**Rural Health Care Services Outreach Program**

**Performance Improvement Measurement System (PIMS)**

1. **DEMOGRAPHICS**

**ACCESS TO CARE**

Information collected in this table provides an aggregate count of the number of people served through program. Please refer to the detailed definitions and guidelines in answering the following measures. Please indicate a numerical figure or DK for do not know, if applicable.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st year Data** |
| **Number of counties served** Denotes the total 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 population** Denotes the number of people in your target population (not necessarily the number of people who availed your services). For example, if a grantee organization’s target population is females in county A, then the grantee organization reports the number of females that resides in county A. |  |  |
| **Number of direct unduplicated encounters** Denotes the number of unique individuals in the target population who have received documented services provided directly to the patient (patient visits, health screenings etc.) |  |  |
| **Number of indirect encounters** Denotes the number of people reached through mass communication methods, such as mailings, posters, flyers, brochures, etc. |  |  |

|  |  |
| --- | --- |
| **Type(s) of services provided through grant funding**  Please check the box that applies to your program | **Selection list** |
| Cardiovascular Disease (CVD) | **🗹** |
| 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 | **🗹** |
| Mental/Behavioral Health | **🗹** |
| Nutrition | **🗹** |
| Oral health | **🗹** |
| Pharmacy | **🗹** |
| Primary Care | **🗹** |
| Substance abuse treatment | **🗹** |
| Telehealth/telemedicine | **🗹** |
| Transportation | **🗹** |
| Workforce | **🗹** |
| Other  Specify: | **🗹** |
|  |  |

**POPULATION DEMOGRAPHICS**

Please provide the total number of people served by race, ethnicity, and age. The total for each of the following questions should equal to the total number of direct unduplicated encounters provided in the previous section (Access to Care section). Please indicate a numerical figure. There should **not** be a N/A (not applicable) response since all measures are applicable.

|  |  |  |
| --- | --- | --- |
| **Number of people served by ethnicity:** | **Baseline** | **1st Year Data** |
| 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.) |  |  |
| Not Hispanic or Latino |  |  |
| Unknown |  |  |
| TOTAL (automatically calculated by the system) |  |  |

|  |  |  |
| --- | --- | --- |
| **Number of people served by race:** | **Baseline** | **1st Year Data** |
| American Indian/Alaska Native |  |  |
| Asian |  |  |
| Asian Indian |  |  |
| Black or African American |  |  |
| Native Hawaiian/Other Pacific Islander |  |  |
| White |  |  |
| More than one race |  |  |
| Unknown |  |  |
| TOTAL (automatically calculated by the system) |  |  |

|  |  |  |
| --- | --- | --- |
| **Number of people served by age group** | **Baseline** | **1st Year Data** |
| Children (0-12) |  |  |
| Adolescents (13-17) |  |  |
| Adults (18-64) |  |  |
| Elderly (65 and over) |  |  |
| Unknown |  |  |
| TOTAL (automatically calculated by the system) |  |  |

**UNINSURED**

Please respond to the following questions based on these guidelines. Please indicate a numerical figure or DK for do not know, if applicable. If your grant program was not funded to provide these services, please type N/A for not applicable.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year Data** |
| **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  The response should be based of the total number of direct unduplicated encounters provided on ‘Access to Care’ section |  |  |
| **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 do not receive health services free of charge |  |  |
| **Number of people who receive health services free of charge** |  |  |

**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 indicate a numerical figure. There should **not** be a N/A (not applicable) response since all questions are applicable.

|  |  |  |
| --- | --- | --- |
| **Number of new clinical staff recruited to work on the program:** | | |
|  | **1st Year Data** | |
|  | **Full-time** | **Part-time** |
| Dental Hygienist |  |  |
| Dentist |  |  |
| Health Educator / Promotoras |  |  |
| Licensed Clinical Social Worker |  |  |
| Nurse |  |  |
| Pharmacist |  |  |
| Physician Assistant |  |  |
| Physician, General |  |  |
| Physician, Specialty |  |  |
| Psychologist |  |  |
| Technicians (medical, pharmacy, laboratory, etc) |  |  |
| Therapist  (Behavioral, PT, OT, Speech, etc) |  |  |
| Other – Specify Type(s) |  |  |

|  |  |  |
| --- | --- | --- |
| **Number of new non-clinical staff recruited to work on the program for each type:** | | |
|  | **1st Year Data** | |
|  | **Full-time** | **Part-time** |
| HIT/CIO |  |  |
| Case Manager |  |  |
| Medical Biller / Coder |  |  |
| Translator |  |  |
| Enrollment Specialist |  |  |
| Other – Specify Type: |  |  |

|  |  |
| --- | --- |
| **Number of staff positions shared between two or more Network partners** |  |

**WORKFORCE/ RECRUITMENT & RETENTION**

Traineeships:

If your grant funds support traineeships, please provide the number of new and existing trainees by type (student or resident).

