

Supporting Statement A

Title of the Data Collection

OMB Control No. 0915-XXXX

Terms of Clearance: For revisions, extensions, or reinstatements list terms of clearance here. Explain how the terms of clearance are addressed in the submission. **If there were no terms of clearance, please indicate “None”.**

A. Justification

1. Circumstances Making the Collection of Information Necessary

Section 5508 of the Affordable Care Act of 2010 (ACA) established the Teaching Health Center Graduate Medical Education (THCGME) program under Title III of the Public Health Service Act to support the expansion of new and existing primary care residency training programs in community-based settings. The primary goals of this program are to increase the production of primary care doctors who are well prepared to practice in community settings, particularly with underserved populations, and to improve the overall number and geographic distribution of primary care providers.

The legislation specifically requires that THC programs report annually on the types of primary care residents trained, the number trained, the number who complete residency, the number who care for vulnerable populations, and any other information as deemed appropriate by the Secretary. The law states:

(1) ANNUAL REPORT. The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information for the residency academic year completed immediately prior to such fiscal year:

A) The types of primary care resident approved training programs that the qualified teaching health center provided for residents.

(B) The number of approved training positions for residents described in paragraph (4).

(C) The number of residents described in paragraph (4) who completed their residency training at the end of such residency academic year and care for vulnerable populations living in underserved areas.

(D) Other information as deemed appropriate by the Secretary.”

This program aims to increase the number of new primary care physicians and dentists trained in community-based settings who go on to practice in primary care and in rural and underserved settings. The THCGME program differs from traditional funding of GME programs, largely through Medicare, by requiring that the funding go directly to a community-based ambulatory patient care site. This program is significantly different than traditional Medicare GME which is paid largely to inpatient hospitals, and therefore the THCGME program is expected to incentivize a different model of training with the aim of producing primary care providers who are better trained to provide primary care and practice in community-based, often underserved, settings.

The George Washington University (GW), through a competitive process, was awarded the Evaluation and Initial Assessment of HRSA Teaching Health Centers contract. The purpose of this contract is to conduct an assessment over a five year period to better understand this model of community-based residency training and examine the outcomes of the THC programs, in terms of production of primary care providers and providers who practice in underserved settings.

GW plans to collect information from THC programs regarding the types of primary care residency programs and numbers trained, as well as information on curricular components that demonstrate community and primary care orientation. GW also plans to directly gather information from THC residents and alumni using a multi-staged survey format to establish a baseline census of the individuals who choose THC programs and determine the career outcomes of THC graduates. Research has shown that certain factors are associated with primary care and underserved career choices. At the individual level these factors include gender, age, rural background, student debt levels, and intent to practice in certain specialties or settings. Medical school level factors have also been shown to correlate with career outcomes, including primary care and rural experiences. Collecting this information is important both to assess whether THC programs are attracting those residents who are most likely to choose primary care and underserved careers, as well as to assess the relationship of these factors with future outcomes for THC programs.

Purpose and Use of Information Collection

In order to ensure the goals and reporting requirements of the THCGME program are met, GW, under contract with BHP, has developed four instruments to collect data from each of the programs and their residents: 1) Program Data Collection Tool, 2) THC Matriculant Survey, 3) THC Graduation Survey and 4) THC Graduate Survey. Data Collection Instruments:

Data Collection Instrument	Subject (Recipient)	Timeline
1. Program Data Collection Tool	Program manager	Annual – August/Sept
2. Matriculant Survey	Matriculating resident	Annual – July*
3. Graduation Survey	Graduating resident	Annual – June*
4. Graduate Survey	Graduate physician (one year post graduation)	Annual – June*

* Surveys will be implemented annually with different cohorts of matriculating, graduating and alumni residents (academic years for residency programs run from July to June); surveys will be implemented by GW, under contract

with HRSA, through the end of the 5 year evaluation contract and then provided as a resource for THC programs to continue collecting information on their residents and graduates.

The Program Data Collection Tool provides information on residency programs that receive funding for THC residents. The Program Data Collection Tool will be administered on an annual basis to THC Program Directors. It will collect basic organizational and training characteristics of the programs (including program specialty, numbers trained, training sites, educational partners, and residency program financing), educational initiatives (particularly around training for changing health care delivery systems and community experiences), and health center characteristics (including current workforce and vacancies, clinical service provided by residents, and participation in workforce programs such as National Health Service Corps).

The tool addresses the following evaluation research questions:

1. What are the types of primary care resident approved training programs provided by the THC programs?
2. What number of approved training positions is being provided by the THC programs?
3. What advanced primary care delivery models (i.e. patient centered medical homes, inter-professional team-based care, quality improvement) are THC residents training in?
4. What community-based experiences are THC residents receiving?
5. What is the amount of training THC residents receive in the primary care setting?

See Appendix A for the Program Data Collection Tool. This information will be used to monitor program activities and inform program management within BHPr. In addition, this information is critical to understand the characteristics of a new program and follow its progress over time.

Furthermore, three questionnaires have been developed for implementation with all THC residents at matriculation, graduation and one year post-graduation: THC Matriculant Survey, THC Graduation Survey, and THC Graduate Survey. These three surveys will be administered to gather information on THC residents at different stages of their training and early clinical practice. The surveys are intended to identify the absolute number of primary care providers and providers that practice in underserved areas. This is a critical outcome measure for the THCGME program as THCs must be new or expanding residency programs. Therefore, THC graduates are new primary care providers above the number that would have been produced in the GME system prior to the THCGME program. The surveys also seek information about resident experience and satisfaction. As the THCGME program emphasizes a model of training that is different than the traditional hospital-based model, trainee satisfaction is an important outcome of the program. Program feedback questions also provide information on how well matched training is to the needs of primary care practice.

The tools address the following evaluation research questions:

1. What number and percent of the THC graduates practice in primary care (plan at graduation and one year after graduation)?
2. What number and percent of the THC graduates go on to practice in underserved settings (plan at graduation and one year after graduation)?
3. What are the characteristics of residents who choose THC programs, by demographics, intention to practice in primary care and intention to practice in rural and/or underserved

areas?

4. Are there correlations between resident characteristics and the intention to practice primary care and/or practice in underserved settings?
5. How satisfied are residents with curriculum and enhanced programmatic features of the THC model?
6. How do residents suggest that the THC residency program can be improved?

The THC Matriculant Survey aims to collect background information on THC residents to better understand the characteristics of individuals who apply and are accepted to THC programs (see Appendix B). The THC Matriculant Survey largely gathers demographic and background information of incoming residents. This information is the first opportunity to examine whether programs are recruiting residents consistent with the goal to produce physicians who will practice primary care in rural and underserved settings. The THC Graduation Survey gathers information on career plans (covered in an identifiable section), and on the quality of training received at the THC (covered in an anonymous section). Please see Appendix C for the THC Graduation Survey. The Graduation Survey is the first opportunity to assess plans to continue to practice in primary care and in underserved areas. The THC Graduate Survey collects information on actual career outcomes, including practice in primary care and in underserved settings following graduation (covered in an identifiable section), as well as feedback on the quality of training (covered in an anonymous section). See Appendix D for the THC Graduate Survey.

The purpose of the Program Data Collection Tool and the three individual level questionnaires is to collect the required reporting information in a standardized manner between all THC programs, and to examine characteristics of THC programs that are aligned with training in relevant and/or innovative health care delivery models. Data from the individual level surveys will be provided back to the THC programs so that they can meet any additional reporting requirements to HRSA and receive program feedback from graduates. Survey tools will ultimately be made available to THC programs to continue post the THC Evaluation contract period.

The questionnaires collect individual level information required by THC programs to meet their annual reporting requirements. Implementation of standardized questionnaires will ensure data can be collated from all programs. If this information is not collected there will be no data to evaluate the effectiveness and impact of the THCGME program.

