**Rural Opioid Overdose Reversal Grant Program**

**Performance Improvement Measurement System (PIMS)**

**Demographics**

|  |  |
| --- | --- |
| **Type of organization**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).  |  |
| **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.  | This field only accepts whole numbers, including 0. Represents the number of counties served. |
| **Partnership Organizations**Denotes the name of all of the organizations in the partnership and their type.  | **Name of Organization**This field accepts alphanumeric characters and expands. | **Type of Organization**Selection list🗹 Hospital/Clinic🗹Rural Health Clinic🗹CAH🗹Health Department🗹Fire Department🗹EMS Service🗹Police Department🗹Substance Abuse Facility🗹Mental Health Facility🗹Community Organization🗹Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Type of device purchased**Denotes the type of administration devices purchased.Selection list🗹 Evzio🗹Adapt intranasal🗹 Intramuscular (syringe) | **Number of devices purchased**Denotes the number of devices purchased by typeThis field only accepts whole numbers, including 0 | **Cost of devices purchased**Denotes the cost of devices purchased by typeThis field only accepts whole numbers, including 0 |
| **Were vials of medication purchased separately from those included with the device?**  | 🗹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)🗹No (if field is clicked no, go to distribution points question) |
| **Number of vials of medication purchased** (if purchased separately from the device)Selection list🗹 1 mL🗹 2mL🗹 Other | Denotes the number of vials purchased by dosage. This field only accepts whole numbers, including 0. |
| **Total Cost of medication**(if purchased separately from the device) | This field only accepts whole numbers, including 0. |
| **Distribution points for the devices/medication**Denotes who received the devices/medication.(This field expands since distribution can be more than one entity)Selection list🗹Fire trucks🗹Ambulances🗹Police cruisers🗹Hospital or other health facility🗹Community organization \_(type of organization)🗹Individuals🗹Other \_\_specify  | **Number distributed**Denotes the number and type of devices/medication distributed by type of entity.This field only accepts whole numbers. If “0” is entered, prompt error message. Field must be completed before moving to next question.  Selection list🗹 Evzio🗹Adapt intranasal🗹 Intramuscular (syringe) |

**USAGE and REFERRAL**

|  |  |
| --- | --- |
| **Number of uses**Denotes the number of times naloxone/narcan was administered.This field only accepts whole numbers, including 0 and DK. | **Disposition after usage**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 \_\_\_\_\_\_ |
| **Were any individuals transported to a health care facility?**🗹Yes (if yes, go to number of individuals transported question)🗹No (if not, go to next question below- referred for further treatment)🗹Unknown🗹Other notes\_\_\_\_\_\_\_\_\_ | **If yes, number of individuals transported to a health care facility.**This field only accepts whole numbers, including 0 and DK. |
| **Were any individuals referred for further treatment? (Check all that apply)** 🗹Substance abuse treatment facility (if checked go to number of referrals)🗹Mental health (counseling) services (if checked go to number of referrals) | **Number of referrals by type of treatment.** This field only accepts whole numbers.Substance abuse treatment facility \_\_\_\_\_Mental health (counseling) services🗹 Within hospital/medical clinic \_\_\_\_\_🗹 Doctor’s office \_\_\_\_\_\_🗹 Private office of psychologist/psychiatrist/therapist \_\_\_\_🗹 School/university setting \_\_\_\_\_🗹 Other (indicate name)\_\_\_\_\_\_\_\_\_\_\_\_ # referrals \_\_\_\_\_ |
| **Was there report of any violent or erratic behavior after administration of naloxone?** | 🗹YesI f yes, number of episodes \_\_\_\_\_\_\_\_\_🗹No🗹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** |
| **In person** | 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 |
| **Video/webinar** | 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 |
| **Was instruction on Basic Life Support/Advanced Life Support provided?**🗹Yes🗹No | **If yes, number of trainings**This field only accepts whole numbers, including 0 | **If yes, number trained**This field only accepts whole numbers, including 0 |
| **Was instruction on use of an Automatic External Defibrillator provided?**🗹Yes🗹No | **If yes, number of trainings**This field only accepts whole numbers, including 0 | **If yes, number trained**This field only accepts whole numbers, including 0 |