**Number of New Students/Residents Recruited to Work on the Program:**

Trainees are considered “New” if:

1. They have never engaged in a training/rotation within a rural community as a part of their certificate/degree/residency program and/or
2. They do not self identify as “having lived”/ “living”/ “claiming residence” within a rural area.

Trainees are considered “Existing” if:

1. They have had prior exposure to rural areas by either engaging in a training/rotation within a rural area as a part of their certificate/degree/residency program prior to the respective budget year and/or
2. They self identify as “having lived”/ “living”/ “claiming residence” within a rural area.

(Please refer to the Definition of Key Rural Health Community-Based Grant Programs to view the detailed definition for “New Trainees” and “Existing Trainees”.)

Please provide the number of trainees by type that complete the trainings/rotations; this figure should not exceed the total number of all trainees recruited by type. Please also provide the number of trainees by type that plan to practice in a rural area after completing their trainings/rotations. If appropriate, of those trainees that completed their trainings/rotations, please specify the number that return to formally practice in rural areas; for this measure, please indicate a numerical figure or type DK for do not know. For example, if there are zero (0) students that completed their trainings/rotations and returned to formally practice in a rural area, 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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **STUDENTS** | |  | **RESIDENTS** | |
| **Baseline** | **1st Year Data** |  | **Baseline** | **1st Year Data** |
| Number of New |  |  |  |  |  |
| Number of Existing |  |  |  |  |  |
| **TOTAL** (**Number (automatically calculated by the system)** |  |  |  |  |  |
| Of the total number recruited, how many completed the training/rotation |  |  |  |  |  |
| Of the total number that complete the training/rotation, how many plan to practice in a rural area |  |  |  |  |  |
| Percentage trained that plan to practice in a rural area (automatically calculated by the system) |  |  |  |  |  |
| Of the total number that complete the training/rotation, how many returned to formally practice in rural areas |  |  |  |  |  |
| Percentage trained that return to formally practice in rural areas (automatically calculated by the system) |  |  |  |  |  |

|  |  |
| --- | --- |
| **Trainee Primary Care Focus Area(s):** | Please check all that apply |
| **Medical** |  |
| **Mental/Behavioral Health** |  |
| **Oral Health** |  |

|  |  |
| --- | --- |
| **Trainee Discipline Type(s):**  Please keep in mind that psychiatrists are either allopathic (MD) or osteopathic (DO) physicians. Also, please specify the types of Mid-Levels, Nurses, and Allied Health Professionals as appropriate. For example, Physician Assistants, Nurse Practitioners, Certified Nurse Mid-Wives, and Certified Registered Nurse Anesthesiologists are considered Mid-Level providers. Allied health professionals, to name a few, include dental hygienists, diagnostic medical sonographers, dietitians, medical technologists, occupational therapists, physical therapists, pharmacists, radiographers, respiratory therapists, community health workers, and speech language pathologists. If the targeted trainee does not fall under the categories listed, please refer to the detailed definition for Allied Health Professionals and specify the discipline(s) in the Allied Health Professionals category.  Please check all that apply | Please check all that apply |
| Allied Health Professional– Please specify type(s) |  |
| Dentist |  |
| Mid-Level Provider – Please specify type(s) |  |
| Nurse – Please specify type(s) |  |
| Physician (DO) |  |
| Physician (MD) |  |

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year Data** |
| **Number of New Trainings/Rotations provided:**  Please provide the number of trainings/rotations provided during the respective budget period as well as the number of training sites by type where the trainings/rotations were conducted. Please indicate a numerical figure. If the total number of trainings/rotations is zero (0), please put zero in the appropriate section. Do not leave any sections blank. |  |  |
| **Number of Training Site(s) by Type:** |  |  |
| Critical Access Hospital |  |  |
| Other Rural Hospital |  |  |
| Clinic |  |  |
| Rural Health Clinic |  |  |
| Community Health Center |  |  |
| Federally Qualified Health Center (FQHC) |  |  |
| Health Department |  |  |
| Indian Health Service (IHS) or Tribal Health Sites |  |  |
| Migrant Health Center (MHC) |  |  |
| Other Community Based Site – Please specify type(s) |  |  |