Use of Improved Information Technology and Burden Reduction

GW has developed data collection tools and questionnaires that utilize technology to administer, collect and analyze the data. The Program Data Collection Tool will be implemented using fillable pdf forms. For subsequent years, programs will receive pre-filled forms when appropriate so that responses will be limited to updating the previous year's form. All of the responses (100%) for each individual level questionnaire (Matriculant, Graduation, and Graduate Surveys) will be collected and submitted electronically. Each of the three surveys will be completed using a secure online survey tool with built in skip logic to minimize the number of questions for respondents. Responses for both the Program Data Collection Tool and surveys will be

downloadable as collated spreadsheets.

Efforts to Identify Duplication and Use of Similar Information

In some cases, the THC programs are implementing graduation and graduate surveys. For existing THC programs, survey instruments were requested and reviewed. The survey instruments developed for the THC Evaluation specifically took into consideration the existing survey instruments – particularly the content and format of questions. The survey instruments have been developed to collect standardized information from THC trainees and graduates, as well as meet the needs of the THCs for program feedback. The survey instruments will ultimately be made available to the individual THC programs to continue collecting relevant training information and add to as needed.

Impact on Small Businesses or Other Small Entities

The survey instruments will be implemented with individual graduate physicians. In all cases, these individuals may be considered “small businesses” and therefore no additional short forms were developed. The surveys generally contain straightforward questions around demographics and practice plans or locations that should require minimal effort and time to complete. In addition, the online survey instruments include “skip logic” to allow respondents to skip questions that are not relevant based on their answers to other preceding questions.

Consequences of Collecting the Information Less Frequently

During the remaining THC Evaluation contract period (4 years) all residents will be expected to respond to the Matriculant Survey once. For those residents that graduate during the contract period, they will be expected to respond once to the Graduation Survey and for those that graduate at least one year prior to the end of the contract period, they will be expected to respond once to the Graduate Survey, one year after graduation. Timing of the survey is required to gather information about the characteristics of residents choosing and entering THC programs as well as the career outcomes of those trained in THC programs. A survey at graduation is the first opportunity to assess career plans; however, a follow up survey after graduation is needed to assess actual career outcomes.

Program Directors will complete a blank Program Data Collection Tool once and update the data collection tool on an annual basis. Annual updates are needed as numbers of residents and graduates can change on an annual basis, and new training initiatives may be implemented with new classes.

There are no legal obstacles to reduce the burden.

Special Circumstances Relating to the Guidelines of 5 CFR 1320.5

In this request, all guidelines are met and this request fully complies with the regulation.

Comments in Response to the Federal Register Notice/Outside Consultation

Section 8A:

A 60-day Federal Register Notice was published in the *Federal Register* on June 12, 2013, vol. 78, No. 113; pp. 35285-86 (see Appendix 5). There were the following public comments:

60 Day Request From	Request for what?	Response
<p>Jeffery Leboeuf - jeffrey.leboeuf@okstate.edu; Gary Slick - gary.slick@okstate.edu; Jeff Hackler - jeff.hackler@okstate.edu</p>	<p>The length of the Graduate Survey is too long.</p> <p>“The length of a survey is inversely related to the response rate. The current resident survey is 13 pages long, the graduating resident survey is six pages long, but the survey for residents who have been out for at least one year is 29 pages long.</p> <p>I strongly suspect that very few physicians busy with developing their practice will take the time to complete a 29 page survey. Perhaps limiting the survey to one secondary site (eliminating pages 14-19) might ease the pain of responding, and increase our response rate.”</p>	<p>The surveys are designed to be implemented by a secure online survey website with significant “skip logic” built into the online versions of the surveys, particularly for the graduate survey. For example, if the respondent provides patient care at only one clinical site, then no further clinical site information will be asked and the survey will skip forward to the patient encounters page.</p> <p>Asking about additional clinical sites is particularly important for the THC program as practice in more underserved or more rural sites may occur as a minority fraction of a provider’s time. For example, a provider might spend 60% time in one clinical site and 40% time in another site, where the 40% time is in a more rural location. In this case, asking for only one site’s information will fail to give credit to the THC program for future practice in rural locations.</p> <p>In addition, the majority of questions are straightforward and should require minimal time to complete.</p> <p>The table provided in the 60 day FRN provides a summary of the forms that the THC program grantees will be completing and the estimated time to complete each form.</p>
<p>Katherine Smalley - KatherineS@yvwfc.org</p>	<p>Surveys are too long and closely match this THC’s resident and</p>	<p>The surveys are designed to be implemented by a secure online</p>

	<p>graduate surveys.</p> <p>“My concerns are:</p> <ol style="list-style-type: none"> 1) The Matriculation and Graduate Surveys are long. 2) On the Matriculation survey it is not clear why current marital status and country of origin are requested. These questions seem unnecessarily invasive. Most of the other information is available from our existing resident’s application. 3) The Graduate and Graduation surveys also closely match the questions we ask on our Program Evaluation and Alumni surveys. 4) This raises the concern of poorer response to all surveys, ours and yours, once residents realize they are being asked for the same information. <p>Instead, I would like to recommend that program directors (or their administrative assistants) provide the information from their surveys and applications (into a format designed by GWU – i.e. spreadsheet), and spare the residents from an additional (and duplicative) set of surveys.”</p>	<p>survey website with significant “skip logic” built into the online versions of the surveys. This will effectively make the implemented versions shorter than the static versions provided for review. In addition, the majority of questions are straightforward and should require minimal time to complete.</p> <p>The table provided in the 60 day FRN provides a summary of the forms that the THC program grantees will be completing and the estimated time to complete each form.</p> <p>The surveys may be similar in nature to the data already collected by some of the THCs. However, it is important to develop and implement standardized surveys in order to successfully analyze and compare measures across each of the THCs. The surveys examine a number of goals of the program set out by legislation for which limited data has been collected across programs in the past. THC programs will ultimately be able to use these surveys for their own benefit after the evaluation project is complete, and modify any surveys as they see fit.</p>
<p>John Saultz, MD MSPH President Society of Teachers of Family Medicine</p> <p>Jeffrey Cain, MD President American Academy of Family Physicians</p> <p>Michael Tuggy, MD President Association of Family Medicine Residency Directors</p> <p>Barbara Thompson, MD President Association of Departments of Family Medicine</p>	<p>Providing support for the Teaching Health Centers (THCs) and the THC evaluation project.</p> <p>“Dear Director Niakan: On behalf of the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, the North American Primary Care Research Group, along with the American Academy of Family Physicians (AAFP), we are pleased to submit comments on the Health</p>	<p>Thank you for your comment, and support for the Teaching Health Center Graduate Medical Education program and the Teaching Health Center evaluation project.</p>

<p>Frank V. deGruy, III, MD, MSFM President North American Primary Care Research Group</p>	<p>Resources and Services Administration notice titled Evaluation and Initial Assessment of HRSA Teaching Health Centers as published in the June 12, 2013 Federal Register.</p> <p>Our organizations continue to support provisions of the Affordable Care Act that establish the Teaching Health Center Graduate Medical Education program, which is designed to establish and expand primary care residency training programs in community-based settings. The primary goals of this program are to increase the production of primary care doctors who are well prepared to practice in community settings, particularly with underserved populations, and to improve the overall number and geographic distribution of primary care providers.</p> <p>The evaluation of this program is critical to understanding the significance of the teaching health center (THC) model. This feedback will be useful for a wide range of stakeholders and funders. We believe HRSA will need several years of data to completely understand the benefits of the program; thus, we urge the agency to continue these evaluations annually. We reviewed the proposed survey instruments and find them reasonable and not burdensome.</p> <p>On behalf of the family medicine organizations, we appreciate the opportunity to respond to the notice. We appreciate the agency's efforts to develop regulations in keeping with the Affordable Care Act and are supportive of the development of data regarding the utility of the Teaching Health Center program. Should you have any questions regarding this letter, please feel free to contact Hope</p>	
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	<p>R. Wittenberg, CAFM Director of Government Relations, at hwittenberg@stfm.org or 202-986-3309, or Robert Bennett, AAFP Federal Regulatory Manager, at rbennett@aafp.org or 202-232-9033.”</p>	
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Section 8B:

The resident surveys were developed based on survey instruments shared by some of the existing THC's as well as other existing similar surveys, such as the Washington, Wyoming, Alaska, Montana, Idaho (WWAMI) Family Medicine Residency Network survey, and the Association of American Medical Colleges (AAMC) matriculant and graduation surveys. The surveys were also developed to correlate with the HRSA Bureau of Health Professions performance measures.

