

NWX-HRSA BHPR

Moderator: Shannon Bolon
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3:29 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the question and answer session press Star 1 on your touchtone phone. Today's conference is being recorded. If you have any objections you may disconnect. And now I'll turn today's meeting over to Anne Patterson. Thank you, you may begin.

Anne Patterson: Good morning and welcome to everyone. Thank you for joining us on the technical assistance webinar to discuss performance measures with a predoctoral training, interprofessional, interdisciplinary joint degree, physician assistant training, and expansion of physician assistant training programs.

My name is Anne Patterson. I am the program officer for the Predoctoral Training in primary care medicine grant program. My colleagues from the bureau that have joined me on this call are Dr. Sylvia Joice, program officer for the interprofessional and interdisciplinary joint degree program; (Cheryl Lynn Crooks), program officer, physician assistant training grant program; Cindy Eugene, program officer, expansion of physician assistant training program; Dr. Shannon Bolon, chief primary care medical education branch;

and Dr. (Cassandra Barnes), performance evaluator for the Bureau of Health Professions.

In an effort to provide you with more technical assistance related to your grant program the Bureau of Health Professions will host a series of quarterly technical assistance webinars on various topics that will help you manage and implement your grant project.

Today's webinar is the first of a series and we welcome your suggestions on topics that you think we should cover on future webinars. The purpose of today's webinar is to provide you with information about revised data elements that will inform bureau wide performance measures.

After we provide you with some initial information we would like to engage in open dialog to get your feedback on some key questions. This call is being recorded and will be available for replay using a toll free number until August 31, 2012. I will provide you with that number and pass code at the end of today's call.

By way of background, BHPR's mission is to increase access to healthcare by developing, distributing, and retaining a diverse culturally competent health workforce. We continuously strive towards fulfillment of this mission through our many grant programs that are awarded throughout the nation to eligible entities.

To ensure that we are good stewards of our resources we use performance measurement to in part gauge the impact of our program. Performance measurement indicates what a program is accomplishing and whether results are being achieved and helps to demonstrate the value of Titles III, VII and VIII programs of the Public Health Service Act.

Performance management helps HRSA by providing us information on how resources and efforts should be allocated to ensure effectiveness and a grantee's focus on the key goals of a program.

It aids in answering questions about our programs from upper management at the Department of Health and Human Services, Congress, and the public. Data collected in the performance measurement process also supports more targeted and rigorous evaluation activities that the bureau conducts periodically.

Finally, performance measurement supports development and justification of budget requests for these programs by indicating how taxpayers and others benefit. The work you do and the performance measurement data you collect related to that work is crucial in making the case for continuity of these programs.

BHPR has four years of experience with current performance measures and has identified the need to revise them to more accurately evaluate our successes in four BHPR strategic focused areas -- quality, quantity, diversity, and distribution in the health professions.

In addition the Affordable Care Act, ACA, reauthorized many of BHPR's programs and the data collected needs to address this and programmatic entities or new program activities. Finally, BPHR needed to renew the Office of Management and Budget, OMB Paperwork Reduction Act clearance of our performance measures.

Some of you may have seen the so-called 60 day notice in the Federal Register soliciting comments on the revised measures. BHPR used this

revision process as an opportunity to examine and improve performance measures across BHPR grant programs covering numerous performance metrics. Approximately 1500 grantees will use these data elements to make program improvements.

The goal is to collect richer, more meaningful data that will enable us to provide more detailed, descriptive answers to questions about our programs as well as to be more useful in evaluating our programs.

In addition, the revision seeks to ensure that all of the critical outputs and outcomes that BHPR programs are charged with accomplishing are represented in the data collected at all points in the grantee process including in the application, at award, and annually after award.

Over the last several months BHPR staff has been reviewing existing measures and methodologies for measuring program impact, exploring the extent to which development of new measures or adaptation of existing measures is appropriate for specific programs.

The revision process has allowed us to identify cost cutting areas and common performance measures across programs eliminating data duplication and unnecessary reporting burdens for grantees.

Existing logic models, data collection forms, and accompanying guidance including data definitions and descriptions of data sources has been examined and revised as needed to support revised performance measures. Discussions were held whenever possible with current grantees to involve them in the review and revision process as well.

And as mentioned earlier, we are currently in a formal 60-day comment period intended to make certain that the public and our grantees have an opportunity to comment on the revised measures.

This process has resulted in a set of refined measures, tools, and guidance to provide more accurate and programmatically relevant data for Government Performance and Results Act, GPRA, and other reporting as well as to support evaluation activities.

In addition to continuing the use of advocated data for most programs reporting individual level data collections will be an added requirement for grantees and selected program areas including programs that produce primary care providers and programs designed to increase the diversity of the health workforce. Please note, not all programs will collect individual level data and this will be discussed in more detail later in the webinar.

Now that I have covered the background of the performance measures revision process I would like to talk a little more concretely about what this means for you as a grantee. The performance data revision package was, will be submitted to the OMB for clearance on July 20, 2011. Clearance is expected from OMB by November 2011.

However, in anticipation of overall approval we are asking grantees to review the data that will need to be corrected and implement any needed changes in their data collection activities beginning as soon as possible. The first reporting of the revised measures will occur in July/August 2012.

Most of the changes to the performance measures are compatible with existing data collection requirements or will ask for data that most grantees already

collect but was not previously requested by us. Therefore, we do not anticipate that the burden of data reporting will increase significantly for grantees.

Performance reports will be submitted through the HRSA electronic handbook system, EHB, so the mechanism that grantees previously used to submit reports will not change. We do however anticipate providing alternative approaches to submitting the performance data for grantees who wish to take advantage of them. More details will be provided at a future date.

To reiterate, grantees are asked to begin collecting data under the new measures beginning on July 1, 2011. The first reporting of the revised measures will occur in July/August 2012 in the HRSA EHB system.

The following tables were developed in order to either meet the Public Health Service Act requirement for data collection, PHS Title VII, Section 799(c)(2), or to provide a denominator for the measures used to meet the Government Performance and Results Act, GPRA, requirement and/or Office of Management and Budgets, OMB's, program assessment and evaluation requirements.

Dr. Sylvia Joice: Moving on to the tables, first looking at Table 1 LR1, total number of students trained. A variation of this table has been used in previous reporting periods. Changes, the instructions have been simplified and revised to accurately account for the number of participants our programs touch. No double counting is allowed.

For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR funded program is considered a student. For each question provide the population data requested for the period between July 1, 2011 and June 30, 2012. Note, program completers excludes

fellowships/residents which should be accounted for in the previous question. Count each student only once. Totals will calculate based on previous responses.

Moving on to the next table, LR2, students being trained by age and gender. A version of this table has been used in previous reporting years. Change, the instructions have been revised to accurately account for the number of participants our programs touch. No double counting is allowed. For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR funded program is considered a student.

Provide data on age and gender data between July 1, 2011 and June 30, 2012. Enrollees are students that were trained in BHPR funded programs and have not graduated or completed programs before June 30, 2012. Count each student only once. Total must equal total entries from LR1. Note, programs providing corresponding individual level data will prepopulate.

Moving on to requiring diversity measures. Strategy, increase health workforce diversity. While DB1 provides data on the percent of underrepresented minority students, DB2 is used to collect data on the percent of disadvantaged students in BHPR funded programs.