1. **ENVIRONMENT & TECHNOLOGY**

**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.

|  |  |
| --- | --- |
| **Non-Profit Organizations** | |
| **Type(s) of member organizations in the consortium / network**  (Check all that apply) | **Number** |
| Area Health Education Center (AHEC) |  |
| Community College |  |
| Community Health Center |  |
| Critical Access Hospital |  |
| Faith-Based Organization |  |
| Health Department |  |
| Hospital |  |
| Migrant Health Center |  |
| Private Practice |  |
| Rural Health Clinic |  |
| School District |  |
| Social Services Organization |  |
| University |  |
| Other |  |
| **TOTAL for Non-Profit Organization** | Number (automatically calculated by the system) |
|  | |
| **For-Profit Organizations** | |
| **Type(s) of member organizations in the consortium / network**  (Check all that apply) | **Number** |
| Community College |  |
| Community Health Center |  |
| Critical Access Hospital |  |
| Faith-Based Organization |  |
| Health Department |  |
| Hospital |  |
| Migrant Health Center |  |
| Private Practice |  |
| Rural Health Clinic |  |
| School District |  |
| Social Services Organization |  |
| University |  |
| Other |  |
| **TOTAL for For-Profit Organization** | Number (automatically calculated by the system) |
| **Total Number of Member Organizations in the Consortium/Network** | **Number** |
| **Total Number of New Members in the Consortium/Network** | **Number** |

**Sustainability**

|  |  |
| --- | --- |
| **Funding/Revenue:** | |
| **Annual program award** Please provide the annual program award based on box 12a of your Notice of Grant Award (NGA). | Dollar amount |
| **Annual program revenue** Please provide the amount of annual revenue made through the services offered through the program. If the total amount of annual revenue made is zero (0), please put zero in the appropriate section. Do not leave any sections blank. | Dollar amount |
| **Additional funding secured to assist in sustaining the program** Please provide the amount of additional funding secured to sustain the program. If the total amount of additional funding secured is zero (0), please put zero in the appropriate section. Do not leave any sections blank. | Dollar amount |
| **Estimated amount of cost savings due to participation in network/consortium** Please provide the estimated amount of savings incurred due to participation in a network/consortium. If the total amount of savings incurred is zero (0), please put zero in the appropriate section. Do not leave any sections blank. | Dollar amount |

|  |  |
| --- | --- |
| **Sources of Sustainability** Select the type(s) of sources of funding for sustainability. Please check all that apply. | Selection list |
| Network/Consortium revenue | 🗹 |
| In-kind Contributions | 🗹 |
| Member fees | 🗹 |
| Fundraising | 🗹 |
| Contractual Services | 🗹 |
| Other grants | 🗹 |
| Other – specify type | 🗹 |
| None | 🞎 |
| **Has a sustainability plan been developed using sources of funding besides grants?** Please indicate if you have developed a sustainability plan | Y/N |

|  |  |
| --- | --- |
| **Sustainability Activities:** Please select your 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 | 🗹 |
| Incorporation | 🗹 |
| Organization Bylaws | 🗹 |
| Business Plan Development | 🗹 |
| SWOT Analysis | 🗹 |
| Other – Specify activity | 🗹 |

|  |  |
| --- | --- |
| **Did you use the HRSA Economic Impact Analysis tool?** 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. | Y/N |
| **Will the network/Consortium sustain?** Please indicate if your current network/consortium will sustain after the grant period is over | Y/N |
| **Will any of the activities of the Network/Consortium sustain?** Please indicate if any of your program’s activities will sustain after the grant period | Y/N |

**Health Information Technology**

Please select all types of technology implemented, expanded or strengthened through this program. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

|  |  |  |
| --- | --- | --- |
| **Type(s) of technology implemented, expanded or strengthened through this program:** (Check all that apply) | **Baseline** | **1st Year Data**  **(Selection list)** |
| Computerized laboratory functions | 🗹 | 🗹 |
| Computerized pharmacy functions | 🗹 | 🗹 |
| Electronic clinical applications | 🗹 | 🗹 |
| Electronic medical records | 🗹 | 🗹 |
| Health Information Exchange | 🗹 | 🗹 |
| Patient/Disease Registry | 🗹 | 🗹 |
| Telehealth/Telemedicine | 🗹 | 🗹 |
| None | 🗹 | 🗹 |
| Other | 🗹 | 🗹 |

**QUALITY IMPROVEMENT**

Report the number of quality improvement clinical guidelines/benchmarks adopted and the number of network members using shared standardized benchmarks. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st year data** |
| **Number of quality improvement clinical guidelines / benchmarks adopted by network/consortium** |  |  |
| **Number of network/consortium members using shared standardized quality improvement benchmarks** |  |  |

**PHARMACY**

Report the overall annual dollars saved by joint purchasing of drugs through your network/consortium. Report the number of people receiving prescription drug assistance and the annual average amount of dollars saved per patient through prescription drug assistance. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year data** |
| **Average amount of dollars saved per patient through joint purchasing of drugs annually** |  |  |
| **Number of people receiving prescription drug assistance annually** |  |  |
| **Average amount of dollars saved per patient through prescription drug assistance annually** |  |  |

