**OMB No. 0915-0319**

**Expiration Date:**

**Office of Rural Health Policy: Rural Health**

**Community-Based Grant Programs**

**Performance Improvement and Measurement System (PIMS) Database**

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**Rural Health Network Development Grant Program**

**Table 1: ACCESS TO CARE**

*Table Instructions: Access to Care*

Information collected in this table provides an aggregate count of the number of counties within the service area and the number of people targeted within the service area, which may or may not be the total population residing within the service area. Please indicate a numerical figure or DK for do not know, if applicable.

Number of counties

* Denotes the number of counties served through the program. Please include entire, as well as partial counties served through the grant program. If your program is serving only a fraction of a county, please count that as one (1) county.

Number of people in target people in target population

* Denotes the number of people in your target population (not necessarily the number of people who availed your services). For example, if the network focuses its mission on serving a particular population such as migrant and seasonal farm workers, then the migrant and seasonal farm workers may be a subset of the total population within the service area.

|  |  |  |
| --- | --- | --- |
| 1 | **Number of counties:**  (If you serve a sub-county area please count this as 1) | **Number/DK** |
|  | Number of counties served in program |  |
| 2 | **Number of people:** | **Number/DK** |
|  | Number of people in the target population (service area) |  |

**Table 2: POPULATION DEMOGRAPHICS**

*Table Instructions: Population Demographics*

Please provide the number of people in target population by race, ethnicity, and age. The target population may or may not be the total population residing within the service area. If the number of people is zero (0), please put zero in the appropriate section, do not leave any sections blank.

Number of people served through program by ethnicity (Hispanic or Latino/Not Hispanic or Latino)

* Hispanic or Latino origin includes Mexican, Mexican American, Chicano, Puerto Rican, Cuban and other Hispanic, Latino or Spanish origin (i.e. Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard etc.)

|  |  |  |
| --- | --- | --- |
| 3 | **Number in target population by ethnicity:** | **Number** |
|  | Hispanic or Latino |  |
|  | Not Hispanic or Latino |  |
|  | Unknown |  |
| 4 | **Number in target population by race:** | **Number** | **DK** | |
|  | American Indian/Alaska Native |  |
|  | Asian |  |
| Black or African American |  |
| Native Hawaiian/Other Pacific Islander |  |
| White |  |
| More than one race |  |
| Unknown |  |
| 5 | **Number in target population by age group:** | **Number** | **0** | **DK** | |
|  | Children (0-12) |  |
| Adolescents (13-17) |  |
| Adults (18-64) |  |
| Elderly (65 and over) |  |
|  | Unknown |  |

**Table 3: UNINSURED**

*Table Instructions: Uninsured*

This table indicates the number of uninsured users receiving preventative and primary care as a result of your Network activities. Please respond to the following questions based on these guidelines:

Number of uninsured people receiving preventive and /or primary care

* Uninsured is defined as those without health insurance and those who have coverage under the Indian Health Service only

Number of total people enrolled in public assistance (i.e. Medicare, Medicaid, SCHIP or any State-sponsored insurance)

* Denotes the number of people who are uninsured but are enrolled in any of these public assistance insurance programs

Number of people who use private third-party payments to pay for the services received

* Denotes number of people who use private third-party payers such as employer-sponsored or private non-group insurance to pay for health services

Number of people who pay out-of-pocket for the services received

* Denotes the number of people who are uninsured, not enrolled in any public assistance (i.e. Medicare, Medicaid, SCHIP or State-sponsored insurance), not enrolled in private third party insurance (i.e. employer-sponsored insurance or private non-group insurance) and does not receive health services free of charge

Please indicate a numerical figure or DK if you do not know. If your grant program was not funded to provide these services, please type N/A for not applicable.

|  |  |  |
| --- | --- | --- |
| 6 | **Number of uninsured people receiving preventive and/or primary care.** | **Number /DK/NA** |
| 7 | **Number of total people enrolled for public assistance, i.e., Medicare, Medicaid, SCHIP, state-sponsored insurance.** | **Number /DK/NA** |
| 8 | **Number of people who use private third-party payments to pay services received, i.e. employer-sponsored, private non-group.** | **Number /DK/NA** |
| 9 | **Number of people who pay out-of-pocket for services received.** | **Number /DK/NA** |
| 10 | **Number of people who receive health services free of charge, i.e. no public or private third party payers.** | **Number/DK/NA** |

**Table 4: STAFFING**

Please provide the number of clinical and non-clinical staff recruited on the program and the number of staff that are shared between two or more Network partners. Please provide the number of new staff that are recruited and retained for at least six months during the respective budget year. If a number is zero (0), please put zero in the appropriate section. Do not leave any sections blank. There should not be a N/A (not applicable) response since all measures are applicable.

