**Rural Health Network Development Planning Program**

**Performance Improvement and Management System (PIMS) Measures**

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**Table 1: Network Infrastructure**

***Table Instructions:*** Please provide information about the network members and network operations. Network members are defined as members who have signed a Memorandum of Understanding or Memorandum of Agreement or have a letter of commitment to participate in the network.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1** | **Identify the types and number of organizations in the consortium or network for your project:** | | | | |
|  |  | **Type of Member Organizations in the Consortium/Network** | | | **Number** |
|  | Non-Profit Organization | Area Health Education Center | | |  |
|  | Behavioral/Mental Health Organization | | |  |
|  | Community College | | |  |
|  | Community Health Center | | |  |
|  | Critical Access Hospital | | |  |
|  | Faith-based organization | | |  |
|  | Free Clinic | | |  |
|  | Health Department | | |  |
|  | Hospice | | |  |
|  | Hospital | | |  |
|  | Migrant Health Center | | |  |
|  | Private Practice | | |  |
|  | Rural Health Clinic | | |  |
|  | School District | | |  |
|  | Social Services Organization | | |  |
|  | University | | |  |
|  | Other – Specify type | | |  |
|  | TOTAL for non-profit organization | | | (Automatically calculated by system) |
|  | For-Profit Organization | Critical Access Hospital | | |  |
|  |  | Hospice | | |  |
|  | Private Practice | | |  |
|  | Rural Health Clinic | | |  |
|  | Other – Specify Type | | |  |
|  | TOTAL for-profit organization | | | (Automatically calculated by system) |
| **2** | Total number of **NEW** member organizations that joined the consortium/network during this project period: | | | | **Number** |
| **3** | **Indicate the total number of full-member (all members that signed MOU, MOA, or letters of commitment) network meetings conducted during the reported budget year by meeting type:** | | | | |
|  | **Meeting Type** | | | | **Number** |
|  | Meeting conducted face-to-face | | | |  |
|  | Meeting conducted via teleconference | | | |  |
|  | Meeting conducted via webinar | | | |  |
|  | Meeting conducted in a manner not listed above (please specify type) | | | |  |
| **4** | **From the beginning of this budget year, assess the following overall Network changes (check one answer for each type of network change):** | | | | |
|  | **Type of Network Change** | | **Increased** | **No Change** | **Reduced** |
|  | Financial Cost Savings | |  |  |  |
|  | Access to Educational Opportunities | |  |  |  |
|  | Access to Equipment | |  |  |  |
|  | Access to Subject Matter Experts | |  |  |  |
|  | Understanding of community health needs | |  |  |  |
|  | Other (Please Specify): | |  |  |  |
| **5** | **What area(s) was the network focusing on for this project period? (Check all that apply)** | | | | |
|  | Cardiovascular disease | | | |  |
|  | Care coordination | | | |  |
|  | Care transition | | | |  |
|  | Children’s health | | | |  |
|  | Diabetes | | | |  |
|  | Elderly/Geriatric care | | | |  |
|  | Emergency Medical Services | | | |  |
|  | Health information technology | | | |  |
|  | Health promotion/disease prevention | | | |  |
|  | Increase access and/or quality of care | | | |  |
|  | Mental/Behavioral health | | | |  |
|  | Obesity | | | |  |
|  | Primary care | | | |  |
|  | Telehealth/telemedicine | | | |  |
|  | Workforce | | | |  |
|  | Other – Specify type | | | |  |

**Table 2: Network Collaboration**

***Table Instructions:*** Please provide information about collaboration and/or integration among the network members. Refer to the activities listed in the project work plan for this project period.

|  |  |  |
| --- | --- | --- |
| **6** | **How many activities from the project work plan were initiated by at least two or more network members?** | *Number* |
| **7** | **How many activities from the project work plan were completed by at least two or more network members?** | *Number* |
| **8** | **Did the network develop the following (this does not include a needs assessment)?** |  |
|  | Strategic Plan | *(Y/N)* |
|  | Business Plan | *(Y/N)* |
|  | Sustainability Plan | *(Y/N)* |
|  | Other (please specify) |  |
| **9** | **What type of Network Planning activities were done during the project period (check all that apply):** |  |
|  | Conduct needs assessment |  |
|  | Develop a plan (ex: strategic, business) |  |
|  | Develop network bylaws |  |
|  | Develop network mission statement |  |
|  | Develop network governance structure |  |
|  | Conduct community engagement activities |  |
|  | Conduct a SWOT analysis |  |
|  | Other (please specify) |  |

**Table 3: Sustainability**

Table instructions: Please provide information about the contribution by network members and the network’s sustainability efforts.

|  |  |  |
| --- | --- | --- |
| **10** | **Annual Program award**  Please provide the annual program award based on box 12a of your Notice of Award |  |
| **11** | **Additional funding secured to assist in sustaining the network**  Please provide the amount of additional funding that has already been secured during this current project period to sustain the program. |  |
| **12** | **Estimated amount of cost savings due to participation in the network during this current project period** |  |
| **13** | **Sources of Revenue (check all that apply)** |  |
|  | Network revenue |  |
|  | In-kind contributions |  |
|  | Member Fees |  |
|  | Fundraising |  |
|  | Contractual Services |  |
|  | Other – specify type |  |
| **14** | **How many of the network members have provided the following in-kind services:** |  |
|  | Goods (Ex: equipment, food) | Number |
|  | Services (ex: meeting space) | Number |
|  | Staff support | Number |
|  | Expertise (ex: legal, business, website/marketing development) | Number |
|  | Other (please specify) |  |
| **15** | **How many network policies or procedures were created during this budget period:** | Number |
| **16** | **How many network policies or procedures were amended during this budget period:** | Number |
| **17** | **How many network policies or procedures were implemented during this budget period:** | Number |
| **18** | **As a result of being part of the network, how many network member organizations were able to integrate joint policies/procedures within their respective organizations during this budget period?** | Number |
| **19** | **Will the activities of the Network/Consortium continue to operate after the Federal grant funding period?** | Y/N |

**Table 4: Network Assessment**

Table instructions: Please provide information regarding the network’s assessment during this project period.

|  |  |  |
| --- | --- | --- |
| **20** | **Does the network include a process or tool to assess effectiveness of network performance?** | Y/N |
| **21** | **If yes, how is network performance assessed?** | open-ended response |
| **22** | **Does the network include a process or tool to assess effectiveness of network director?** | Y/N |
| **23** | **If yes, how is the network director assessed?** | open-ended response |
| **24** | **Did the network meet its program objectives?** | Y/N |