Teaching Health Center Program Characteristics Survey

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**

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. PGY-1 residents are currently enrolled but have not yet completed their first year of training.

	Total Number of 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**

Complete for each of the following Academic Years (Enter N/A if not applicable):				
	2014-2015	**2013-2014**	**2012-2013**	**2011-2012**
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:

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? o HPSA: Federally designated health professional shortage area o MUA: Federally designated medically underserved area o MHC: Federally designated migrant health center o CHC: Federally designated community health center o RHC: Federally designated rural health clinic o NHSC: National Health Service Corps o IHS: Indian Health Service site or tribal clinic o FQHC: Federally Qualified Health Center o FQHC Look Alike o State qualified health center/clinic o State or Local Health Department	Write all the federally designated areas/practices that apply to this site here:
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? ○ 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	Write all the federally designated areas/practices that apply to this site here:		
Training objectives for site:			
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Year 1			
Year 2			
Year 3			
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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?	

Inpatient Training Sites:

Inpatient Training Site Name:		
Address:		
Does this site fall into any of the categories? o Non-profit hospital o For-profit hospital o Children's Hospital o Rehabilitation Hospital o Critical Access Hospital	Write all the categories that this site falls into here:	
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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Address:	
Does this site fall into any of the categories? o Non-profit hospital o For-profit hospital	Write all the categories that this site falls into here:

○ 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		

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	Average number of weeks per year	**Required/Elective (weeks/weeks)**
Year 1		
Year 2		
Year 3		
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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:	

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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?			

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Year 2			
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Year 1			
Year 2			
Year 3			
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How many patients do faculty physicians typically see during a half-day session when not supervising residents?			

***** Add more if needed *****

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		

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J-1 visa waiver		

***** Add more if needed *****