|  |  |  |
| --- | --- | --- |
| 11 | **Number of new clinical staff recruited to work on the program:** | **Number** |
|  | Dentist |  |
|  | Dental Hygienist |  |
|  | Health Educator / Promotoras |  |
|  | Licensed Clinical Social Worker |  |
|  | Nurse |  |
|  | Pharmacist |  |
|  | Psychologist |  |
|  | Physician, General |  |
|  | Physician, Specialty |  |
|  | Physician Assistant |  |
|  | Therapist (Behavioral, PT, OT, Speech, etc) |  |
|  | Technicians (medical, pharmacy, laboratory, etc) |  |
|  | Other – Specify type |  |
|  | None | **Selection List** |
| 12 | **Number of new non-clinical staff recruited to work on the program:** | **Number** |
|  | Case Manager |  |
|  | Enrollment Specialist |  |
|  | HIT/CIO |  |
|  | Medical Biller / Coder |  |
|  | Translator |  |
|  | Other – Specify Type |  |
|  | None | **Selection List** |
| 13 | **Number of all staff positions** | **Number** |
|  | Number of staff positions shared between two or more Network Partners |  |
|  | Number of new staff recruited by the Network |  |
|  | Number of new staff retained by the Network for at least six months |  |
|  | Percentage of new staff retained | **Percent (automatically calculated by the system)** |

**Table 5: WORKFORCE/ RECRUITMENT & RETENTION**

*Table Instructions: Workforce/ Recruitment and Retention*

If your grant funds support traineeships, please provide the number of trainees by type, select the trainee primary care focus area and select the types of training sites. If your grant funds support traineeships, please indicate either a numerical figure, DK for do not know or N/A for not applicable.

|  |  |  |
| --- | --- | --- |
| 14 | **Number of new trainees by each type** | **Number/NA/DK** |
|  | Students |  |
|  | Residents |  |
| 15 | **Trainee primary care focus area(s):**  (Please check all that apply) | **Selection list** |
|  | Medical |  |
|  | Mental/Behavioral Health |  |
|  | Oral Health |  |
| 16 | **Types of training site(s):** | **Selection list** |
|  | Clinic |  |
|  | Community Health Center |  |
|  | Critical Access Hospital |  |
|  | Federally Qualified Health Center (FQHC) |  |
|  | Health Department |  |
|  | Indian Health Service (IHS) or Tribal Health Sites |  |
|  | Migrant Health Center (MHC) |  |
| Rural Health Clinic |  |
|  | Other Rural Hospital |  |
|  | Other Community Based Site – Please specify |  |
|  | Unknown |  |

**Table 5: NETWORK**

*Table Instructions: Network*

Please identify the types of formal member organizations in the consortium or network by non-profit and for-profit status for your program. Please indicate a number for each category.Please provide the total number of member organizations in the consortium or network. Then, out of the total number of organizations in consortium/network, please provide the total number of ***new*** member organizations acquired within the budget year.  Please refer to the detailed definitions for consortium/networks, as defined in the program guidance. Please select the focus area(s) of the consortium/network for the budget year.

|  |  |  |
| --- | --- | --- |
| 18 | **Type(s) of member organizations in the Consortium / Network** | **Number** |
| **Non-Profit Organization:** | Area Health Education Center (AHEC) |  |
|  | Community College |  |
| Community Health Center |  |
| Critical Access Hospital |  |
| Faith-based organization |  |
| Free Clinic |  |
| Health Department |  |
| Hospital |  |
| Migrant Health Center |  |
| Private Practice |  |
| Rural Health Clinic |  |
| School District |  |
| Social Services Organization |  |
| University |  |
| Other – Specify Type: |  |
| **TOTAL for Non-Profit Organization** | **Number (automatically calculated by the system)** |
| **For-Profit Organization:** | Community College |  |
|  | Community Health Center |  |
| Critical Access Hospital |  |
|  | Faith-based organization |  |
| Organization Free Clinic |  |
|  | Health Department |  |
| Hospital |  |
|  | Migrant Health Center |  |
| Private Practice |  |
|  | Rural Health Clinic |  |
| School District |  |
|  | Social Services |  |
| University |  |
|  | Other – Specify Type: |  |
| **TOTAL for For-Profit Organization** | **Number (automatically calculated by the system)** |
| 19 | **Total number of member organizations in the Consortium/Network:** | **Number** |
| 20 | **Total number of new member organizations in the Consortium/Network:** | **Number** |
| 21 | **Focus area(s) of the Consortium/Network** (Check all that apply) | **Selection list** |
|  | Cardiovascular Disease |  |
|  | Case Management |  |
|  | Diabetes/Obesity Management |  |
|  | Elderly Geriatric Care |  |
|  | Emergency Medical Services (EMS) |  |
|  | Health Education |  |
|  | Health Literacy/Translation Services |  |
|  | Health Promotion/Disease Prevention |  |
|  | Maternal and Child Health/Women’s Health School Board |  |
|  | Mental/Behavioral Health |  |
|  | Network Development Activities |  |
|  | Nutrition |  |
|  | Oral Health |  |
|  | Pharmacy |  |
|  | Primary Care |  |
|  | Substance Abuse Treatment |  |
|  | Telehealth/Telemedicine |  |
|  | Transportation |  |
|  | Workforce |  |
|  | Other – Specify Type: |  |

