**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 |
|  | |
| **If yes, please list all members of the GME consortium and briefly describe their role in the consortium and residency program:** | |
| **Name** | **Role** |
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| Which organization employs the residency director? |  |
| Which organization employs the residents? |  |

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

**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** |
| **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** |
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| --- | --- | --- | --- | --- |
| **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  *Example, 2012-2013 would be the number who graduated during or at the end of this academic year* |  |  |  |  |
| 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:**

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| --- | --- | --- |
| **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 |  |  |

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| **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** |
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| --- | --- | --- |
| **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. | * 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 * FQHC Look Alike * State qualified health center/clinic * 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 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 |  |  |  |
|  | | | |
| 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. | * 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 * FQHC Look Alike * State qualified health center/clinic * 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? |  | | |

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| --- | --- | --- | --- |
| **Outpatient Training Site:** | | | |
| Name: |  | | |
| Address: |  | | |
| Does this 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 * FQHC Look Alike * State qualified health center/clinic * 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:**

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| --- | --- | --- |
| **Inpatient Training Site:** | | |
| Name: |  | |
| Address: |  | |
| Does this site fall into any of the categories? Check all that apply. | * Non-profit hospital * For-profit hospital * Children’s Hospital * Rehabilitation Hospital * 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? |  | |

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| --- | --- | --- |
| **Inpatient Training Site:** | | |
| Name: |  | |
| Address: |  | |
| Does this site fall into any of the categories? Check all that apply. | * Non-profit hospital * For-profit hospital * Children’s Hospital * Rehabilitation Hospital * 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. | * Non-profit hospital * For-profit hospital * Children’s Hospital * Rehabilitation Hospital * 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: |  |

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

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

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| 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)** |
|  |  | |  |
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|  | | | |
| 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** | |
|  | |  | |
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|  | | | |
| **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)** |
|  |  | |  |
|  |  | |  |
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|  | | | |
| 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** | |
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| **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 |  | |  |