On to the next table. For DB1 it's split into DB1a and DB1b. Moving on to DB1a, Hispanic or Latino students by race. For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR funded program is considered a student.

Provide the number of students by race and ethnicity that have graduated or completed programs between July 1, 2011 and June 30, 2012. For enrollees provide the number of students who received training and have not graduated

or completed programs before June 30, 2012. Count each student only once. Note, programs providing corresponding individual level data will prepopulate.

DB1b, non-Hispanic or Latino students by race. For the purpose of compiling and analyzing data, anyone who receives training or education in a BHPR funded program is considered a student.

Provide the number of students by race and ethnicity that have graduated or completed programs between July 1, 2011 and June 30, 2012. For enrollees provide the number of students who received training and have not graduated or completed programs before June 30, 2012. Count each student only once. Note, programs providing corresponding individual level data will prepopulate.

Table DB2, disadvantaged means an individual who one, educationally comes from an environment that has inhibited the individual from obtaining the knowledge, skills, and abilities required to enroll and graduate from a health profession school.

Two, economically 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 Census adjusted annually for changes in the Consumer Price Index and adjusted by the Secretary for use in all health profession programs.

Note, programs providing corresponding individual level data will prepopulate the total number of disadvantaged students. Note, rows 2 and 4 will prepopulate - will be prepopulated for everyone.

Individual level data. We realize that many of you may be concerned about reporting individual level data and issues of confidentiality. We also acknowledge that you may have to make changes in your data collection process including informed consent procedures, NIRB review.

HRSA is fully aware of and sensitive to these issues and we will work with grantees to ensure that one, the information that you send to us is properly safeguarded and two, that you receive any needed technical assistance to help facilitate the process.

We will only be asking for personally identifiable information in selected programs where BHPR intends to conduct follow-ups and/or longitudinal evaluations. All other programs will report individual data using grantee assigned unique identifiers that do not identify the individual.

Being able to identify specific participants of our programs is essential to longitudinal tracking of participants that will help us understand where these individuals end up after they have graduated from health profession training programs funded by Title III, Title VII, and Title VIII grants. More generally collecting individual level data on participants will increase usefulness of the data for program evaluation purposes.

We are asking all grantees to create a seven digit numeric unique identifier for all program participants that you will be reported on. This unique identifier would be used for the same participant through the duration of this grant and should remain consistent in all of your reports. And let me just say this, that all pre doc, joint degree, physician assistant, and expansion grantees will provide this data.

Dr. Shannon Bolon: Thank you Sylvia. Good morning, this is Shannon Bolon, I'm the primary care medical education branch chief and I supervise the administration of these programs. Operator you can open the line for questions. We will be taking questions intermittently throughout the next portion of the presentation.

Coordinator: Thank you ma'am. If you would like to ask a question please press Star 1.

Dr. Shannon Bolon: I'm going to review with you the tables that you will be filling out in the next portion of the webinar. For each of the tables I will introduce them and then I will then indicate which grantees will complete the specific table. Please refer to the table labeled Table PC1, Program Level Supply Indicators for Primary Care.

Table PC1 will be completed by predoctoral training, joint degree, PA training, and expansion of PA training grantees. The purpose of this table is to obtain information about your program's training capacity and to learn about the current trainees and program completers.

There are three parts to Table PC1 labeled A, B, and C. You will all complete PC1a, b, and c. You will note that instructions and clarifications follow each table. We will walk through a brief example.

A medical school that as part of their grant related activities provides training to its students and faculty would select the following from drop down menus. First, health profession, they would select physician. Second, for primary program focus you would select undergraduate medical education.

Although this example grantee has multiple levels of training, the principal purpose of their program and their grant is medical student training.

Therefore, undergraduate medical education is the correct primary program focus.

For trainee level in this example we would select medical student, faculty academic, and faculty community based. There are two faculty options available to allow grantees to distinguish between academic health sector or base faculty and community preceptors. The remainder of the fields will be completed for each of the trainee levels.

If your particular program does not offer a degree you will select none. You will only report the number of current trainees and program completers for the reporting period.

For example, if you are completing this program in July 2011 you would only count the number of trainees and the number who completed the program between July 1, 2010 and June 30, 2011. These dates are consistent with the reporting period. Are there any questions regarding Table PC1?

Coordinator: We do have two questions in the queue. Our first question comes from (Deborah Winton).

Dr. Shannon Bolon: Go ahead.

(Deborah Winton): The question I had regarding disadvantaged definition. Is that reposted in the guidance?

Dr. Shannon Bolon: Yes.

Woman: Those are our standard definitions that we use throughout the agency and they will be posted in our glossary and they are currently found in our current manual for FY '11 and '10 and '11 reporting.

(Deborah Winton): Thank you.

Coordinator: Our next question comes from (Joyce Brown).

(Joyce Brown): Hello. If we have a grant and the project period ends at the end of August 2011, are we going to be reporting our data as part of this new collection system?

Woman: This new collection system is only for reporting periods starting July 1, 2011 through June 30, 2012. So anything ending in - before July 1, 2011 will be reported in this current cycle.

(Joyce Brown): Okay so just to be clear, ours actually ends August 31, 2011 so we would have to report data from July 1, 2011 through August 31, 2011 in this new reporting cycle. Is that correct?

Woman: Correct.

(Joyce Brown): Okay so two months worth of data. Okay thank you.

Dr. Shannon Bolon: Are there any additional questions regarding Table PC1?

Coordinator: We have another question from (Mark O'Connell).

Dr. Shannon Bolon: Go ahead.

(Mark O'Connell): Hi, this isn't directly related to this table but it's about the issue of informed consent and IRB approval to get the individual enrollees' information. That would be a voluntary agreement with the students. What if they refuse to provide all of their individual information? How do programs get around that?

Woman: We'll go into more detail about individual level data when we get to that particular table. But yes, we do understand that. We'll require IRB approval and it is a matter of informed consent so we will just have to deal with that at that time. But yes, we just request their consent and if they don't give us then they can't participate in the longitudinal study.

(Mark O'Connell): Okay I actually have another question on this table. In the field for degree of - the degree's focus area, our program is an MD/MPH combined degree program. None of - those categories seem a bit too restrictive. Are we really limited to that drop down choice or could we put in other, more accurate?

Woman: Well we're interested in the best way to capture your or describe your program so if you have recommendations we'll be glad to take those and include that in the drop down.

(Mark O'Connell): Can you put in more than one of these? Because for example if you just take the MPH component of the program, the choices there are a bunch of sub disciplines in public health of which they touch on everything in a general MPH.

Woman: What is your recommendation?

(Mark O'Connell): Either pick multiples or maybe - I guess you want to focus in those areas so you don't want us to use something that's just general public health which would cover what it is.

Dr. Shannon Bolon: That's true. This is an opportunity to get more detailed information about where your trainees are focusing. So if we need to have a more general public health option that could certainly be considered in those programs that have more of a specific focus area for their trainees as they obtain their masters in public health then they would be able to select a more detailed response.

(Mark O'Connell): That makes sense, or allow multiple primary focus areas but I guess that's kind of a contradiction in terms.

Woman: We'll consider adding a general category. Thank you for bringing that to our attention.

(Mark O'Connell): Okay.

Dr. Shannon Bolon: Other questions regarding Table PC1?