The GW team consulted the following individuals in developing the survey instruments:

Paul Ford, Department of Family Medicine, University of Washington (pford@fammed.washington.edu) – Dr. Ford administers the WWAMI Family Medicine Residency Network alumni survey. He was consulted to discuss the content, implementation, and challenges faced in implementing the survey instrument among Family Medicine residency programs in the WWAMI Network. He was consulted in 2013.

Henry Sondheimer, Association of American Medical Colleges (hsondheimer@aamc.org) – Dr. Sondheimer administers the AAMC Medical Student Matriculant and Graduation Surveys. He was consulted to discuss the content of these surveys and the potential for future collaboration in order to compare resident responses to medical student responses. He was consulted in 2013.

In both cases, survey questions were modeled after those in the WWAMI and AAMC surveys in order to allow comparison of responses – both individuals reported there were no proprietary concerns over using the same question formats.

Explanation of any Payment/Gift to Respondents

No payments or gifts will be given to the respondents.

Assurance of Confidentiality Provided to Respondents

All data will be collected through a secure online survey site or through secure password-protected e-mail. Program level data is aggregated and therefore by nature de-identified. Individual level data will be collected with personal identifiers (ex. e-mail addresses provided by the THC programs). Personal identifiers are needed in order link surveys completed over time to examine individual characteristics that are related to different career outcomes – for example, practice in rural or other underserved areas. In addition, identified individual level data will be provided back to the THC program directors in order for THC programs to provide accurate information for the HRSA performance measures. HRSA performance measures are required at an individual level, reported with a unique identifier created by the THC program. The survey

instruments developed for the THC Evaluation will allow THC programs to gather individual level data in a standardized manner that can then be reported to HRSA for the required performance measure reporting. In all cases, respondents will be informed that surveys are identified and information will be provided back to their THC programs in an identified manner.

Justification for Sensitive Questions

The THC Matriculant Survey asks the respondent to identify their race/ethnicity. This question is important to determine the different demographic characteristics of the individuals entering into the THC program. This information will identify if the THC programs are training diverse providers to treat a diverse population.

No information is gathered on social security number, sexual behavior and attitudes, alcohol or drug use, religious beliefs, and other matters that are commonly considered private.

Estimates of Annualized Hour and Cost Burden

This section summarizes the total burden hours for this information collection in addition to the cost associated with those hours.

12A. Estimated Annualized Burden Hours

Type of Respondent	Form Name	Number of Respondents	Number of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours
THC Program Directors	Program Data Collection Tool	45	1	8*	360
Graduated THC Residents	THC Graduate Survey	200	1	20/60	66
THC Residents	THC Matriculant Survey	200	1	15/60	50
THC Residents	THC Graduation Survey	200	1	15/60	50
Total		---	---	---	526

* Future years of implementation will require significantly less time as respondents will be asked only to update the previous year’s data.

12B. Estimated Annualized Burden Costs

Type of Respondent	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
THC Programs	360	\$21.44 ¹	\$7,718
Graduated THC Residents	66	\$86.95 ²	\$5,739

THC Residents	50	\$24.17 ³	\$1,209
THC Residents	50	\$26.14 ⁴	\$1,307
Total	526		\$15,973

¹ Hourly rate determined using Labor Category ID CES6500000008

² Hourly rate determined using Occupation Code 29-1062

³ Calculated based on a mean annual 1st year resident salary of \$50,274 with a 40 hour work week¹

⁴ Calculated based on a mean annual 3rd year resident salary of \$54,373 with a 40 hour work week¹

13. Estimates of other Total Annual Cost Burden to Respondents or Recordkeepers/Capital Costs

No additional recordkeeping or capital costs are expected for respondents. All data requested reflects basic program characteristics or individual demographics, practice characteristics, or program feedback. Therefore no additional cost burden to respondents other is expected outside of the time required to complete the survey instruments.

14. Annualized Cost to Federal Government

The systems used to collect the data will be at GWU. It is estimated that the amount of staff time needed for the contract representative and review and approval of reports is 2 FTEs at the GS-13 level—for a total of \$180,000. Collectively the estimated annualized cost to the government in staff time is estimated to be \$180,000.

15. Explanation for Program Changes or Adjustments

This is a new data collection.

16. Plans for Tabulation, Publication, and Project Time Schedule

Data collected through the Program Data Collection Tool and individual level surveys serve a number of important purposes including strengthening program performance, responding to federal reporting requirements, and responding to congressional inquiries. Since programs are publicly-funded, data collected may be showcased in peer-reviewed articles, conferences, and/or reports published through and/or sponsored by HRSA. In the case of publication, all personally identified information will be aggregated and de-identified.

The process for cleaning, analyzing, and reporting data will consist of the following steps:

Step 1: Data cleaning. Data will be cleaned using a series of predetermined analytic rules within 30 days of receipt. Errors or discrepancies in data will be flagged and followed up with THC programs where appropriate.

Step 2: Analysis. Analysis of all data will be conducted under the THC Evaluation contract at the George Washington University for the duration of the contract period (approximately 4 more years). Analysis during this time period will be descriptive as insufficient time will have passed

¹ AAMC Survey of Resident/Fellow Stipends and Benefits, 2012. Available at: <https://www.aamc.org/download/312786/data/2012stipendsurveyreportfinal.pdf>

to conduct correlation analyses of the relationships between resident characteristics and career outcomes. However, we note that such analysis may be possible in later years.

Step 3: Reporting. Data will be reported on an annual basis to HRSA in September of each year, at the time of the required annual reporting. Any additional data requests from the THC Evaluation HRSA project officers will be provided in a time period to be determined based on the status of the data collection activities and the requirements for analysis.

17. Reason(s) Display of OMB Expiration Date is Inappropriate

There is no request to seek exemption for display of the OMB expiration date.

18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification.

Appendix

Appendix A: Program Data Collection Tool

Appendix B: THC Matriculant Survey

Appendix C: THC Graduation Survey (including both identified and anonymous parts)

Appendix D: THC Graduate Survey (including both identified and anonymous parts)

Appendix E: 60-day Federal Register Notice

Appendix A: Program Data Collection Tool

Teaching Health Center Data Collection Tool

Please complete a separate data collection tool for each residency program receiving THCGME funding (for example, if your institution sponsors a Family Medicine and Dental program, please complete a data collection tool for each specialty).

General Program Information:

THC Name:	
THC Contact Address:	

Residency Program Director Name:	
Residency Program Director Phone Number:	
Residency Program Director Email:	

THC Primary Contact Name:	
THC Primary Contact Position:	
THC Primary Contact Phone Number:	
THC Primary Contact Email:	

Residency Program Specialty:	
Sponsoring Institution designated for Accreditation:	
Primary Training Site designated for Accreditation:	
Accrediting Body(ies), indicate all:	

Is your THC sponsoring institution for Accreditation a GME consortium?	Yes/No
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If yes, please list all members of the GME consortium and briefly describe their role in the consortium and residency program:	
Name	Role

Which organization employs the residency director?	
Which organization employs the residents?	

Please list any medical schools or universities your residency program is affiliated with:	
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Residents:

Enter information for your current residency program classes. The current PGY-1 class is generally the class that entered training in July 2013.

