IND-PAR

Questions 2 and 3 asks for information that could be considered personal and/or sensitive and would be problematic and may also cause the respondent not to complete the form. Why is this necessary?

Question 6 needs an "other" category as per survey protocol.

Question 7 contains a mix of roles and employer (e.g., Fed govt employee), should be kept to roles.

Question 8. Isn't relevant to the AETC programming and just lengthens the form, please delete.

Question 9. As many HIV IPE programs are integrated into the larger IPE curricula of schools (actually important for sustainability), respondents will not necessarily know this information. Data captured here will not be of good quality.

Question 10. Same as Q 9. As HIV IPE programs are integrated into the larger IPE curricula of schools, respondents will not necessarily know this information. Data captured here will not be of good quality.

Question 11. It is not clear who should be answering this or why. Is this for those indicating their role as student above?

Question 14. This is where the Fed Govt option should be.

TAR

Question 4. It is not clear what is meant by "activity". Is this the training date? If so, we should use clear language.

Question 14. is not inclusive of all National HIV Guidelines. Is that intentional?

Questions 25-26. Modalities. The options listed appear to be a mix of methodologies and training modalities, e.g., case discussions can be used in multiple modalities, e.g., preceptorships or workshops. The options listed are not inclusive of all AETC activities, e.g., PT coaching is missing. We recommend the following modified list:

Case Discussion/Clinical Consultation
Clinical Training/Preceptorship
Community of Practice
Didactic
Interactive/Workshop
Technical Assistance/Coaching

Question 29. This will need clarification and definition. What is included in "activity"?

PPA

Questions 2, 3, and 5. The scale as written is not applicable. The response options for "decrease" are inappropriate. It reads as if we are implying participation in continuing education can actually decrease your knowledge and/or skills. Instead, we should assess if the respondent agrees/disagrees that the training had the desired impact. Consider using a Strongly Agree to Strongly Disagree Likert-scale and ask,

An option of "Not Applicable" needs to be added, since training may not directly address HIV prevention, care, and treatment

Question 7 is about the individual provider and not about the training. It shouldn't be on a post-training evaluation.

PT-SC

Most of the questions should be completed by the AETC program not the PT sites.

Question 9 needs a definition of minority serving health care facility.

Questions 14-23. It is not clear what is meant by "Number of new protocols, processes and/or policies". How is a ***number*** of new protocols, processes and/or policies a measure of PT success? The existence of appropriate, measurable and implementable protocols and policies is of importance.

The table after Question 23.
There should be consideration that there is a significant lag in data collection and reporting; the timeframe needs to reflect the availability of data.

The data are not aligned with the PT criteria.

These data may not reflect what PT sites are working to improve and hence will not be captured on this form. As per the NOFO,
"The purpose of PT is to implement process improvement, training, and technical assistance to increase the capability of organizations to implement system-level changes and enhance clinical practice to improve the provision of care and treatment to people with HIV and prevention of HIV in priority populations at increased risk.

IPE-LT

I fear this limited approach to measuring the success of IPE program will miss the greater impact the program has on our future workforce. We know increasing exposure to various health topics during professional education better prepares one to address these topics in practice. This is true whether or not one becomes a specialist in that field. We are exposing potential primary care and other providers to HIV prevention and care. As a result, they will be better

providers for all of their patients - those living with HIV, those at risk for HIV or those unsure of their risk of HIV. (Having been exposed to statistics in graduate school was invaluable to me in my future professional work, it has made me a better professional, but I did not become a statistician.)

Having said that, I appreciate the need to evaluate IPE. However, it should align with the timing and dosage of the program and assess the impact accordingly. With the expertise at the AETCs in evaluation, special evaluation programs could be developed and yield fruitful information.

That's said regarding the items on this form.
Questions 2 and 3 captures what may be considered personal data that respondents may not want to report and create respondent resistance to collect any other data on the form. It is not clear that this is necessary.

Question 4. As stated preciously, many HIV IPE programs are often integrated into the larger IPE programming at the institutions (in fact, this is desirable to enhance sustainability) so respondents will not be able to answer this question. They also will not have "graduated" from the program.

Question 5. As noted previously, the response categories are not appropriate for educational programming. Consider the agree/disagree option as listed above.