Coordinator: Yes ma'am, our next question comes from (David Mulnar).

Dr. Shannon Bolon: Go ahead.

(David Mulnar): We are opening a distance campus which is being funded by the grant. Do you want us to report numbers for the whole program or only for the campus that is receiving funding?

Dr. Shannon Bolon: The campus that's receiving funding would be appropriate. As we - we're actually working internally at this time on how to define institution and

campuses and we hope to have more clarity for future versions. At this time the campus that is receiving the funding would be your most appropriate data source.

(David Mulnar): Okay thank you.

Dr. Shannon Bolon: Thank you.

Coordinator: Ma'am we have a question from (Mary Smith).

Dr. Shannon Bolon: Go ahead.

(Mary Smith): Yes I have two questions. The first one was just to clarify if this table is for predoctoral training in family medicine. Is that correct?

Dr. Shannon Bolon: That is correct.

(Mary Smith): Okay. Secondly regarding the collection of disadvantaged background, financially or economically, is this going to - is it acceptable to have self reported identification by the students or the trainees or is there going to be anything else required?

Dr. Shannon Bolon: For verification?

(Mary Smith): Right.

Dr. Shannon Bolon: No. We would ask that you provide that validation of the responses internally before you give that information to HRSA using the definitions that are standard and provided.

(Mary Smith): So we do need to verify it or can we accept a - if we give the student the definitions and they self identify either yes or no, is that acceptable?

Woman: If you're willing to be able to stand by that data, then that's up to you. You can ask your colleagues, I think others probably do it that same way. We just ask that you report the data and by any chance you get audited, you know, you're willing to, you know, stand by the data that you presented.

(Mary Smith): I think if the form that the student goes out I sense clearly this is we accept a self disclosure that has to be sufficient I would think.

Woman: Well I would have to say that other of your colleagues do it the same way.

(Mary Smith): Okay thank you.

Coordinator: Our next question, I'll open your line. I did not get your name to report your name so if you asked a question if you wanted to ask a question go ahead, your line is open.

(Mark O'Connell): Yes thank you, this is (Mark O'Connell) again. On the form on the PC1 table, the trainee level specific program focus, again we've got this MD/MPH program and it asks you to select between options that include undergraduate medical education or public health. So again it's both, it's not or.

Dr. Shannon Bolon: We can certainly provide an option to select more than one. Another approach to that would be that their first point of entrance was their undergraduate medical education and so that would be their primary focus. That's not in any way belittling the importance of their public health degree but the fact that they're going into their public health degree through their route of their undergraduate medical education.

So if there was only one option, select the undergraduate medical education would be the specific program focus and then through the degrees offered and degree focus areas we would be able to collect data on the public health component of their training.

(Mark O'Connell): Okay thanks.

Dr. Shannon Bolon: Thank you.

Coordinator: And we have another question, I don't have your name so if you've queued up to ask a question please go ahead, your line is open. Please check your mute button. Ma'am I'll go to the next question, it was (Betsy Jones). Your line is open ma'am.

(Betsy Jones): Yes back to Table PC1a, can you explain a little bit more about how you're defining FTEs in this context, the last three columns?

Dr. Shannon Bolon: How we're defining that?

(Betsy Jones): Are you talking about students or trainees?

Dr. Shannon Bolon: Yes we're talking about trainees there. And as the table from training level forward will be - the rest of that data will be specific to the training level. Like in our example we had medical students as well as faculty. You would report on FTEs for both the medical students and then the faculty separate.

I realize that we typically don't count medical students as FTEs or students as FTEs but this is a way for us to gather information about from the most programs that have part-time trainees as well as those such as residency

programs which also use this table that can report on FTEs. So this is a way to create some generality in our data collection. Does that answer your question?

(Betsy Jones): Yes I guess so but, I mean, would another way to phrase it just be the number of full time students by training year? Talking about a student, predoctoral training grant for example?

Dr. Shannon Bolon: Exactly. Other questions at this time? Okay then we're going to move forward.

Coordinator: I'm sorry ma'am, I was just checking with a participant. We do have a question from (Josh Cullen).

Dr. Shannon Bolon: Okay go ahead.

(Josh Cullen): Hi, I was wondering where we can get a copy of this form that we're going to fill out.

Dr. Shannon Bolon: Those forms should have been sent to you on the 5th via email from your program officer.

(Josh Cullen): Okay.

Dr. Shannon Bolon: And so if you did not receive that email please email your program officer and we'll be sure to send that information to you directly.

(Josh Cullen): Okay great, thank you.

Dr. Shannon Bolon: Thank you. Okay, please refer to table labeled Table PCR Curriculum Content. Table PCR will be completed by predoctoral training, joint degree, PA training, and expansion of PA training grantees.

The purpose of this table is to obtain information about the innovative or out-of-the-box curriculum content that your program is providing that is beyond the standard curriculum. These are topics that set your program apart. You will again see that instructions and clarifications precede the table.

The first column lists content areas. You will first decide if the content area is a highlight of your program then if it is taught as part of your required, elective, or both required and elective activities.

You will indicate if the material is taught through research, a traditional didactic or classroom model, or experiential learning. Experiential learning may include clinical work, community or population interventions or outreach, and other public health strategies.

The “teaching strategies” listed in the first column in the latter half refer not to how your faculty teach the content but what teaching strategies your trainees are being taught. Are there any questions regarding Table PCR?

Coordinator: Again if you would like to ask a question please press star 1, unmute your telephone, and record your first and last name. One moment please. Our next question is from Mr. (Bolger).

(Jim Bolger): Yes hi, this is (Jim Bolger) in Duluth and on your table PCR you keep referring here to residency programs different from the standard curriculum but I thought you said this was for predocs.

Woman: Correct and so residencies also use this table. Some would be predocs and residencies.

Dr. Shannon Bolon: As well as the physician assistants.

Woman: Right, so we will make that adjustment in the instructions but yes this is used by all our primary care programs.

(Jim Bolger): All rightie, thank you.

Coordinator: Our next question is from Mr. (O'Connell).

(Mark O'Connell): Hi. I guess what you enter in the cell is the number code of what teaching methodology or mode was used. Can you enter multiple mode codes in each cell?

Dr. Shannon Bolon: Yes you can.

(Mark O'Connell): Thank you.

Coordinator: Our next question is from (Jay Morrow).

(Jay Morrow): Hi, I had a question about the curriculum content. We're actually being funded to teach EHR informatics type skills and I don't see an Other but that would be a category suggestion we would have.

Dr. Shannon Bolon: Thanks (Jay), that's a great suggestion.

(Jay Morrow): Thanks Dr. Bolon.

Coordinator: The next question is from (Mary Smith).

(Mary Smith): Yes thank you. We just answered two questions before you said this was for most of the primary care programs. What about for faculty development? Are these tables going to be used for faculty development programs as well?

Dr. Shannon Bolon: Yes they are. The faculty development technical assistance session is scheduled for tomorrow morning.

(Mary Smith): Oh I see, okay. Can somebody participate in that if they're - if we're applying for a program as a faculty development program but haven't been invited yet because we don't have an existing one?

Dr. Shannon Bolon: There is no restriction in that but for new awardees from the current cycle in competition there will be a second technical assistance call this fall.

(Mary Smith): Oh okay fine, thank you very much.

