solid Organ Transplant	
Urology	
Subtotal	
Other Training Programs	
Child Abuse	
Hospice and Palliative Medicine	
Medical Toxicology	
Neonatal-Perinatal Medicine	
Neurodevelopment Disabilities	
Emergency Medicine	
Gastroenterology	
Infectious Diseases	
Transplant Hepatology	
Sleep Medicine	
Sports Medicine	
Child-Adolescent Psych	
Subtotal	

Other Training Programs Not Reported Above (Please Specify)	
Subtotal	
Grand Total (All Training Programs)	

Table 1(b)		
Have you added, expanded or contracted any of your residency training programs during Academic Year 2006 - 2007?	Yes ___	No ___

If “yes”, please complete the table below:

Table 1(c)			
Changes to the Number of Residency Training Programs by Specialty			
	Added	**Expanded**	**Contracted**
General Pediatrics			
Internal Medicine/Pediatrics			
Subtotal			
Pediatric Subspecialties			
Adolescent Medicine			
Allergy			
Anesthesiology			
Cardiology			
Cardiovascular Surgery			
Critical Care			
Dentistry			
Dermatology			
Developmental Medicine			
Endocrinology			
Genetics			
Gynecology			
Hematology			

Infectious Diseases			
Nephrology			
Neurology			
Neurosurgery			
Newborn Medicine			
Nuclear Medicine			
Ophthalmology			
Orthopedic Surgery			
Otolaryngology			
Pathology			

Table 1(c) (cont'd)

Changes to the Number of Residency Training Programs by Specialty

	Added	**Expanded**	**Contracted**
Pediatric Surgery			
Plastic Surgery			
Psychiatry			
Pulmonology			
Radiation Oncology			
Radiology			
Rehabilitation Medicine			
Rheumatology			
Solid Organ Transplant			
Urology			
Subtotal			
Other Training Programs			
Child Abuse			
Hospice and Palliative Medicine			
Medical Toxicology			
Neonatal-Perinatal Medicine			
Neurodevelopment Disabilities			
Emergency Medicine			
Gastroenterology			
Infectious Diseases			
Transplant Hepatology			
Sleep Medicine			
Sports Medicine			
Child-Adolescent Psych			
Subtotal			
Other Training Programs Not			

Reported Above (Please Specify)			
Subtotal			
Grand Total (All Training Programs)			

2: Number of Pediatric Residency Training Positions

In the table below, for Academic Year 2006 - 2007, please report the number of currently offered residency training slots, and filled positions by specialty. Please report the number of training positions not the number of full time equivalents. These include ACGMER and AOA approved programs.

Table 2(a)

	Number of Training Positions	
TRAINING PROGRAMS	**Offered**	**Filled**
General Pediatrics		
Internal Medicine/Pediatrics		
Subtotal		
Pediatric Subspecialties		
Adolescent Medicine		
Allergy		
Anesthesiology		
Cardiology		
Cardiovascular Surgery		
Critical Care		
Dentistry		
Dermatology		
Developmental Medicine		
Endocrinology		
Genetics		
Gynecology		
Hematology		
Infectious Diseases		
Nephrology		
Neurology		
Neurosurgery		
Newborn Medicine		
Nuclear Medicine		
Ophthalmology		
Orthopedic Surgery		
Otolaryngology		
Pathology		

Table 2(a) (cont'd)

	Number of Training Positions

TRAINING PROGRAMS	Offered	Filled
Pediatric Surgery		
Plastic Surgery		
Psychiatry		
Pulmonology		
Radiation Oncology		
Radiology		
Rehabilitation Medicine		
Rheumatology		
Solid Organ Transplant		
Urology		
Subtotal		
Other Training Programs		
Child Abuse		
Hospice and Palliative Medicine		
Medical Toxicology		
Neonatal-Perinatal Medicine		
Neurodevelopment Disabilities		
Emergency Medicine		
Gastroenterology		
Infectious Diseases		
Transplant Hepatology		
Sleep Medicine		
Sports Medicine		
Child-Adolescent Psych		
Subtotal		
Other Training Programs Not Reported Above (Please Specify)		
Subtotal		
Grand Total (All Training Programs)		

3: Changes in Residency Training Curricula, Experiences and Programs and Resulting Benefits

In the tables below, please report changes in training curricula and training experiences, and their associated benefits since the federal fiscal year that your hospital began participating in the CHGME PP:

Table 3(a)		
Ac. Year	**Has CHGME Funding Allowed Your Hospital to Incorporate Changes in Training Curricula and Training Experiences?**	
	YES	**NO**
2000		
2001		
2002		
2003		
2004		
2005		
2006		
2007		

Response: This is an excellent list of potential educational changes. The proposed data collection instrument does not ask for year-by-year changes, but , rather, changes since CHGME PP funding began.

Table 3(b)								
If 'Yes', Indicate, By Year, Which of the Changes Listed Below Apply:								
	FFY							
	2000	2001	2002	2003	2004	2005	2006	2007
Developed/enhanced training aids								
Added/enhanced training curricula related to medical education research								
Enhanced training by acquiring new medical technology								
Offered additional electives for training								
Introduced curriculum using ACGME competencies								
Added staff to support teaching, including faculty and other staff								

JCAHO training for residents								
Table 3(b) (cont'd)								
If 'Yes', Indicate, By Year, Which of the Changes Listed Below Apply:								
	2000	2001	2002	2003	2004	2005	2006	2007
Enhanced education for researchers								
Involved residents in published research								
Required research projects from residents								
Implemented a new research program								
Offered cultural diversity training								
Implemented communication skills training								
Enhanced clinical information systems								
Purchased state of the art medical equipment and technology								
Provide electronic health records								
Added handheld computers to allow storage and access to patient data								
Other enhancements to training curricula and experiences, such as new training partnerships with organizations serving at-risk children (Please specify below)								

Please Summarize the Examples of Changes in Your Residency Programs Training Curricula and Training Experiences and the Resulting Benefits Since Participating in the CHGME Payment Program since the first year your hospital received CHGME payments:

Response: The proposed data collection instrument asks for similar information.