**Table 6: SUSTAINABILITY**

*Table Instructions: Sustainability*:

Please provide the following funding/revenue amounts:

* The annual program award based on box 12a of your Notice of Grant Award (NGA).
* The amount of annual revenue (if any) for the Network.
* The amount of additional funding secured to sustain the program.
* Please provide the estimated amount of savings incurred due to participation in a network/consortium
* Please indicate if you have a sustainability plan and select your sustainability activities.

If the total amount of additional funding secured is zero (0), please put zero in the appropriate section. Do not leave any sections blank.

Please identify the sources(s) of revenue for sustainability and indicate if you have developed a sustainability plan. Please identify the types of sustainability activities that the network/consortium engaged in during the respective budget year; please check all that apply.

Please indicate if you used HRSA’s Economic Impact Analysis Tool (website TBD). If so, please provide the ratio for Economic Impact vs. HRSA Program Funding.

For networks/consortiums in Year 3 of grant funding, please indicate the following:

* If your current network/consortium will sustain after the grant period is over
* If **any** of your network’s/consortium’s activities will sustain after the grant period
* If your network’s/consortium’s objectives have been met as a result of grant funding

|  |  |  |
| --- | --- | --- |
| 22 | **Funding/Revenue:** | **Dollar Amount** |
|  | Annual program award |  |
|  | Annual network revenue |  |
|  | Additional funding secured to assist in sustaining the program |  |
|  | Estimated amount of cost-savings due to participation in the network |  |
| 23 | **Sources of Revenue:**  (Check all that apply) | **Selection list** |
|  | Network/Consortium revenue |  |
| In-Kind Contributions |  |
| Member Fees |  |
| Fundraising |  |
| Contractual Services |  |
| Other – Specify Type: |  |
| Other grants |  |
| None |  |
| Has a sustainability plan been developed using sources of funding besides grants? | **Y/N** |
| 24 | **Sustainability Activities:**  (Check all that apply) | **Selection list** |
|  | Local, State and Federal policy changes |  |
|  | Media campaigns |  |
|  | Consolidation of activities, services and purchases |  |
|  | Communication plan development |  |
|  | Economic impact analysis |  |
|  | Return on investment analysis |  |
|  | Marketing plan development |  |
|  | Community engagement activities |  |
|  | Business plan development |  |
|  | Incorporation |  |
|  | Organization bylaws |  |
|  | SWOT analysis |  |
|  | Other – Specify activity: |  |
| 25 | **Did you use the HRSA Economic Impact tool?** | **Y/N** |
| 26 | **If yes, what was ratio for Economic Impact vs. HRSA Program Funding** | **Number** |
| 27 | **Will the Network/Consortium sustain?** | **Y/N** |
| 28 | **Will any of the activities of the Network/Consortium sustain?** | **Y/N** |
| 29 | **Have the objectives of the Network/Consortium been met?** | **Y/N** |

**Table 7: HEALTH INFORMATION TECHNOLOGY**

*Table Instructions: Health Information Technology (HIT)*

Please select all types of technology implemented, expanded or strengthened through this program. If your grant program did not fund these activities, please select “Not Applicable. Please select all of the Meaningful Use Stage criteria achieved through this program. Please specify the Health Information Technology (HIT) Meaningful Use Stage (1, 2, or 3) that the network/consortium organization as a whole has attained. If the network/consortium has been funded to do these activities but has not acquired HIT, please mark “None”. Please refer to the detailed definition for consortium/networks, as defined by program guidance and please refer to the detailed definition for HIT Meaningful Use Stage.