Dr. Shannon Bolon: Thank you.

Coordinator: I have another question without a name recorded. Please check your mute button. If you did queue up to ask a question your line is open. If you have queued up to ask a question please check your mute button. I'll go to the next question is (Mark O'Connell).

(Mark O'Connell): Hi. If your - if our HRSA contract directly supports a subset of our four year curriculum, do we just report on the specific curricular components that the project is funding or do we try to comment on the whole four year curriculum, even those components that aren't directly supported by the contract?

Dr. Shannon Bolon: You will report for these tables on your entire curriculum, even those components that are not supported by your grant.

(Mark O'Connell): Okay.

Dr. Shannon Bolon: The reason why this is the case is that we feel that it would be very false to try to separate those activities. We're hoping that the elements that you are using to teach and the content will be infused throughout your curriculum so we feel that you would not be able to capture that truly by asking you to separate the activities to those funded by BHPR grants and those not. Next question please?

Coordinator: Once again if you do have a question press Star 1. One moment. Our next question is (Betsy Jones).

(Betsy Jones): Thank you. I'm asking as part of the answer to what I want to know when I was giving my name for my question. The previous questioner was asking about PCR and the curriculum content and whether or not we're reporting on the subset funded by HRSA grant or the entire curriculum and the answer was report on the entire curriculum.

That takes me back to the previous table, the - I can't remember what it's called, the PC1 and so on tables. Is that true of those tables as well where we're reporting on the entire curriculum (unintelligible)?

Dr. Shannon Bolon: That is correct.

(Betsy Jones): Okay thank you.

Dr. Shannon Bolon: Thank you.

Coordinator: The next question is from (Mary Smith).

(Mary Smith): Yes another training content area, what about like community outreach service learning? Do you want to add something like that to your list?

Dr. Shannon Bolon: Thank you for the suggestion. We're making note.

Coordinator: Once again if you have a question press Star 1 and record your name.

Dr. Shannon Bolon: If there's not another question in queue let's move on. Please refer to the table labeled Table EXP1, Experiential Training. Portions of Table EXP1 will be completed by joint degree, PA training, and expansion of PA training grantees. Predoctoral training and primary care will not complete Table EXP1.

The purpose of this table is to obtain detailed information about the experiential learning activities provided by the grantee. Examples of experiential learning may include clinical work, community or population intervention through outreach, and public health strategies.

Table EXP1 differs from Table PCR. Table PCR gathers information about how specific content is taught. Table EXP1 gathers information about the actual experiential teaching strategy.

There are four parts to Table EXP1 labeled A, B, C, and D. Joint degree will complete EXP1a, b, and c. PA training and expansion of PA training will not complete EXP1a, b, or c. Joint degree applicants should report on all experiential training, not just that supported by BHPR grants.

In Table EXP1a, you will first give the name of the training site, for example McComb County Health Department. Next you will give the zip code for the location of the site. At times this differs from their postal address. Site type choices will be provided in a drop down menu. In this example you would select health department.

The training setting choices will also be provided in a drop down menu and are comprised of different designations such as qualified health community center, rural health clinic, health profession shortage area, or HIPSA. You will select all that apply to the named training site.

The training objective field is where you will state the learning objectives of the experiential training that occurs at this site. This should be consistent with your curriculum objectives.

You will then check only the vulnerable populations that are principally served at the site. For example, if trainees are working in a substance abuse treatment clinic at the health department in our example and the majority of the patients have mental health disorders and there is a secondary focus on treating patients with coexisting substance abuse disorders and HIV Aids, you would select both mental health and HIV Aids as vulnerable populations. You will not select descriptors of all of the types of patients or clients seen at the site, only those targeted populations.

The partnering leveraging field asks for any formal partners that you the grantee is collaborating with at this training site. Partners should be essential to achieving the educational objective and identified by your grant.

Interprofessional work is that between different healthcare professions, for example a family physician, a physician assistant, and a public health analyst.

Interdisciplinary work is that between different primary care specialties, for example a pediatrician and a general internist.

Table EXP1b will link with individual level data. You will enter the unique identifier that you created for each trainee and then provide the requested demographic information.

Table EXP1c will be prepopulated with information that you provided in Table EXP1a. The only field that you will add data to is the mean percent time trainees spent at each site per discipline. Remember that discipline refers to primary care specialty. Are there any questions regarding Table EXP1a, b, or c? Remember only joint degree grantees on this call will be completing this table.

Coordinator: Once again, to ask a question press Star 1. We do have a question from (Sue Ling).

Dr. Shannon Bolon: Go ahead.

(Sue Ling): Hi, this is (Sue Ling). I see we're referring to something different than what you talked about. Is that okay?

Dr. Shannon Bolon: Have we covered it previously?

(Sue Ling): Yes.

Dr. Shannon Bolon: Okay go ahead.

(Sue Ling): Okay so I just want to try to make sure I understand the requirement here. Our grant started last fall in September 2010 and so for the reporting we are using

the performance measure on the existing website, right, so which is different from what you are talking about yours. This program is for July 2011 through the following year.

Dr. Shannon Bolon: That is correct.

(Sue Ling): Okay. So if our last year of funding year was for planning we really did not start our curriculum so do we answer zero to everything that's on the existing website? We'll have some number to put in for this - for what you're proposing, this new system, but for the current system since we have not started our curriculum then our training will be zero, right?

Dr. Shannon Bolon: We would best be able to answer your question for you if you gave your program officer, I believe that's Anne Patterson, a call regarding the 2011 performance measures.

(Sue Ling): But that's 2010-2011, right?

Dr. Shannon Bolon: Right. Thank you very much.

(Sue Ling): Okay.

Dr. Shannon Bolon: She'll look forward to your call this afternoon. Are there any additional questions?

Coordinator: Our next question comes from (Mark O'Connell).

Dr. Shannon Bolon: Hi (Mark).

(Mark O'Connell): Hi, on Table EXP1c, the column that says mean percent of resident or clinical training time. When I look at the definition of that it actually looks like the average number of hours per learner, not really a percent of total time. Can you clarify that for me?

Woman: Well you know what, and I think you're right. We need to clarify the instructions. We were going back and forth on really how best to describe it. The point of this table was to look at the various types of training sites since (unintelligible) participants and try to get a feel for what, you know, how much training they get in those particular sites.

So if you have training sites in a community health center or community health service or mobile van, we really want to know for say your year ones or year twos what percentage of time that an average student gets at any of those particular settings. So it's really trying to better describe your program as a whole and what types of training you're offering. So that would be the attempt.

So we realize we need to kind of tweak the instructions a little bit but that was the purpose of the table. So if you guys have some instructions, I mean, some recommendations on how to better capture that, that was the point of this table.

(Mark O'Connell): Well if it's really going to be the percent time in any individual experiential training site it's not, you know, you don't go student by student, you just look at the curriculum I think.

Woman: Right and that was the intent so it is, it's about the percent of experience related to the curriculum that (unintelligible).

(Mark O'Connell): Right, right. So yes, so you could redefine that. But your intent is to say they spend 10% of their clinical training time on the pediatric mobile van for example. Is that what you want?

Woman: Correct.

(Mark O'Connell): So the denominator is going to be weeks of clinical training in say the year three curriculum.

Woman: Correct.

(Mark O'Connell): And the numerator will be how many of those weeks are in the site.