	Total Number Residents	Number Male	Number Female	Number IMGs	Number THC Resident FTE
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PGY-1 Class					
PGY-2 Class					
PGY-3 Class					
PGY-4 Class or Graduates					

	Number of Residents Matched Through Each:			
	ACGME	AOA	ADA	Outside Match
PGY-1 Class				
PGY-2 Class				
PGY-3 Class				
PGY-4 Class or Graduates				

Please describe any pipeline or other special recruitment programs for your residency program.	
Name of program	Description

Complete for each of the following Academic Years (Enter N/A if not applicable):				
	2012-2013	2011-2012	2010-2011	2009-2010
Number of Graduates Who Started the Program Year 1 and Finished This Program <i>Example, 2012-2013 would be the number who graduated during or at the end of this academic year</i>				
Number of Graduates Regardless of Whether they Began in this Program				
Number of Residents Who Withdrew from the Program, for all training years				
Number of Residents Who Transferred to Another Program, for all training years				
Number of Residents Dismissed from the Program, for all training years				
Number Residents Complete but not Promoted, for all training years				

Curriculum:

Please briefly describe how each of the following has been incorporated into the operations of your health center and into the curriculum of your THC residency program (including how you evaluate residents in these areas if appropriate).		
	Health Center Operations	Residency Curriculum and Evaluation
Patient Centered Medical Homes		

Accountable Care Organizations		
Health Information Technology		
Quality Improvement		
Interdisciplinary Teams		
Health Policy		
Health Advocacy		
Community Medicine or Public Health		
Research		

Please list and briefly describe any accreditation or programs your health center and/or residency program participates in for any of the above areas.

For example, NCQA accreditation for PCMH, Meaningful Use for HIT, or any regional or state practice transformation programs.

Name	Description

Please briefly describe how each of the following has been incorporated into the curriculum of your THC residency program (including how you evaluate residents in these areas if appropriate).

	Residency Curriculum	Resident Evaluation
Health Center Management Training		
Leadership Training		

Outpatient Training Sites:

Please indicate established outpatient clinical training sites, where all or the majority of your residents rotate for your THC residency program.

Outpatient Training Site:	
Name:	
Address:	
Does this site fall into any of the following federally designated areas/practices? Check all that apply.	<input type="checkbox"/> HPSA: Federally designated health professional shortage area <input type="checkbox"/> MUA: Federally designated medically underserved area <input type="checkbox"/> MHC: Federally designated migrant health center

	<input type="checkbox"/> CHC: Federally designated community health center <input type="checkbox"/> RHC: Federally designated rural health clinic <input type="checkbox"/> NHSC: National Health Service Corps <input type="checkbox"/> IHS: Indian Health Service site or tribal clinic <input type="checkbox"/> FQHC: Federally Qualified Health Center <input type="checkbox"/> FQHC Look Alike <input type="checkbox"/> State qualified health center/clinic <input type="checkbox"/> State or Local Health Department																				
Training objectives for site:																					
Indicate the time spent by residents in this site and whether the rotation is required or elective, indicate N/A if appropriate:																					
	<table border="1"> <thead> <tr> <th></th> <th>Average number of weeks per year in this site</th> <th>Average number of ½ day sessions per week</th> <th>Average number of full time rotation weeks per year</th> </tr> </thead> <tbody> <tr> <td>Year 1</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 2</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 3</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Year 4</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Average number of weeks per year in this site	Average number of ½ day sessions per week	Average number of full time rotation weeks per year	Year 1				Year 2				Year 3				Year 4			
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Year 1																					
Year 2																					
Year 3																					
Year 4																					
Is there a written contract between the sponsoring institution and this site?																					
Is there a financial relationship with this site for the purposes or residency training? If yes, please describe.																					
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)																					
In what year did this site first become a training site for the residency program?																					

Outpatient Training Site:			
Name:			
Address:			
Does this site fall into any of the following federally designated areas/practices? Check all that apply.	<input type="checkbox"/> HPSA: Federally designated health professional shortage area <input type="checkbox"/> MUA: Federally designated medically underserved area <input type="checkbox"/> MHC: Federally designated migrant health center <input type="checkbox"/> CHC: Federally designated community health center <input type="checkbox"/> RHC: Federally designated rural health clinic <input type="checkbox"/> NHSC: National Health Service Corps <input type="checkbox"/> IHS: Indian Health Service site or tribal clinic <input type="checkbox"/> FQHC: Federally Qualified Health Center <input type="checkbox"/> FQHC Look Alike <input type="checkbox"/> State qualified health center/clinic <input type="checkbox"/> State or Local Health Department		
Training objectives for site:			
Indicate the time spent by residents in this site and whether the rotation is required or elective, indicate N/A if appropriate:			
	Average number of	Average number of ½	Required / Elective

	weeks per year	day sessions per week	
Year 1			
Year 2			
Year 3			
Year 4			
Is there a written contract between the sponsoring institution and this site?			
Is there a financial relationship with this site for the purposes or residency training? If yes, please describe.			
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)			
In what year did this site first become a training site for the residency program?			

Outpatient Training Site:			
Name:			
Address:			
Does this site fall into any of the following federally designated areas/practices? Check all that apply.	<input type="checkbox"/> HPSA: Federally designated health professional shortage area <input type="checkbox"/> MUA: Federally designated medically underserved area <input type="checkbox"/> MHC: Federally designated migrant health center <input type="checkbox"/> CHC: Federally designated community health center <input type="checkbox"/> RHC: Federally designated rural health clinic <input type="checkbox"/> NHSC: National Health Service Corps <input type="checkbox"/> IHS: Indian Health Service site or tribal clinic <input type="checkbox"/> FQHC: Federally Qualified Health Center <input type="checkbox"/> FQHC Look Alike <input type="checkbox"/> State qualified health center/clinic <input type="checkbox"/> State or Local Health Department		
Training objectives for site:			
Indicate the time spent by residents in this site and whether the rotation is required or elective, indicate N/A if appropriate:			
	Average number of weeks per year	Average number of ½ day sessions per week	Required / Elective
Year 1			
Year 2			
Year 3			
Year 4			
Is there a written contract between the sponsoring institution and this site?			
Is there a financial relationship with this site for the purposes or residency training? If yes, please describe.			
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)			
In what year did this site first become a training site			

for the residency program?	
----------------------------	--

Inpatient Training Sites:

Inpatient Training Site:		
	Name:	
	Address:	
Does this site fall into any of the categories? Check all that apply.	<input type="checkbox"/> Non-profit hospital <input type="checkbox"/> For-profit hospital <input type="checkbox"/> Children's Hospital <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Critical Access Hospital	
Training objective for site:		
Indicate the duration of resident rotations and whether the rotation is required or elective, indicate N/A if appropriate:		
	Average number of weeks per year	Required/Elective (weeks/weeks)
Year 1		
Year 2		
Year 3		
Year 4		
Is there a written contract between the sponsoring institution and this site?		
Is there a financial relationship with this site for the purposes or residency training? If yes, please describe.		
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)		
In what year did this site first become a training site for the residency program?		

Inpatient Training Site:		
	Name:	
	Address:	
Does this site fall into any of the categories? Check all that apply.	<input type="checkbox"/> Non-profit hospital <input type="checkbox"/> For-profit hospital <input type="checkbox"/> Children's Hospital <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Critical Access Hospital	
Training objective for site:		
Indicate the duration of resident rotations and whether the rotation is required or elective, indicate N/A if appropriate:		
	Average number of weeks per year	Required/Elective (weeks/weeks)
Year 1		
Year 2		
Year 3		
Year 4		
Is there a written contract between the sponsoring institution and this site?		
Is there a financial relationship with this site for the		

purposes or residency training? If yes, please describe.	
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)	
In what year did this site first become a training site for the residency program?	

