

**Rural Opioid Overdose Reversal Grant Program  
Performance Improvement Measurement System (PIMS)**

**Demographics**

<p><b>Type of organization</b> Denotes the type of organization for the lead grantee administering the grant (health department; hospital; fire department; police department; school; county, state, or city government; etc).</p>		
<p><b>Number of counties served</b> 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.</p>	<p style="color: red;">This field only accepts whole numbers, including 0. Represents the number of counties served.</p>	
<p><b>Partnership Organizations</b> Denotes the name of all of the organizations in the partnership and their type.</p>	<p><b>Name of Organization</b> This field accepts alphanumeric characters and expands.</p>	<p><b>Type of Organization</b> Selection list  <input checked="" type="checkbox"/> Hospital/Clinic  <input checked="" type="checkbox"/> Rural Health Clinic  <input checked="" type="checkbox"/> CAH  <input checked="" type="checkbox"/> Health Department  <input checked="" type="checkbox"/> Fire Department  <input checked="" type="checkbox"/> EMS Service  <input checked="" type="checkbox"/> Police Department  <input checked="" type="checkbox"/> Substance Abuse Facility  <input checked="" type="checkbox"/> Mental Health Facility  <input checked="" type="checkbox"/> Community Organization  <input checked="" type="checkbox"/> Other _____</p>
<p><b>Type of device purchased</b> Denotes the type of administration devices purchased.</p> <p>Selection list  <input checked="" type="checkbox"/> Evzio  <input checked="" type="checkbox"/> Adapt intranasal  <input checked="" type="checkbox"/> Intramuscular (syringe)</p>	<p><b>Number of devices purchased</b> Denotes the number of devices purchased by type  <span style="color: red;">This field only accepts whole numbers, including 0</span></p>	<p><b>Cost of devices purchased</b> Denotes the cost of devices purchased by type  <span style="color: red;">This field only accepts whole numbers, including 0</span></p>
<p><b>Were vials of medication purchased separately from those included with the device?</b></p>	<p><input checked="" type="checkbox"/> Yes (If field is clicked yes, go to next two questions – number of vials and cost of medication will be hidden unless yes is clicked)  <input checked="" type="checkbox"/> No (if field is clicked no, go to distribution points question)</p>	
<p><b>Number of vials of medication purchased</b> (if purchased separately from the device)</p>	<p style="color: red;">This field only accepts whole numbers, including 0.</p>	
<p><b>Total Cost of medication</b> (if purchased separately from the device)</p>	<p style="color: red;">This field only accepts whole numbers, including 0.</p>	
<p><b>Distribution points for the devices/medication</b> Denotes who received the devices/medication.  <span style="color: red;">(This field expands since distribution can be more than one entity)</span></p> <p>Selection list  <input checked="" type="checkbox"/> Fire trucks  <input checked="" type="checkbox"/> Ambulances  <input checked="" type="checkbox"/> Police cruisers  <input checked="" type="checkbox"/> Hospital or other health facility  <input checked="" type="checkbox"/> Community organization <u>_(type of organization)</u></p>	<p><b>Number distributed</b> Denotes the number of devices/medication distributed by type of entity.  <span style="color: red;">This field only accepts whole numbers. If "0" is entered, prompt error message. Field must be completed before moving to next question.</span></p>	

<input checked="" type="checkbox"/> Individuals <input checked="" type="checkbox"/> Other <u>    specify    </u>	
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## USAGE and REFERRAL

<b>Number of uses</b> Denotes the number of times naloxone/narcan was administered. This field only accepts whole numbers, including 0 and DK.	<b>Disposition after usage</b> Denotes the disposition of the individual after administration. This field accepts whole numbers, including 0 and DK.  Number of individuals in which opioid overdose was reversed _____
<b>Were any individuals transported to a health care facility?</b>  <input checked="" type="checkbox"/> Yes (if yes, go to number of individuals transported question) <input checked="" type="checkbox"/> No (if not, go to next question below- referred for further treatment) <input checked="" type="checkbox"/> Unknown <input checked="" type="checkbox"/> Other notes _____	<b>If yes, number of individuals transported to a health care facility.</b> This field only accepts whole numbers, including 0 and DK.
<b>Were any individuals referred for further treatment?_</b> <b>(Check all that apply)</b> <input checked="" type="checkbox"/> Substance abuse treatment facility (if checked go to number of referrals) <input checked="" type="checkbox"/> Mental health (counseling) services (if checked go to number of referrals)	<b>Number of referrals by type of treatment.</b> This field only accepts whole numbers. Substance abuse treatment facility _____  Mental health (counseling) services <input checked="" type="checkbox"/> Within hospital/medical clinic _____ <input checked="" type="checkbox"/> Doctor's office _____ <input checked="" type="checkbox"/> Private office of psychologist/psychiatrist/therapist _____ <input checked="" type="checkbox"/> School/university setting _____ <input checked="" type="checkbox"/> Other (indicate name) _____ # referrals _____
<b>Was there report of any violent or erratic behavior after administration of naloxone?</b>	<input checked="" type="checkbox"/> Yes <u>If yes, number of episodes _____</u> <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Unknown

## TRAININGS

Type of training Denotes the number of trainings related to use of naloxone/narcan (how to use the administration devices, how much medication to dispense, signs of overdose, etc.)	Number of trainings	Number of responders trained (police, fire, EMS, health facility staff)	Number of laypersons trained	Total Cost of training by type
<b>In person</b>	This field only accepts whole numbers, including 0.	This field only accepts whole numbers, including 0	This field only accepts whole numbers, including 0	This field only accepts whole numbers, including 0
<b>Video/webinar</b>	This field only accepts whole numbers, including 0	This field only accepts whole numbers, including 0	This field only accepts whole numbers, including 0	This field only accepts whole numbers, including 0
<b>Was instruction on Basic Life Support/Advanced Life Support provided?</b> <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<b>If yes, number of trainings</b> This field only accepts whole numbers, including 0		<b>If yes, number trained</b> This field only accepts whole numbers, including 0	

<b>Was instruction on use of an Automatic External Defibrillator provided?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If yes, number of trainings</b> This field only accepts whole numbers, including 0	<b>If yes, number trained</b> This field only accepts whole numbers, including 0
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