Woman: Correct.

(Mark O'Connell): And if it varies among students because not everybody gets exactly the same thing, that's where it will probably get a little messy.

Woman: Right so that's why it was kind of like the average percent of time. And how this connects to - for those that are actually completing part of the longitudinal study, we will get information about training times, training contact hours from each individual student.

So this was an attempt at an aggregate level to better describe the program as a whole and then on the individual level we'll actually be able to see each student in the amount of time they spend with case and contact hours. So that's how those were supposed to connect.

(Mark O'Connell): Yes so I think it would be not - it would be pretty easy for us to just if not all students spend the same number of weeks on the PD van but to kind of

average that and then what's that out of the average total curriculum. We could come up with defensible descriptors here I guess.

Woman: Okay. And we'll work on clarifying this to make it very clear that it's about the program as a whole, the program curriculum.

(Mark O'Connell): Yes, yes, you have to really change that definition that's currently in the document.

Woman: Okay thank you.

Coordinator: And at this time we have no further questions.

Dr. Shannon Bolon: Great. PA training and expansion of PA training grantees will complete Table EXP1d. Joint degrees and predoctoral training will not. Table EXP1d requests information on how much training occurs in four training settings -- those found in FQACs, HIPSAs, MUCs, and rural areas.

Definitions for these designations are the standard HRSA definition and will be provided. Rotations should be blocks of training time. For example, a four week period when the trainees spend the majority of their time working in this location. Are there any questions regarding Table EXP1d?

Coordinator: Again please press Star 1.

Woman: So let me give a little more explanation for this for 1d. So 1d will be completed by the programs that are actually taking part in the individual level data but individual level, and we'll go through that information in a few minutes, will collect information on the particular training experiences for each individual.

Therefore, what we need from - at a program, on an aggregate level is really just to kind of describe out of the trainings that are being offered in your programs which - what's the percentage offered in a particular designation. And so we're interested in medically underserved areas, HIPSA's, FQAC's, and rural locations in particular.

And so we understand that each of your participants may not receive training in one of these clinical settings but just as a general for year ones or year twos or particular training objectives, what's the number of rotations that are offered in these particular designations and again the percent of time on the curriculum.

Coordinator: We have a question from (David Mulnar).

(David Mulnar): If a clinical training site is for instance both a rural area and a medically underserved community, would we answer the same information in both of those cells?

Woman: Yes.

(David Mulnar): Thank you.

Coordinator: Our next question is from (Betsy Jones).

(Betsy Jones): I just want some clarification on what you mean by number of rotations. You mean the number that you have offered for your trainees to participate in or how many actually received training? Do you want an aggregate number of all the trainees who trained in any one of those sites or just how many that you have available to your trainees?

Woman: We want to know the number of rotations offered at these particular settings and then when we look at our individual level data we'll be able to see which students participated in particular training settings.

Dr. Shannon Bolon: So this is the number of rotations based on your curriculum. For example if you have a required rotation at, you know, a rural health clinic you would count that as one, not the fact that it was offered five months of the year or that four of your ten trainees participated in that. So you offer a rotation at a rural health clinic. That would be what you would indicate.

(Betsy Jones): In our case all of our primary care clinics have HIPSA designations. Would we count all of those clinical rotations then for say third year medical students?

Dr. Shannon Bolon: Yes. So if their outpatient family medicine clerkship takes place in a HIPSA, that would be one.

(Betsy Jones): Gotcha. And then one other question. You've got on the headings here, the third one says resident or clinical training time but then the last one says students trained. I assume that you mean trainees, the total number of trainees trained.

Woman: Yes, and we'll correct that. Thank you for bringing it to our attention.

Coordinator: Our next question is from (Leonard Levy).

(Leonard Levy): Yes, I just wanted to ask a question. Does faculty development relate to any of these?

Dr. Shannon Bolon: If you're - let me clarify. A faculty development and primary - physician
faculty development and primary care grant?

(Leonard Levy): Yes.

Dr. Shannon Bolon: Okay, is that what you're referring to?

(Leonard Levy): Exactly.

Dr. Shannon Bolon: Okay. The faculty development technical assistance call will be held
tomorrow morning but the faculty development does fill out this table. But
we'll be going over this in detail with faculty development tomorrow in
addition to the other tables the faculty development will complete.

(Leonard Levy): Thank you.

Dr. Shannon Bolon: Thank you.

Coordinator: We have no further questions at this time.

Woman: We have an additional question from (Mark Raffi). Can you unmute your
line?

Coordinator: He will need to press Star 1.

Woman: We still can't hear him.

Coordinator: Okay I do have - go ahead sir, your line is open.

(Mark Raffi): Okay thank you. I just wanted to make sure EXP1 forms are not for predocs.

Dr. Shannon Bolon: That is correct. Those of you that are from undergraduate medical education and have predoc grants, do you think that this - these EXP1 tables would be appropriate for you to fill out? Would that be giving us valuable information? Dr. (Raffi) do you have an opinion on that?

Woman: For clinical predocs we'll get information about your education, your degree programs, the number of students that are in the program, their primary focus, and that type of stuff but we really didn't have a way of capturing their clinical experience. So if they are offered clinical experience then we want to know your feelings about completing at least the EXP1a and b tables. So any predocs grantees want to comment on that?

Dr. Shannon Bolon: And really the EXP1d table would be appropriate too because they will be able to - that's very high aggregate level. One of the reasons why we were concerned in our discussions internally about having predocs complete these tables was the vast variety of clinical locations or sites that you have your clinical training at and the sheer numbers of training. Obviously this may potentially provide very valuable information so we're certainly very interested in your feedback on that.

If you're not comfortable sharing that with us over the phone now, please do so via email. And we have our contact information at the end of the presentation today.

Woman: We actually have one additional question from (Gabrielle Saron) questioning whether or not (AHAC) designated locations will be reported as there currently is not a spot indicated.

Woman: Thank you for that question and actually under our clinical setting we can add (AHAC). At one point we did have that on there so we'll add that back. So under clinical setting we'll add (AHAC) as a possible designation. Thank you for bringing that to our attention.

Coordinator: We have a question from (Emily Wheeler).

Dr. Shannon Bolon: Go ahead.

(Emily Wheeler): Yes, my question, I am from a predoc grant and we're actually working with clerkship students and so they do rotations and we actually are trying to expand the rural part of their rotations through their clerkships.

Dr. Shannon Bolon: Great.

(Emily Wheeler): So that might, I mean, I'm not sure if I have a suggestion as to whether or not or how that can be reported but just to let you know that is, I mean, that's definitely a piece of our program, actually a very, very large piece of our program. So, you know, I'm not sure how that could be reported but it's definitely a part of our predoc program because it's all about the clerkship.

Dr. Shannon Bolon: Certainly and that's definitely the model that our predoc programs have to follow at this time so is using a clerkship model. But we also would ideally like to be able to capture those elective opportunities that are being provided in the undergraduate medical education setting too. So thanks (Emily) for sharing your thoughts.

Coordinator: Our next question is from (Jim Bolger).

(Jim Bolger): Yes, following up a little bit on (Emily)'s question there. There are of course a lot of students that do rotations in rural areas potentially or in underserved areas that are not in family medicine and the institutional version for tracking that kind of material is going to be considerably greater than it is now.