Inpatient Training Site:		
Name:		
Address:		
Does this site fall into any of the categories? Check all that apply.	<input type="checkbox"/> Non-profit hospital <input type="checkbox"/> For-profit hospital <input type="checkbox"/> Children's Hospital <input type="checkbox"/> Rehabilitation Hospital <input type="checkbox"/> Critical Access Hospital	
Training objective for site:		
Indicate the duration of resident rotations and whether the rotation is required or elective, indicate N/A if appropriate:		
	Average number of weeks per year	Required/Elective (weeks/weeks)
Year 1		
Year 2		
Year 3		
Year 4		
Is there a written contract between the sponsoring institution and this site?		
Is there a financial relationship with this site for the purposes or residency training? If yes, please describe.		
Is there an exchange of resources with this site for the purposes or residency training? If yes, please describe. (Resources may include personnel.)		
In what year did this site first become a training site for the residency program?		

*** Add more if needed ***

Community Experiences:

Please indicate any additional established community experiences for your THC residency program.

Experience:	
Training Objectives:	
Description of timing and duration of experience:	

Experience:	
Training Objectives:	
Description of timing and duration of experience:	

Experience:	
Training Objectives:	
Description of timing and duration of experience:	

Experience:	
-------------	--

Training Objectives:	
Description of timing and duration of experience:	

Experience:	
Training Objectives:	
Description of timing and duration of experience:	

*** Add more if needed ***

Primary Care Clinical Service:

* Complete for all clinical sites where residents routinely provide primary care. Primary care may include general family medicine, internal medicine, pediatrics, geriatrics, ob-gyn, psychiatry, or dental services.

Clinical Site Name:			
	Average number of patient visits per ½ day session	Average number of patient visits per year seen in health center	Average patient panel size
Year 1			
Year 2			
Year 3			
What is the average preceptor to resident ratio in your health center?			
How many patients do faculty physicians typically see during a half day session when supervising residents?			
How many patients do faculty physicians typically see during a half day session when not supervising residents?			

Clinical Site Name:			
	Average number of patient visits per ½ day session	Average number of patient visits per year seen in health center	Average patient panel size
Year 1			
Year 2			
Year 3			
What is the average preceptor to resident ratio in your health center?			
How many patients do faculty physicians typically see during a half day session when supervising residents?			
How many patients do faculty physicians typically see during a half day session when not supervising residents?			

Clinical Site Name:			
	Average number of patient visits per ½ day session	Average number of patient visits per year seen in health center	Average patient panel size
Year 1			
Year 2			
Year 3			
What is the average preceptor to resident ratio in your health center?			

How many patients do faculty physicians typically see during a half day session when supervising residents?	
How many patients do faculty physicians typically see during a half day session when not supervising residents?	

*** Add more if needed ***

Residency Program Financing:

Please list all funding sources for your THC residency program, including the amount and time period or funding. Funding sources may include THCGME and Medicare payments, as well as state funding and local, state, or national grants.		
Funding Source	Annual Amount	Time Period (indicate funding cycle if recurrent funding or grant period for grants)
THCGME Payment Program		
Medicare		
Medicaid		
Other (please specify):		

Health Center Information:

Health centers include any community-based ambulatory health center systems affiliated with your Teaching Health Center program. These systems may include multiple clinical sites.

Health Center Name:		
Please list all health center clinical sites and addresses.		
Name	Address	Is this a residency teaching site? (yes/no)
Has your health center or is your health center planning to expand, either in operations or in sites? If yes, please describe.		
Please list any additional health education students or residents training at your health center, and briefly describe the duration of their rotations (for example, 1 month rotations or weekly ½ day continuity clinics).		
Name	Duration	
For each of the following, please indicate the number of physicians currently participating in the program in your health center. Enter N/A if appropriate.		
	Number of physicians	Number of dentists
NHSC scholarship		
NHSC loan repayment		

State loan repayment		
J-1 visa waiver		

Health Center Name: _____

Please list all health center clinical sites and addresses.

Name	Address	Is this a residency teaching site? (yes/no)

Has your health center or is your health center planning to expand, either in operations or in sites? If yes, please describe.

Please list any additional health education students or residents training at your health center, and briefly describe the duration of their rotations (for example, 1 month rotations or weekly ½ day continuity clinics).

Name	Duration

For each of the following, please indicate the number of physicians and dentists currently participating in the program in your health center. Enter N/A if appropriate.

	Number of physicians	Number of dentists
NHSC scholarship		
NHSC loan repayment		
State loan repayment		
J-1 visa waiver		

Appendix B: Matriculant Survey

Background

1. What is your gender?

- Female
 Male

2. What is your age (please enter an integer)?

3. What is your ethnicity?

- Hispanic or Latino
 Not Hispanic or Latino

4. What is your race? Select one or more.

- American Indian or Alaska Native
 Asian
 Black or African-American
 Native Hawaiian or Other Pacific Islander
 White

5. What is your country of origin?

6. What language(s) do you feel competent and confident in providing safe and effective care to patients?

7. Please enter the following information for the high school you graduated from:

Name	<input type="text"/>
City	<input type="text"/>
County	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>
Country	<input type="text"/>
Year of Graduation	<input type="text"/>

Rural/Disadvantaged Background

8. Would you consider yourself from an "environmentally disadvantaged background?" Please answer to the best of your ability.

This means an individual who:

(1) Comes from an environment that inhibited the individual from obtaining the knowledge, skill and ability required to enroll in and graduate from a health professions school; or

(2) Comes from a family with an annual income below a level based on low-income thresholds according to family size published by the U.S. Bureau of the Census, adjusted annually for changes in the Consumer Price Index, and adjusted by the Secretary for use in all health professions programs.

Yes

No

9. Do you fall into any of the following categories? Please choose all that apply.

You are from a high school with low average SAT/ACT scores

You are from a school district where 50% or less of graduates on to college

You have a diagnosed physical/mental impairment substantially limiting participation in education

English is not your primary language and has been a barrier to academic performance

You are the first generation in your family to attend college

You are from a high school where > 30% of students were eligible for free or reduced lunch prices

You come from a family with an annual income < 200% of the Federal Poverty Level (Currently \$31,020 for a family of 2; \$39,060 for a family of 3; \$47,100 for a family of 4; \$55,140 for a family of 5)

You come from a family that received public assistance (e.g. Aid to Families with Dependent Children, food stamps, Medicaid, public housing)

You qualified for a need based scholarship

10. Do you consider yourself from a rural background?

Yes

No

11. Please indicate your veteran status.

- Active Duty Military
- Reservist
- Veteran–Prior Service
- Veteran–Retired
- Not a Veteran

Medical School and Dental School

12. Please enter the following information for your Medical School or Dental School:

Name	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Country	<input type="text"/>

13. Does your Medical School or Dental School have more than one campus?

- Yes
 No

14. If your Medical School or Dental School had more than one campus, please indicate which campus you primarily attended? (Enter N/A if not applicable)

15. Did your Medical School or Dental School have special "paths" or "tracks"?

- Yes
 No

16. If you participated in a special "track" or "pathway" at your Medical School or Dental School, please indicate that "track" or "pathway" below.

17. What year did you graduate from Medical School or Dental School?

18. Did you enter residency in the academic year immediately following graduation from Medical School or Dental School?

- Yes
 No

19. If you did not enter Residency immediately after graduating from Medical School or Dental School, how did you spend the time in between?

Pre-Medical or Pre-Dental Education

20. Please enter the following information for any education (degrees or certificate) either before or after Medical School or Dental School, including any undergraduate education.

School 1:

Name	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Country	<input type="text"/>
Study Area	<input type="text"/>
Degree Conferred	<input type="text"/>
Start Year	<input type="text"/>
End Year	<input type="text"/>

21. School 2 (if applicable):

Name	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Country	<input type="text"/>
Study Area	<input type="text"/>
Degree Conferred	<input type="text"/>
Start Year	<input type="text"/>
End Year	<input type="text"/>

22. School 3 (if applicable):

Name	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Country	<input type="text"/>
Study Area	<input type="text"/>
Degree Conferred	<input type="text"/>
Start Year	<input type="text"/>
End Year	<input type="text"/>

23. School 4 (if applicable):

Name	
City	
State	
Country	
Study Area	
Degree Conferred	
Start Year	
End Year	

Pre-Medical School or Pre-Dental School Experience

24. Did you enter Medical or Dental School in the academic year immediately following graduation from college?

Yes

No

25. If you did not enter Medical School or Dental School immediately after graduating from college, how did you spend the time in between?