**HEALTH PROMOTION/DISEASE MANAGEMENT**

Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year Data** |
| **Number of health promotion/disease management activities offered to the public through this program.**  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. |  |  |
| **Number of people referred to health care provider/s**  Report the number of people that were referred to a health care provider. The response to this question should be based on the number reported in the previous question (Number of health promotion/disease management activities offered to the public through this program). Therefore, the number reported here should not be more than the number reported in the previous question. |  |  |

**MENTAL/BEHAVIORAL HEALTH**

Report the number of people receiving mental and/or behavioral health services through your program and the number of network members integrating primary and mental health services. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year data** |
| **Number of people receiving mental and/or behavioral health services in target area.** |  |  |
| **Number of network members integrating primary and mental health services.** |  |  |

**ORAL HEALTH**

Report the number of people receiving dental/oral health services in target area.

|  |  |  |
| --- | --- | --- |
|  | **Baseline** | **1st Year Data** |
| **Number of people receiving dental / oral health services in target area.** |  |  |
| **Type(s) of dental / oral health services provided.**  Please select the appropriate types of services and provide the number of network/consortium members integrating oral health services. Please check all that apply. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this. Check all that apply. | | |
|  | **Baseline** | **1st Year Data** |
| Screenings / Exams |  |  |
| Sealants |  |  |
| Varnish |  |  |
| Oral Prophylaxis |  |  |
| Restorative |  |  |
| Extractions |  |  |
| Other |  |  |
| **Number of network members integrating primary and dental / oral health services.** |  |  |

1. **MEASURES**

**CLINICAL MEASURES**

Please refer to the specific instructions for each field below. Please indicate a numerical figure or N/A for not applicable if your grant program did not fund this**.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Baseline** | | |  | **1st Year data** | | |
| **Numerator** | **Denominator** | **Percent** (Automatically calculated by the system) |  | **Numerator** | **Denominator** | **Percent** (Automatically calculated by the system) |
| **Percentage of adult patients, 18 -85 years of age, who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year**  *Numerator:* Patients from the denominator that have the most recent blood pressure less than 140/190 mm Hg, within the last 12 months.  *Denominator:*  All patients 18-85 years of age seen at least once during the last 12 months with a diagnosis of hypertension within 6 months after measurement start date. |  |  |  |  |  |  |  |
| **Percent of adult patients in the target population who have been screened for depression**  *Numerator:* Number of adult patients in the target population that have been screened for depression.   *Denominator:* All patients ≥ 18 years of age in the target population. |  |  |  |  |  |  |  |
| **Percent of adult patients, 18-75 years of age with diabetes (type 1 or type 2) who had hemoglobin A1c less than 8.0%**  *Numerator:* Number of patients 18-75 years of age whose most recent hemoglobin A1c level during the measurement year is less than 8.0%  *Denominator:* Number of patients 18-75 years of age during measurement year with a diagnosis of type 1 or type 2 diabetes. |  |  |  |  |  |  |  |
| **Percent of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mm/Hg**  *Numerator:* Number of patients 18-75 years of age with diabetes (type 1 or type 2) who had blood pressure less than 140/90 mm/Hg  *Denominator:* All patients 18-75 years of age during measurement year with a diagnosis of type 1 or 2 diabetes. |  |  |  |  |  |  |  |
| **Percent of patients 2-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or OB/GYN and who had evidence of Body Mass Index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year**  *Numerator:* Patients in the denominator with Body Mass Index (BMI) percentile documentation, counseling for nutrition, counseling for physical activity during the measurement year  *Denominator:* All patients 2-17 years of age |  |  |  |  |  |  |  |
| **Percent of patients aged 18 years and older with a calculated Body Mass Index (BMI) in the past six months or during the current visit documented in the medical record and if the most recent BMI is outside parameters, a follow-up is documented**  *Numerator:* Patients in denominator with (1) Body Mass Index (BMI) charted and (2) follow-up plan documented if patient is overweight and underweight  *Denominator:* All patients age 18 years or older |  |  |  |  |  |  |  |
| **Percent of children by 2 years of age with appropriate immunizations (please see types of immunizations as listed in the instructions)**  *Numerator:* Number of children who have received four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (HepB); one chickenpox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.  The measure calculates a rate for each vaccine and nine separate combination rates. *Denominator:* Number of children who turn two years of age during the measurement year. |  |  |  |  |  |  |  |
| **Percent of adolescents 13 years of age with appropriate immunizations documented according to age group**  *Numerator:* Number of adolescents who have received a second MMR, completion of three hepatitis B (HepB) and Varicella (VZV). *Denominator:* Number of adolescents who are 13 years of age during measurement year. |  |  |  |  |  |  |  |