Has there been any thought given to increasing the indirect cost recovery rate for training grants? Because if I go to the dean and say we have all these additional costs that somebody in the school, not family medicine, is going to have to bear, he will not be a happy camper.

Woman: Well we understand that this is a - this type of reporting is very different from what you are used to. We also want you to understand that the pressure let's say that we are under to really produce some evidence about the success and efficiency of our programs.

Therefore we are trying our best to really show what the vast experiences are that our trainees are receiving and trying to reach our goal of the quality, quantity distribution and diversity of the health profession.

And so as we ask you guys to report this type of information we are looking at the best technological ways to make this easy for you, for instance providing templates. Instead of having you manually enter the data we will actually provide templates where there is a different software that we provide for you or some type of spreadsheet or access or something like that. We will make this providing the data to us much easier than it is currently.

Dr. Shannon Bolon: But also considering the variables that we are selecting, we are actively trying to engage you the grantees in helping refine those because we do need to show that our programs are either successful or that they're not and in what areas so we can improve them. We are being held just like everyone else to

quality performance measures and if we're not able to show the quality of our program that will just make future funding less secure.

Woman: And then the point of individual level data is really so we can answer questions about impact, impacts of our programs. The big question really is are we increasing the supply of health professions.

And we really only know that if after they finish in your programs if we ask them in another year or two or three years are they actually practicing in family care, are they serving an underserved area. And so we need to be able to collect information from you now in order to have that information to be able to follow up in another year or two.

So we understand the changes that will have to occur but being that the political climate the way it is, this was the best means that we could come up with right now to making sure that we can answer the questions that are being asked of us.

Dr. Shannon Bolon: And to answer your immediate question instead of a philosophical tangent that we went on there but we thought that was important information, that, you know, no there is not a current plan on the table to change the indirect rates. However, you are welcome to incorporate evaluation as well as performance measures data collection costs into your budgets. So these are items that can be budgeted. Thank you for bringing up that good point.

(Jim Bolger): Thank you.

Coordinator: We have no further questions or comments.

Dr. Shannon Bolon: Great. I'm going to turn it over to (Cassandra) who is going to go into a little bit more detail about the individual data collection.

Dr. (Cassandra Barnes): All right, we'll put that back on the screen now. And that is a document entitled Proposed VFPR Individual Level Data Elements. And these elements are for the programs that are participating in our proposed longitudinal study and this came out of the requirements from the Reportable Care Act to do a longitudinal study.

And so the document details at certain points - oh and so yes, they included all of the programs that are on this call right now that will participate in the longitudinal study.

And so the document is broken up into various points of time, certain elements that we're collecting at certain points of time. So at the entry point which is the beginning of your grant period we will match each of the students or trainees with your grant number and the personal ID number that you will create and that should be a seven digit numeric number that programs are responsible for maintaining for this particular student throughout the life of the grant and we hope throughout your recordkeeping practices.

And so again it's basic demographic information regarding the participant at the entry level, also what are their current achievement levels. So if their last degree earned was a high school education or an associate degree we want to capture that information, basic GPA, and MCAT score if that's applicable.

And then we'll see the individual, the unique ID numbers will be linked to your aggregate tables that we just discussed. And that will be your PC1 tables that describes your degree programs or your experiential tables which describe

your clinical training. So each of these unique IDs can be linked to your particular aggregate tables.

And then if the student - if the trainee is already a professional there is particular information we want to know about them or particularly are they currently working in a medically underserved area or in a rural setting.

And then to move down to the annual collection, this means annually we will ask for certain information based off of the year of training. So again their unique ID will be linked to your grant number. Depending on what year they're in, what is the appropriate achievement level information to collect.

For instance a year one medical student we would ask for their GPA, for a year two student we would want their GPA plus their MBE or their USMLE score. And then again if they participate in any clinical experiential training that you would report in your aggregate tables we'll link their unique ID to those aggregate tables.

If they receive any financial support from us so that's a site and a traineeship, any tuition assistance, we want to know that amount from the grant for this particular individual, whether they're part time or full time, and again if they are a professional, information about their employment and licensure or certifications that they receive.

And then moving down on the sheet, regarding their clinical experiential training again will be linked to the aggregate tables but we would also want to know about the particular student, if they were trained to work with any particular populations. So if this student was interested in working with women or children then we would get that information about that student and their patient contact hours for each of their rotations or clinical experiences.

And moving along, we also ask about whether or not they were mentored or served as a mentor and if they conducted any research. And at exit point so that would be at the end of your grant period or end of your time with this student whether they left the program for any reason we would want to of course know whether they completed the program, that means whether they got a degree or not or whether they completed the residency and if not what was the reason that they did not complete.

Any particular achievement levels for that particular year related to GPA or any type of testing scores or clerkship ratings. And then also at the end at the exit point we also want to get some information about their intent to further their practice or further their studies.

Again so this will be very important information for us to collect at this point because the agency will actually take this information and use it in our longitudinal study so within another year or three years we will ask them again if they are continued in the particular field that they trained in. And if they have employment we of course want to know about that type of information.

And only at this point of exit will we ask for personal identifiable information. So at entry point and annually we will only have a participant unique ID that will not give us any personal identifiable information.

So at the end you will have to link that unique ID to the personal identifiable information and that's what we will use to again follow up with the student longitudinally. And of course the informed consent form, it has to be attached to the information.

And this individual level data was actually referenced with the Jefferson longitudinal study that several schools participate in so that's how we based the information that we asked for on this study.

So the purpose again is to really be able to look at the various experiences that our trainees are receiving and to be able to monitor the differences between the experiences to try to track what students are more likely to remain in primary care or practice in a medically underserved area so we can have information that can help us better target our programs and help us make better decisions about where to put our resources. So do we have any questions?

Coordinator: Yes we do have questions from (Leonard Levy).

(Leonard Levy): Yes I'm looking again at this experiential training piece and we have the predoctoral grant which focuses on the homeless population, certainly a vulnerable population.

But the training sites sort of don't compute with this because the places that we provide the care are homeless shelters which are not necessarily, in fact usually not in MUCs or HIPSAs and so on and the homeless themselves live anywhere. They could live in the most affluent areas under bridges. How do we capture the training sites as being relevant to what kind of data you are trying to capture?

Dr. Shannon Bolon: So you bring up a great point. And one of our options is or was, (Cassandra) please confirm is the mobile training sites. And so that would be able to capture for example mobile migrant clinics, mobile homeless clinics or vans. So it sounds like we would definitely want to reintroduce that option.

We would also capture the homeless population under the vulnerable population third. That is an option there. But you're right, we do want to be sure that we capture that training site because although that does not have a designation we will be able to get that data through the vulnerable population.

(Leonard Levy): Right and these are not necessarily even mobile sites, these are locations.

Dr. (Cassandra Barnes): Right. So that's fine, we will capture the site where the actual training is going on and then under the population that you serve you can describe that population. So we understand that just because the zip code or the site may not be in a designated area that you may see various types of populations so that's why we ask the population question.

(Leonard Levy): Thank you.

Dr. Shannon Bolon: Yes we look at the specific designations because are recordable data points for us. So just because your clinic is - does not fall into one of those designations that doesn't mean that it's not a valuable tracking point for us, it just falls into a different category.

(Leonard Levy): Thank you.