Residency Choice

26. What were your primary reasons for choosing your current Residency Program?

Career Plans

27. Are you planning to do additional residency or fellowship training after this residency training program?

- Yes
 No
 Not Yet Decided

28. If yes, what additional residency/fellowship training are you planning after this residency training program?

29. Do you know what geographic location you want to work following all residency/fellowship training?

- Yes
 No
 Unsure

30. If yes, where do you hope to work after completing your residency/fellowship training program? Complete as much as you know.

City/Town:
State:
Country:

31. Please indicate the setting(s) in which you plan to work after the completion of your residency/fellowship training. Choose all that apply.

- Large City (Population 500,000 or More)
 Suburb of a Large City
 City of Moderate Size (Population 50,000 to 500,000)
 Suburb of Moderate Size City
 Small City (Population 10,000 to 50,000 - other than suburb)
 Town (Population 2,500 to 10,000 - other than suburb)
 Small Town (Population less than 2,500)
 Rural/Unincorporated Area
 Undecided or No Preference

32. Do you plan to locate your practice in an underserved area?

- Yes
 No
 Undecided

33. If you plan to locate your practice in an underserved area, please indicate the likely location.

- Rural community
 Inner-city community

Other (please specify)

34. Regardless of location, do you plan to work primarily with minority populations?

- Yes
 No
 Undecided

35. If you plan to work primarily with minority populations, please indicate the minority population you intend to work with. Select all that apply.

- Black/African American
 Hispanic/Latino
 Native American
 Asian

Other (please specify)

Student Debt

36. Did you receive a scholarship with a service requirement for medical school (for example, National Health Service Corps Scholarship, State or local scholarship, or private scholarship)?

- Yes
 No

37. If you did receive a scholarship with a service requirement, please indicate the name of the scholarship

38. Do you plan to apply for National Health Service Corps (NHSC) or other loan repayment program with a service requirement?

- Yes
 No
 Undecided
 Don't Qualify
 Unaware of such programs

39. What is the total amount of your outstanding educational loans for your college/premedical or predental education?

- No debt
 \$1 to \$ 24,999
 \$25,000 to \$ 49,999
 \$50,000 to \$ 74,999
 \$75,000 to \$ 99,999
 \$100,000 to \$124,999
 \$125,000 to \$149,999
 \$150,000 to \$174,999
 \$175,000 to \$199,999
 \$200,000 to \$224,999
 \$225,000 to \$249,999
 \$250,000 to \$274,999
 \$275,000 to \$299,999
 \$300,000 or more

40. What is the total amount of your outstanding educational loans for your medical or dental education?

- No debt
- \$1 to \$ 24,999
- \$25,000 to \$ 49,999
- \$50,000 to \$ 74,999
- \$75,000 to \$ 99,999
- \$100,000 to \$124,999
- \$125,000 to \$149,999
- \$150,000 to \$174,999
- \$175,000 to \$199,999
- \$200,000 to \$224,999
- \$225,000 to \$249,999
- \$250,000 to \$274,999
- \$275,000 to \$299,999
- \$300,000 or more

Appendix C: Graduation Survey

The Graduation Survey will collect both identified and anonymous data, and is separated into two parts: 1) the collection of identifiable data (career plan information and updated contact information); and 2) the collection of anonymous feedback on the THC residency program.

Career Plans

1. What are your plans following graduation?

2. After all residency and fellowship training, do you plan to practice in Primary Care?

- Yes
- No
- Undecided

3. After all residency and fellowship training, do you plan to practice in an underserved area?

- Yes
- No
- Undecided

4. If you plan to practice in an underserved area, please indicate the likely location.

- Rural community
- Inner-city community

Other (please specify)

Job Information

5. Have you accepted a job (non-training) following graduation from your current residency program?

Yes

No

Job Information

6. Please provide the following information for your post-residency job:

Position Title	<input type="text"/>
Organization Name	<input type="text"/>
Address (primary clinical site)	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code	<input type="text"/>
Country	<input type="text"/>
Primary Responsibilities	<input type="text"/>

7. How would you classify your employer for this position?

- Academic
- Private Practice
- Community Health Center
- Community-based organization/non-profit
- Hospital - Non-Academic
- Federal Government
- State Government
- City/County Government
- Unknown

Other (please specify)

8. Will you be practicing clinical medicine or dentistry?

- Yes
- No

9. If yes, will you be practicing in any of the following federally designated areas/practices?

Check all that apply.

- HPSA: Federally designated health professional shortage area
- MUA: Federally designated medically underserved area
- MHC: Federally designated migrant health center
- CHC: Federally designated community health center
- RHC: Federally designated rural health clinic
- NHSC: National Health Service Corps
- IHS: Indian Health Service site or tribal clinic
- FQHC: Federally Qualified Health Center
- State qualified health center/clinic
- State or Local Health Department
- None of the above

Other underserved population (please specify)

10. Will you be participating in a loan repayment program in this position?

- Yes
- No
- Unsure

11. If you will receive loan repayment in your next position, please indicate the type of loan repayment program. Choose all that apply.

- Department of Education's Public Service Loan Forgiveness (PSLF)
- National Health Service Corps Scholarship
- National Health Service Corps Loan Repayment
- Indian Health Service Corps
- Armed Services (Navy, Army, Air Force)
- Uniformed Service (CDC, HHS)
- State loan forgiveness program
- Hospital program (e.g. sign-on bonus)

Other (please specify)

Fellowship Training

12. Are you planning any additional residency or fellowship training after your current residency program?

- Yes
 No
 Unsure

13. If you have a residency or fellowship position, please provide the following information:

Specialty	<input type="text"/>
Program Name	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Country	<input type="text"/>

Contact Information

14. Please provide the best contact information to follow up with you after graduation.

Name:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City/Town:	<input type="text"/>
State:	<input type="text"/>
ZIP:	<input type="text"/>
Country:	<input type="text"/>
Email Address:	<input type="text"/>
Phone Number:	<input type="text"/>

Residency Program Feedback

1. What are the strengths of your residency program?

2. How do you think your residency program could be improved?

Residency Program Career Planning

3. Please describe any career planning/mentorship provided by your residency program.

4. Based on your experience, indicate your level of satisfaction with the career planning/mentorship you received during your residency.

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Preparedness for Practice

5. Please indicate whether you agree with the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel well prepared to practice independently in an inpatient hospital setting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel well prepared to practice independently in an outpatient primary care setting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel well prepared to practice independently in an underserved setting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel well prepared to practice independently in a rural setting.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix D: Graduate Survey

The Graduate Survey will collect both identified and anonymous data, and is separated into two parts: 1) the collection of identifiable data (career plan information and updated contact information); and 2) the collection of anonymous feedback on the THC residency program.

Certification & Licensing

1. Are you currently board certified?

- Yes
 No

2. If yes, what board certifications do you maintain? Please check all that apply and add any specialty certifications as appropriate.

- Family Medicine - ABFM
 Family Medicine - AOA
 Internal Medicine - ABIM
 Internal Medicine - AOA
 Pediatrics - ABP
 Pediatrics - AOA
 OB/Gyn - ABOG
 OB/Gyn - AOA
 Psychiatry - ABPN
 Psychiatry - AOA
 General Dentistry - ABGP
 Pediatric Dentistry - ABPD

Other (please specify)

3. Do you currently hold an active medical or dental license?

- Yes
 No

4. If yes, in what state(s) do you hold an active license?

5. Do you have an active National Provider Identifier (NPI) number?

- Yes
 No
 Don't Know/Prefer Not to Submit

6. If yes, please enter your NPI number.

Currently in Training

7. Are you currently in a training position, such as a residency or fellowship?

- Yes
- No

Current Training Position

8. Please provide the following information for the training position:

Specialty of Program:

Training Institution Name:

City/Town:

State:

ZIP:

Country:

Additional Training

9. Have you completed any additional training, such as a residency or fellowship, since your primary care residency program?

