**Rural Opioid Overdose Reversal Grant Program**

**Performance Improvement Measurement System (PIMS)**

**Demographics**

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| **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 type  This field only accepts whole numbers, including 0 | **Cost of devices purchased**  Denotes the cost of devices purchased by type  This 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**

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| --- | --- |
| **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?** | 🗹Yes  I f yes, number of episodes \_\_\_\_\_\_\_\_\_  🗹No  🗹Unknown |

**TRAININGS**

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| --- | --- | --- | --- | --- |
| **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 | |