Coordinator: The next question is from (David Mulnar).

(David Mulnar): Our PA program requires the GRE, not the MCAT so I wanted to suggest that you had GRE as a field.

Dr. Shannon Bolon: We agree.

Dr. (Cassandra Barnes): Thank you.

(David Mulnar): And also an exit for PAs you probably want to know whether they passed the certification exam on the first attempt or not.

Dr. Shannon Bolon: Okay thank you.

Dr. (Cassandra Barnes): Yes, this is the type of feedback we want to have. Are there any other important points that we should be collecting data that you think may influence a student or a trainee (unintelligible)?

(David Mulnar): Not that comes immediately to mind but I am going to reflect on this and I will communicate with you other ideas.

Dr. Shannon Bolon: We would appreciate that.

Dr. (Cassandra Barnes): Any other comments or ideas?

Coordinator: Yes we have several questions ma'am. The next question is from (Mark O'Connell).

(Mark O'Connell): Hi, these are questions, not really suggestions. I've got a few of them. At the higher level I'm concerned about the need to get the students to sign an informed consent to allow us to report all of this personal performance information.

They're going to have concerns if we tell them we want to be able to report things like their clerkship examination grades, their clerkship ratings, their board scores. Those are the kinds of things that in my experience students get a little antsy about not knowing where it's going to go no matter how much we assure them it's confidential.

And the AAMC has run into a big problem with this with their graduation questionnaire and needing to make parts of it voluntary because of these reasons and the response rate has plummeted in many schools. So that's a high level concern. I'd like to know how other schools experience have been with this or other grantees.

Then a more specific question, and then along those lines, why do you really want all their GPAs and board scores and clerkship exam grades and performance measures? Are those really the kinds of things that are going to be used in any meaningful way?

And where can you get definitions of like childhood and how do they know where they grew up and whether it was an MUC or an urban or frontier area? And I'll stop right there because I go on and on.

Woman: Right, well thank for your concerns. Again so all of the achievement levels and data points we're asking for are points we're asking for now as we develop our evaluations that we're planning to do.

And so yes, so they are pieces of information that tell a lot about the particular student and that we use to gauge how a student may practice or where they may practice or how long they may remain in practice.

And as far as the childhood residence goes, we will provide definitions about that but basically, you know, a place that you grew up with in a rural or urban area. And based off of the zip code we can determine whether or not it was in an MUC or not.

Dr. Shannon Bolon: And in cases like that, defining childhood is less of a point of importance but more so do they have experiences in this area that may have been - in living in this setting that may have been formative. So it would be difficult to say well between the ages of 3 and 7 did you live in this area because that would be rather false.

So it's more of did you have meaningful life experiences in these areas that may have been formative because there's plenty of strong literature that supports the fact that those that "grew up" in certain underserved areas are more likely to go and practice in underserved areas. Next question?

Coordinator: The next question is from (Mark O'Connell) - oh I'm sorry, (Jim Bolger). Excuse me.

(Jim Bolger): Hi, (Jim Bolger) again. As one who has done longitudinal research, follow up data into demographics or prediction of where people practice and all that for the last 40 years, I can't even respond to some of these without your definitions of what they are.

It's not as simple, it's not as clear, and you're going to have a very difficult time I think even something like was just mentioned, how did you define childhood.

There is also an implicit assumption here that med schools are med schools are med schools. How do you get clerkship ratings when each school does it differently? How do you get different GPAs when grading systems vary across medical schools significantly?

These are - each one of these I have some questions about and I'll be happy to forward those questions to Anne Patterson and everything but you're opening

up about 100,000 cans of worms here that don't have nicely encapsulated answers.

So I'm really kind of concerned that we're getting to the point where we're collecting a lot of data, we're asking for informed consent when we don't have the ability to truly inform the persons coming into our training programs what information is actually going to be collated and used in what ways. They can't give a truly informed consent because we can't give that yet. So I'm really kind of concerned about that.

Woman: Well thank you for mentioning that. We will actually provide more guidance on the individual data level pieces so we do respect your concerns. Again this was based on other longitudinal studies that have been conducted over the years so we realize this was really just a snapshot for you guys to kind of get your reaction and for us to continue the dialog about this.

So we will if not have a workgroup but we will continue to engage you guys in this dialog as we continue to provide the guidance for the guidance on this.

Dr. Shannon Bolon: And Dr. (Bolger), please send forward your comments with your expertise. That would be extremely valuable. And that's not exclusive to you but, you know, for all that are within the grantee field.

(Jim Bolger): Yes I'm happy to do that. I'm not sure however that I can get our IRB to go along with 90% of this. Our IRB at Minnesota is extremely stringent and the Minnesota Data Practices Act conflicts in many, many ways with some of these requests in here. It's going to be a real tussle I'm afraid.

Woman: Well again we have, you know, legislative requirements we conduct a longitudinal study from the Affordable Care Act. But like I said, we have not

finalized what the actual data elements will be so we are still looking at, you know, keeping some of these elements and finalizing it. So we look forward to more of your comments and engaging you guys further.

(Jim Bolger): Thank you.

Coordinator: Our next question is from (Sue Ling).

(Sue Ling): Yes I want to echo what the last speaker had talked about. And just recently we had something less sensitive information than this and I think our Dean of Medical Education really had trouble with it.

And I think I'm (unintelligible) dealing with these very sensitive data because even though you're going to collect this data that is deidentified but our IRB will be very - will require that we have whoever is doing the code for the identification be not related to evaluating the student just so that the grades I'm going to, we're not going to privilege this information that might influence how we grade the students.

And I think finding that neutral person is going to be very difficult because I'm thinking about okay my - the person who is going to support my grant activities might be the clerkship coordinator but most of the people who work in our department knows the students so you're not going to find a neutral person who is not going to have some impact or work with the students.

So I think it's going to be very problematic to try to keep these information confidential and I think the student will feel very worried about these data being used to have a negative impact on them. So I really echo what the other person said, that I think this is very problematic. And IRB would also have a lot of issues with it. I'm just not sure how I can get it approved in our IRB.

Woman: Yes we understand that is a hurdle that everyone will have to cross and we will conduct more technical assistance on for instance creating the unique ID and providing you with more information on how we intend to view information in the longitudinal study. Next question?

Coordinator: Our next question comes from (Betsy Jones).

(Betsy Jones): Thank you. I have a lot of the same questions and concerns but I just want to be sure I understand. Is it your plan that the individual grantee's schools will be responsible for collecting this data or will the students receive some sort of more higher level tickler email to access an online data collection instrument that comes from you as opposed to us?

Woman: Individual level data elements are attached to the grant so that will be the grantees' responsibility. Now the longitudinal follow up will come from the agency and we'll provide more guidance as to how we will interact with the students longitudinally. But annually this individual level will be reported by the grantee.

(Betsy Jones): And will it be collected electronically through some sort of web based interface or will it be collected with a paper instrument?

Woman: Well we're thinking about giving both options.

(Betsy Jones): Okay and finally my biggest reservations are that program exit and I assume that's, you know, very optional to give name, birth date, social security number. But I'm really curious about why that's even on there, particularly things like social security number and Facebook page and all that kind of thing.