Yes

No

Additional Training Positions

10. Please provide the following information for the most recent training position:

Specialty of Program:

Training Institution Name:

City/Town:

State:

ZIP:

Country:

11. Please provide the following information for the next most recent training position (if applicable):

Specialty of Program:

Training Institution Name:

City/Town:

State:

ZIP:

Country:

12. Please provide the following information for the next most recent training position (if applicable):

Specialty of Program:

Training Institution Name:

City/Town:

State:

ZIP:

Country:

Post-Graduation Employment

13. Are you currently employed in a non-training position?

Yes

No

Post-Graduation Employment

14. If yes, how would you classify your current primary employer?

- Academic
- Private Practice
- Community Health Center
- Community-based organization/non-profit
- Hospital - Non-Academic
- Federal Government
- State Government
- City/County Government
- Unknown

Other (please specify)

Practicing Clinical Medicine/Dentistry

15. Are you currently practicing clinical medicine or dentistry?

Yes

No

Principal Clinical Practice Site

The following questions gather information about the sites where you practice clinically (i.e. provide patient care) - this may include seeing patients independently or with trainees, such as students or residents.

16. Please enter the following information for you PRINCIPAL practice site - this is the physical location where you spend most of your patient care time.

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

17. What specialty do you primarily practice in this setting? Choose one.

- General Family Medicine
- General Internal Medicine
- General Pediatrics
- OB/Gyn
- Psychiatry
- Geriatrics
- Dentistry

Other (please specify)

18. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

19. Which of the following best describes the principal method by which you are paid in this practice setting? Check one:

- Salary
- Receipts
- Base salary plus production incentive
- Locums

Other (please specify)

20. Which of the following best describes your principal practice setting's reimbursement model?

- Fee for service practice
- Health Maintenance Organization (HMO)
- Accountable Care Organization
- Concierge/Membership

Other (please specify)

21. Which of the following best describes your principal practice setting (check all that apply)?

- Community-based Health Center
- Private Practice
- Teaching program
- Hospital
- Emergency Medicine
- Urgent Care
- Military

Other (please specify)

22. Which of the following best describes the practice organization of your principal practice (check only one):

- Solo
- Partnership (2-physician practice)
- Single specialty group (3 or more physicians)
- Multi-specialty partnership or group
- Hospital owned
- Academic program

Other (please specify)

23. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- HPSA: Federally designated health professional shortage area
- MUA: Federally designated medically underserved area
- MHC: Federally designated migrant health center
- CHC: Federally designated community health center
- RHC: Federally designated rural health clinic
- NHSC: National Health Service Corps
- IHS: Indian Health Service site or tribal clinic
- FQHC: Federally Qualified Health Center
- State qualified health center/clinic
- State or Local Health Department
- None of the above

Other underserved population (please specify)

24. Please describe the ethnicity of your patient population at this site (approx):

% Hispanic or Latino

% Not Hispanic or Latino

25. Please describe the race of your patient population at this site (approx):

% American Indian or
Alaska Native

% Asian

% Black or African-American

% Native Hawaiian or Other
Pacific Islander

% White

26. What is the approximate percent of patients who are on Medicaid in this practice?

- 0-9%
- 10-30%
- 31-50%
- 51-70%
- 71-90%
- 91-100%
- Don't know

27. What is the approximate percent of patients who are on Medicare in this practice?

- 0-9%
- 10-30%
- 31-50%
- 51-70%
- 71-90%
- 91-100%
- Don't know

28. What is the approximate percent of patients who are uninsured in this practice?

- 0-9%
- 10-30%
- 31-50%
- 51-70%
- 71-90%
- 91-100%
- Don't know

29. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

30. Are you providing patient care at any other sites?

- Yes
- No

Additional Clinical Site #1

31. Please enter the following information for the clinical site you spend the next most time in:

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

32. What specialty do you primarily practice in this setting? Choose one.

- General Family Medicine
- General Internal Medicine
- General Pediatrics
- OB/Gyn
- Psychiatry
- Geriatrics
- Dentistry

Other (please specify)

33. Which of the following best describes this practice setting (check all that apply)?

- Community-based Health Center
- Private Practice
- Teaching program
- Hospital
- Emergency Medicine
- Urgent Care
- Military

Other (please specify)

34. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- HPSA: Federally designated health professional shortage area
- MUA: Federally designated medically underserved area
- MHC: Federally designated migrant health center
- CHC: Federally designated community health center
- RHC: Federally designated rural health clinic
- NHSC: National Health Service Corps
- IHS: Indian Health Service site or tribal clinic
- FQHC: Federally Qualified Health Center
- State qualified health center/clinic
- State or Local Health Department
- None of the above

Other underserved population (please specify)

35. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

36. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

37. Are you providing patient care at any other sites?

- Yes
- No

Additional Clinical Site #2

38. Please enter the following information for the clinical site you spend the next most time in:

Name:
Address:
Address 2:
City/Town:
State:
ZIP:
Country:

39. What specialty do you primarily practice in this setting? Choose one.

- General Family Medicine
 General Internal Medicine
 General Pediatrics
 OB/Gyn
 Psychiatry
 Geriatrics
 Dentistry

Other (please specify)

40. Which of the following best describes this practice setting (check all that apply)?

- Community-based Health Center
 Private Practice
 Teaching program
 Hospital
 Emergency Medicine
 Urgent Care
 Military

Other (please specify)

41. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- HPSA: Federally designated health professional shortage area
- MUA: Federally designated medically underserved area
- MHC: Federally designated migrant health center
- CHC: Federally designated community health center
- RHC: Federally designated rural health clinic
- NHSC: National Health Service Corps
- IHS: Indian Health Service site or tribal clinic
- FQHC: Federally Qualified Health Center
- State qualified health center/clinic
- State or Local Health Department
- None of the above

Other underserved population (please specify)

42. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

43. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

44. Are you providing patient care at any other sites?

- Yes
- No

Additional Clinical Site #3

45. Please enter the following information for the clinical site you spend the next most time in:

Name:

Address:

Address 2:

City/Town:

State:

ZIP:

Country:

46. What specialty do you primarily practice in this setting? Choose one.

- General Family Medicine
- General Internal Medicine
- General Pediatrics
- OB/Gyn
- Psychiatry
- Geriatrics
- Dentistry

Other (please specify)

47. Which of the following best describes this practice setting (check all that apply)?

- Community-based Health Center
- Private Practice
- Teaching program
- Hospital
- Emergency Medicine
- Urgent Care
- Military

Other (please specify)

48. Does this practice site fall into any of the following federally designated areas/practices? Check all that apply.

- HPSA: Federally designated health professional shortage area
- MUA: Federally designated medically underserved area
- MHC: Federally designated migrant health center
- CHC: Federally designated community health center
- RHC: Federally designated rural health clinic
- NHSC: National Health Service Corps
- IHS: Indian Health Service site or tribal clinic
- FQHC: Federally Qualified Health Center
- State qualified health center/clinic
- State or Local Health Department
- None of the above

Other underserved population (please specify)

49. What percent of a full-time equivalent (FTE) are you working at this site (Full-time =100%; Each half day per week is generally considered 10%)?

50. How many patients do you typically see in this practice setting during a half day of practice? (Please use an integer)

51. Are you providing patient care at any other sites?

- Yes
- No

Patient Encounters

52. On average, how many face-to-face patient encounters do you have per week in each of the following settings? (Please use an integer for each)

Office	<input type="text"/>
Hospital	<input type="text"/>
Nursing Home	<input type="text"/>
Home Visit	<input type="text"/>
Emergency Department	<input type="text"/>
Other (Specify setting and number)	<input type="text"/>

Non-Patient Care Time

53. Do you have time in your job reserved for non-patient care related activities (such as teaching, research or administration)?