Table 3(c)	
1	Changes:
	Benefits:
2	Changes:
	Benefits:
3	Changes:
	Benefits:

4: Changes in Curricula and Types of Training Programs Related to Measuring and Improving Patient Care Quality and Safety

In the table below, where appropriate, please note annual changes in residency training for purposes of measurement and improvement of quality and safety of patient care since your hospital began participating in the CHGME Payment Program:

Response: Again, the proposed data collection instrument asks for similar information from the beginning of the hospital's CHGME funding rather than for each single year in an effort to reduce data and burden and improve accuracy.

Table 4(a)

	Academic Year							
	2000	2001	2002	2003	2004	2005	2006	2007
Designed curricula to train residents in the measurement and improvement of quality of patient care and safety								
Introduced Mortality and Morbidity conferences in curriculum								
Provided in-services to residents on patient safety or "quality of care"								
Added "quality of care" as part of curriculum								
Involved residents in patient safety initiatives								
Provided courses on patient safety standards								
Trained residents on medication safety protocols								
Other enhancements to training related to patient safety and quality experiences (Please specify below)								

Please Summarize Examples of Changes in Your Residency Programs Related to Measuring and Improving Patient Care Quality and Safety Training and the Resulting Benefits Since Participating in the CHGME Payment Program:

	Table 4(b)
1	Changes:
	Benefits:
2	Changes:
	Benefits:
3	Changes:
	Benefits:

5: Ensure Local/Statewide Availability of Pediatric Providers

In the tables below, please report 1) the numbers of residents and fellows completing their training; 2) the number and percent of residents and fellows completing their training and practicing within the hospitals service area, defined as primary and secondary service areas; and 3) the number and percent of residents and fellows completing their training and practicing within the state in which the children's hospital is located:

Table 5(a)	
Local/Statewide Availability of Residents Trained By You	
Number of Residents Trained By You Completing Residency Training In Ac. Year 2002	
Number of Those Pediatric Residents Trained By You That Practice Within Your Primary and Secondary Service Areas After Completion of Training	
% of Those Pediatric Residents That Practice Within Your Primary and Secondary Service Areas After Completion of Training	
Number of Those Pediatric Residents That Practice Within Your State After Completion of Training	
% of Those Pediatric Residents That Practice Within Your State After Completion of Training	

Table 5(b)	
Local/Statewide Availability of Fellows Trained By You	
Number of Fellows Trained By You Completing Fellowship Training in Ac. Year 2004	
Number of Those Pediatric Fellows Trained By You That Went on to Practice Within Your Primary and Secondary Service Areas After Completion of Training	
% of Those Pediatric Fellows Trained By You That Went on to Practice Within Your Primary and Secondary Service Areas After Completion of Training	
Number of Those Pediatric Fellows That Went on to Practice Within Your State After Completion of Training	
% of Those Pediatric Fellows That Went on to Practice Within Your State After Completion of Training	

Definitions:
Service Area: A hospital’s primary and secondary service areas **Primary and Secondary Service Area:** Zip codes from which the top 75% of hospital patients originate

6: Ensure Access to Care for Financially Vulnerable Pediatric Populations

Response: The proposed data collection instrument will capture this information by using data about the funding sources for hospital discharges.

Table 6(a)		
Academic Year 2006 – 2007		
Does your children's hospital provide care to children from low income families?	Yes ___	No ___

Table 6(b)		
Academic Year 2006 – 2007		
Does your hospital offer training programs designed to expose residents to financially vulnerable pediatric populations?	Yes ___	No ___

If 'YES', please provide up to three specific examples:

Table 6(c)

Table 6(d)	
What proportion of your residents rotated into or otherwise spent time in community-based clinics or other settings serving low-income children in Academic Year 2006 - 2007	

Response: A similar question is included in the proposed data collection instrument.

The proposed data collection instrument includes a detailed list of definitions of terms used in the instrument.

Definitions:
Low-Income Families: Families whose children are covered by Medicaid,

a State Children's Health Insurance Program, or are uninsured

7: Ensure Access to Care for Geographically Vulnerable Pediatric Populations

In the tables below, please indicate the extent to which your hospital provided training experiences to residents and access to children underserved by virtue of their geographic location in FFY 2007:

Response: These data are also captured by zip code of hospital discharges in the proposed data collection instrument.

Table 7(a)		
Does your children's hospital provide care to children residing in low-income urban areas?	Yes ___	No ___

Table 7(b)		
Does your children's hospital provide care to children residing in rural areas?	Yes ___	No ___

Table 7(c)	
What proportion of your residents rotates into or otherwise spend time in community-based clinics or other settings located in rural areas?	

Table 7(d)		
Does your hospital provide training specific to care of children in rural areas?	Yes ___	No ___

Definitions:
Underserved Urban Location: Areas designated by HRSA as medically underserved urban area (MUA) or medically underserved urban population (MUP) **Rural Areas:** Designated as defined by the Bureau of the Census