Woman: The point of the personal identifiable information that will only be collected at exit again is for the longitudinal study. Because even though you provide us with a unique ID annually regarding your participants, in order for us to follow up longitudinally we would have to have some information to find them in another year or two or three years after they have left your program. And so that's why the birthday and social security number of course are the best means to ensure that you are speaking with the same person.

(Betsy Jones): Well so that takes me back to the question of IRB approval. So in what you have to explain to the trainee at the outset when they're deciding whether to participate or not participate which I think we all agree is going to have to be the trainee's option, will it be at that point indicated that at the conclusion of your training when you complete the exit version of this you will also be expected to provide, you know, these personal identifiers? I mean, how does that kind of get revealed to the trainee and at what point?

Woman: Well they would have to provide the informed consent for it to be used in the longitudinal study.

(Betsy Jones): Right but that's for the longitudinal study when they finish their training with us.

Woman: Right, the exit point, yes when they sign the informed consent.

(Betsy Jones): Right but they are essentially giving informed consent by filling it out in the first place and so there is going to have to be at least from my IRB's perspective some sort of language at the outset of the really of every instrument that gets - that our trainees are asked to complete that says you are giving - by completing this instrument you are giving consent to participate in

a longitudinal study even if the longitudinal study, even if you guys are not thinking longitudinal study until after they are at the exit point.

I mean, it is a longitudinal study if you're collecting it, you know, over the five years of the grant. So it's really the consent issues from the beginning and not just at the exit point.

Woman: Well from our perspective, you know, we collect - the grant is responsible for providing annual performance information to us and so we're not asking for personal identifiable information in the beginning. And so that's why we asked for the informed consent at the end when you are at - when we will collect the personal identifiable information.

(Betsy Jones): Okay, personal identifying information yes but you are asking for a lot of personal information. And so even at the earlier points when you're collecting the data that's going to be viewed both by the students and residents and any other trainee and by the IRB as being, you know, a fairly invasive series of questions even if it does have identifiers.

Woman: Okay well we definitely will, you know, keep that under consideration. Next question?

Coordinator: Thank you. Our next question is from (Mary Smith).

(Mary Smith): Yes I want to echo concerns about the IRB and just make one suggestion that perhaps you should have a technical assistance call sent out to all the IRBs of the institutions that are applying as those people sit in on this since they are the ones that are going to either allow us to proceed or not.

Woman: That's a good suggestion. We'll make that note.

(Mary Smith): Okay so I do have a couple of other questions. The individual data, is this for all medical students at the institution, is that correct? Not just the one that might be involved in a specific funded program?

Woman: Correct.

(Mary Smith): Correct, okay. Now some of our students take a year off or a leave of absence for a variety of reasons. Are they - is that then - are they then considered an exit point when they leave the institution for a year and then they get reentered, you know, the following year as an entry point?

Woman: That's a good point. If you know that they are just going to take a year off and come back then we would ask that you maintain that unique ID for them and then just the year that they're off it would just be no data or we'll have some kind of recognition of them taking some time off.

(Mary Smith): Okay.

Woman: And then when they return use their same unique ID.

(Mary Smith): Okay and then with the grading questions that you're asking for, that - all of that information is confidential information and as a clerkship director we only have access to grades that we give. So how is...

Woman: What particular information are you referring to, the GPA?

(Mary Smith): The achievement levels, I'm sorry.

Woman: Okay.

(Mary Smith): You know, year one, year two, year three, year four. You want examination grades, clerkship ratings, that type of thing. So, I mean, the student will go through, you know, eight clerkships, ten clerkships during the year and you want us to get - have access or somebody in the institution to put in the grades from each of those clerkships. Is that what you're asking for?

Woman: Yes.

(Mary Smith): So that has to - so actually not only IRB has to be involved but student records. This is something that student records would have to provide. We as a family medicine clerkship do not have access to those students' grades in other clerkships.

Woman: We understand that.

(Mary Smith): You understand that? Okay. I mean, this is going to be as somebody else said a can of worms. And what if our IRB, you know, says we can't do this? Do we then not apply for funds through HRSA?

Woman: Well we don't want to say that right now. We're still developing the guidance for this and that's why we appreciate your feedback as we continue to make adjustments and think about what needs to be done.

Again this was told to us through the Affordable Care Act and we will conduct longitudinal studies and so this is kind of our first go around by looking at other studies that are going on throughout the United States and our first attempt to conduct our own. But we're still open to a better way to do it.

(Mary Smith): Okay, (unintelligible) about pushing buttons to submit for a new application based on, you know, the requirements that are going to be expected of us? I mean, you know, the deadline to send the new application is a couple of days.

And I did not present these issues to our IRB ahead of time to get some kind of initial approval or I didn't present this to student records to say that we're going to need this information if we're going to accept funds from HRSA. So it's kind of, you know, we're kind of looking at this - the timing is not the best.

Woman: Right, we understand. So I know some of you said that you participated in longitudinal studies before. We're really interested in talking more to you, all of you about your ideas on what is the best way to capture this information. Like I said, this is our first attempt but we really, we have to - we're really interested in conducting a longitudinal study.

Again we're looking at impact of what are the impacts of our program. And so please feel free to contact us. We're going to give you the email address for the Federal Register notice. We can provide comments there. If you're not comfortable with that (Sharon) has already said it's okay to contact your project officer. So we really want to engage you in this so don't panic, we're still open to discussion.

(Mary Smith): Thank you.

Coordinator: Our next question comes from (Deborah Winton).

(Deborah Winton): Hello, I had a question regarding data collection. Our program collects the data that this report calls for from a variety of sources. If HRSA is requesting

this specific data, have you developed the database that we can copy and paste to make - because this is a hugely labor intensive task.

Woman: Well the information that we're asking will be provided in a template or again we mentioned that there will be some type of software or something where you can either reformat like your class rolls or your registration records or something like that to provide us the data and then just upload it to us or we'll provide a spreadsheet or there will be a couple of ways for you to provide us the data.

(Deborah Winton): Okay.

Woman: Yes because the intent is not for it to be labor intensive so we will provide some type of template or way for you to easily just upload the information to us.

Dr. Shannon Bolon: This has been a very rich conversation and one that we realize we're not going to be able to come to a good conclusion in our call today. So we look forward to having future conversations with you.

In respect of everyone's time, we are over time and we would like to just give some additional last summary information for you. Thank you for all of your great questions today and for your comments particularly your directive comments with the individual level data collection. I'm going to turn it back over to Sylvia at this point.

Dr. Sylvia Joice: So as a reminder you will be able to access the final revised reporting guidance at <http://bhpr.hrsa.gov/grants/reporting/index.html>. Once the guidance is finalized all grantees will receive a notice indicating the document is ready to be viewed. We expect grantees to begin collecting data as per the

revised performance measures beginning July 1, 2011. The first reporting period will be July/August 2012.

As mentioned previously, the 60-day period for comments on the performance measure revisions is currently open and will close on July 20, 2011. If you have any comments please send them to paperwork@hrsa.gov.

This webinar has been recorded and can be replayed until July 31, 2012. To access the replay please dial the toll free number 1-800-294-0344. I'm sorry, there is a correction to - dial the recorded webinar at 1-800-679-9654. The pass code is 7423. The expectation is that new data will be collected beginning July 1.

We would like to thank you again for your participation on this webinar. Have a great day. Thank you.

Coordinator: Thank you for participating in today's conference. You may disconnect at this time.

END