Yes

No

54. If yes, please indicate what percent FTE, regardless of location, you are working in each of the following areas:

Teaching	<input type="text"/>
Research	<input type="text"/>
Administration	<input type="text"/>
Other (Please specify area and FTE)	<input type="text"/>

55. Are you currently involved in community service related to your position as a health care provider in the community? Examples might include working with a free clinic, conducting health outreach, or working with a local health related agency.

Yes

No

56. If yes, please describe how you are involved in community service related to your position as a health care provider in the community.

Non-Practicing

57. If you are not practicing clinical medicine or dentistry, what are you currently doing?

Previous Employment

58. Have you held any other jobs since graduating from your primary care residency?

- Yes
- No

Previous Employment

59. Please provide the following information for the most recent employment:

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date: (Month/Yr)

End Date: (Month/Yr)

60. How would you classify this employer?

- Academic
- Private Practice
- Community-based organization/non-profit
- Hospital - Non-Academic
- Federal Government
- State Government
- City/County Government
- Unknown

Other (please specify)

61. Please provide the following information for the next most recent employment (if applicable):

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date: (Month/Yr)

End Date: (Month/Yr)

62. How would you classify this employer?

- Academic
- Private Practice
- Community-based organization/non-profit
- Hospital - Non-Academic
- Federal Government
- State Government
- City/County Government
- Unknown

Other (please specify)

63. Please provide the following information for the next most recent employment (if applicable):

Specialty of Practice:

Organization:

City/Town:

State:

ZIP:

Country:

Start Date (Month/Yr):

End Date (Month/Yr):

64. How would you classify this employer?

- Academic
- Private Practice
- Community-based organization/non-profit
- Hospital - Non-Academic
- Federal Government
- State Government
- City/County Government
- Unknown

Other (please specify)

Loan Repayment

65. Have you participated in a loan repayment program since finishing your primary care residency?

- Yes
 No

66. If you have received any kind of loan repayment since completing your primary care residency program, please indicate the type of loan repayment program. Choose all that apply.

- Department of Education's Public Service Loan Forgiveness (PSLF)
 National Health Service Corps Scholarship
 National Health Service Corps Loan Repayment
 Indian Health Service Corps
 Armed Services (Navy, Army, Air Force)
 Uniformed Service (CDC, HHS)
 State loan forgiveness program
 Hospital program (e.g. sign-on bonus)

Other (please specify)

Contact Information

67. Please provide any updates in your contact information for your residency program:

Name:	<input type="text"/>
Address:	<input type="text"/>
Address 2:	<input type="text"/>
City/Town:	<input type="text"/>
State:	<input type="text"/>
ZIP:	<input type="text"/>
Country:	<input type="text"/>
Email Address:	<input type="text"/>
Phone Number:	<input type="text"/>

Comments

Thank you for completing this survey. Please provide any additional comments either in regard to the survey or to your residency program in the space below.

68. Comments

Residency Feedback

1. Are there areas that should have received MORE emphasis during your residency?

2. Are there areas that should have received LESS emphasis during your residency?

3. How satisfied are you with your residency training in the following areas?

	1 (Unsatisfied)	2	3	4	5 (Highly Satisfied)
Medical Knowledge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Procedural Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Practice Management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communication Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medical Ethics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Practice Satisfaction

4. Please indicate your level of satisfaction with your principle practice in the following areas:

	1 (Unsatisfied)	2	3	4	5 (Highly Satisfied)
Location	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colleagues	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Employer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Income	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. In your practice, what is the greatest source of satisfaction?

6. In your practice, what is the greatest source of dissatisfaction?

7. Please answer the following:

	1 (Unsatisfied)	2	3	4	5 (Highly Satisfied)
How satisfied are you with your choice of medicine/dentistry as a profession?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How satisfied are you with your choice of specialty?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments

Thank you for completing this survey. Please provide any additional comments either in regard to the survey or to your residency program in the space below.

8. Comments

Appendix E: 60-day Federal Register Notice

Federal Register / Vol. 78, No. 113 / Wednesday, June 12, 2013 / Notices

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities; Proposed Collection; Public Comment Request

AGENCY: Health Resources and
Services Administration, HHS.
ACTION: Notice.

SUMMARY: In compliance with the requirement for opportunity for public comment on proposed data collection projects (Section 3506(c) (2)(A) of the Paperwork Reduction Act of 1995), the Health Resources and Services Administration (HRSA) announces plans to submit an Information Collection Request (ICR), described below, to the Office of Management and Budget (OMB). Prior to submitting the ICR to OMB, HRSA seeks comments from the public regarding the burden estimate, below, or any other aspect of the ICR.

DATES: Comments on this Information Collection Request must be received within 60 days of this notice. **ADDRESSES:** Submit your comments to paperwork@hrsa.gov or mail the HRSA Information Collection Clearance Officer, Room 10-29, Parklawn

Building, 5600 Fishers Lane,
Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT:
To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, email paperwork@hrsa.gov or call the HRSA Information Collection Clearance Officer at (301) 443-1984. **SUPPLEMENTARY INFORMATION:** When submitting comments or requesting information, please include the information request collection title for reference. *Information Collection Request Title:* Evaluation and Initial Assessment of

HRSA Teaching Health Centers. OMB No. 0915-xxxx—New. *Abstract:* Section 5508 of the Affordable Care Act of 2010 amended section 340H of the Public Health Service Act to establish the Teaching Health Center Graduate Medical Education program to support the expansion of new and existing primary care residency training programs in community-based settings. The primary goals of this program are to increase the production of primary care doctors who are well prepared to practice in community settings, particularly with underserved populations, and to improve the overall number and geographic distribution of primary care providers. To ensure these goals are achieved, the George Washington University (GW) will conduct an evaluation of the training, administrative and organizational structures, clinical service, challenges, innovations, costs associated with training, and outcomes of Teaching Health Centers (THCs). GW has developed a program data collection tool that assesses basic organizational and training characteristics of the programs (including program specialty, numbers trained, training sites, educational partners, and residency program financing), educational initiatives (particularly around training for changing health

care delivery systems and community experiences), and health center characteristics (including current workforce and vacancies, clinical service provided by residents, and participation in workforce programs such as the National Health Service Corps). Questionnaires have also been developed for implementation with all THC matriculating residents, graduating residents, and graduated residents at one year post-graduation. The matriculation questionnaire aims to collect background information on THC residents to better understand the

characteristics of individuals who apply and are accepted to THC programs. The graduation questionnaire collects information on career plans. The alumni questionnaire collects information on career outcomes (including practice in primary care and in underserved settings) following graduation as well as feedback on the quality of training.

Statute requires that THC programs report annually on the types of primary care resident approved training programs that the THC's provided for residents, the number of approved training positions for residents, the number of residents who completed their residency training at the end of the academic year and care for vulnerable populations, and any other information as deemed appropriate by the Secretary. The described data collection activities will serve to meet this statutory requirement for the THC programs in a uniform and consistent manner and will allow

comparisons of this group to other trainees in non-THC programs.

Burden Statement: Burden in this context means the time expended by persons to generate, maintain, retain, disclose or provide the information requested. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information; to search data sources; to complete and review the collection of information; and to transmit or otherwise disclose the information. The total annual burden hours estimated for this Information Collection Request are summarized in the table below.

Total Estimated Annualized burden hours:

Form name	Number of respondents	Number of responses per respondent	Total responses	Average burden per response (in hours)	Total burden hours
Program Data Collection Tool	40	1	40	8	320
THC Graduate Survey	200	1	200	0.33	66
THC Matriculant Survey	200	1	200	0.25	50
THC Graduation Survey	200	1	200	0.25	50
Total	640	640	486

Dated: June 6, 2013.

Bahar Niakan,

Director, Division of Policy and Information Coordination.

[FR Doc. 2013-13918 Filed 6-11-13; 8:45 am]

BILLING CODE 4165-15-P