|  |  |  |
| --- | --- | --- |
| 26 | **Type(s) of technology implemented, expanded or strengthened through this program:** (Check all that apply) | **Selection list** |
|  | Computerized laboratory functions |  |
|  | Computerized pharmacy functions |  |
|  | Electronic clinical applications |  |
|  | Electronic medical records |  |
|  | Health Information Exchange |  |
|  | Patient/Disease Registry |  |
|  | Telehealth/Telemedicine |  |
|  | Other – Please specify criteria |  |
|  | None |  |
|  | Not Applicable |  |
| 27 | **HIT Meaningful Use Stage implementation criteria through this program** (Check all that apply) | **Selection list** |
|  | **Meaningful Use Stage 1** |  |
|  | Initiating the reporting of clinical quality measures and public health information |  |
|  | Electronically capturing health information in a coded format |  |
|  | Using health information to track key clinical conditions |  |
|  | Communicating health information for care coordination purposes |  |
|  | Establishing the functionalities in certified EHR technology allowing for continuous quality improvement and information exchange ease |  |
|  | Other – Please specify criteria |  |
|  | None |  |
|  | Not Applicable |  |
|  | **Meaningful Use Stage 2** |  |
|  | Disease management |  |
|  | Clinical decision support |  |
|  | Medication management |  |
|  | Quality measurement and research |  |
|  | Other – Please specify criteria |  |
|  | **Meaningful Use Stage 3** |  |
|  | Achieving improvements in quality, safety and efficiency |  |
|  | Decision support for national high priority conditions |  |
|  | Patient access to self-management tools |  |
|  | Access to comprehensive patient data |  |
|  | Improving population health outcomes |  |
|  | Other – Please specify criteria |  |
|  | None |  |
|  | Not Applicable |  |
| 28 | **Consortium/Network Classification by HIT Meaningful Use Stage:**  (Please check one) | **Selection list** |
|  | Stage 1 |  |
|  | Stage 2 |  |
|  | Stage 3 |  |
|  | None |  |
|  | Not applicable |  |

**Table 8: FOCUS AREAS**

|  |  |  |
| --- | --- | --- |
| 29 | **Number of quality improvement clinical guidelines / benchmarks adopted by network** | **Number** |
| 30 | **Number of network members using shared standardized quality improvement benchmarks** | **Number** |
| 31 | **Average amount of dollars saved per patient through joint purchasing of drugs by Network** | **Dollar Amount** |
| 32 | **Number of health promotion/disease management activities offered to the public through this program** | **Number** |
| 33 | **Number of network members integrating primary and mental health services.** | **Number** |
| 34 | **Number of network members integrating primary and dental / oral health services.** | **Number** |

*Table Instructions: Focus Areas*

Report the number of quality improvement clinical guidelines/benchmarks adopted and the number of network members using shared standardized benchmarks. Report the average amount of dollars saved by joint purchasing of drugs by network. Report the number of health promotion/disease management activities offered to the public through this program. Some examples include: health screenings, health education, immunizations, etc. Report the number of network members integrating primary and mental health services. Report the number of network members integrating oral health services. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

**Definition of Key Terms for Rural Health Community-Based Grant Programs**

**Charity Care:** any services provided free of cost or reimbursement

**Consortium/Network:** Comprised of at least 3 separately owned organizations that are working together towards the program’s goals and objectives. Specifically respond only for the formal member organizations, for the purposes of your grant program.

**HIT Meaningful Use Stage**: \*Meaningful Use Criteria as proposed by the Centers of Medicare and Medicaid Services (CMS). Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs), which participate in Medicare and Medicaid programs, that adopt and successfully demonstrate meaningful use of certified electronic health record (EHR) technology may receive CMS incentive payments. CMS incentives are linked to each Meaningful Use Stage and a timeframe for completion. Each Stage Criteria and its respective timeframe are as follows:

* Stage 1 Criteria\* (up through 2013)
  + Electronically capturing health information in a coded format
  + Using that information to track key clinical conditions
  + Communicating that information for care coordination purposes
  + Initiating the reporting of clinical quality measures and public health information. (25 objectives/measures for eligible providers and 23 objectives/measures for eligible hospitals)
  + Establishing the functionalities in certified EHR technology allowing for continuous quality improvement and information exchange ease
* Stage 2 Criteria\* (met by end of 2014)
  + Disease management
  + Clinical decision support
  + Medication management
  + Support for patient access to their health information
  + Transitions in care
  + Quality measurement and research
  + Bi-directional communication with public health agencies
* Stage 3 Criteria\* (met by end of 2015)
  + Achieving improvements in quality, safety and efficiency
  + Decision support for national high priority conditions
  + Patient access to self-management tools
  + Access to comprehensive patient data
  + Improving population health outcomes

**Medical Home:** provides patients with continuous access to services.

**Target Population:**  The population identified by the grant program to receive services.