Rural Health Care Coordination Network Partnership (Care Coordination) Program

SECTION 1: ACCESS TO CARE

Table Instructions: This table collects information about an aggregate count of the number of people served through the program and the types of services that were provided during this budget period. Please report responses using a numeric figure. If the total number is zero (0), please put zero in the appropriate section. Do ***not*** leave any sections blank. There should ***not*** be an N/A (not applicable) response since all measures are applicable to all grantees.

Please refer to these detailed definitions and guidelines in providing your answers to the following measures:

Number of counties served in project and **number of people in target population** should be consistent with the figures your program reported in your grant application. The number of counties served should reflect your project's service area.

Direct Services are defined as a documented interaction between a patient/client and a clinical or non-clinical health professional that has been funded with FORHP grant dollars. Examples of direct services include (but are not limited to) patient visits, counseling, and education.

For the purposes of this data collection activity, **indirect services** will be limited to:

1) billboards,
2) flyers,
3) health fairs,
4) mailings/newsletters, and
5) other mass media (radio, television, newspaper and social media)*

*For radio, television and newspaper please report estimated total circulation. For social media, please report the reach (number of followers).

		Baseline	End of Budget Period
1	**Number of counties served in project**		
2	**Number of people in the target population** (This is the number of people in your target		

	population, but not the number of people who actually received your direct services)		
3	**Number of unique individuals who received direct services during this budget period** Please report the number of unique (i.e. unduplicated count) patients/clients that received *direct services* from your organization		

SECTION 2: POPULATION DEMOGRAPHICS

Table Instructions: This table collects information about an aggregate count of the people served by race, ethnicity, age and insurance status. The total for *each* of the following questions should equal the total of the number of unique individuals who received only direct services reported in the previous section. Please do ***not*** leave any sections blank. There should not be a N/A (not applicable) response since the measures are applicable to all grantees. If the number for a particular category is zero (0), please put zero in the appropriate section (e.g., if the total number that is Hispanic or Latino is zero (0), enter zero in that section).

Note: The expectation is that you would collect baseline data, and then again report at the end of the budget period. "Unknown" may include those who refused to answer ethnicity/race.

Number of people served through program by ethnicity (Hispanic or Latino/Not Hispanic or Latino) is defined as:

- 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.)

		Baseline	**End of Budget Period**
4	**Number of people served by ethnicity:**		
	Hispanic or Latino		
	Not Hispanic or Latino		
	Unknown		
	Total (automatically calculated)	Equal to the total of the number of unique individuals who received direct services	Equal to the total of the number of unique individuals who received direct services
5	**Number of people served by race:**		
	American Indian or Alaska Native		

	Asian		
	Black or African American		
	Native Hawaiian or Other Pacific Islander		
	White		
	More than one race		
	Other		
	Unknown		
	Total (automatically calculated)	Equal to the total of the number of unique individuals who received direct services	Equal to the total of the number of unique individuals who received direct services
6	**Number of people by insurance status:**		
	Uninsured/self-pay		
	Dual Eligible (covered by both Medicaid and Medicare)		
	Medicaid/CHIP only		
	Medicare plus supplemental		
	Medicare only		
	Other third party		
	Unknown		
	Total (automatically calculated)	Equal to the total of the number of unique individuals who received direct services	Equal to the total of the number of unique individuals who received direct services

SECTION 3: STAFFING

Table Instructions: This table collects information about an aggregate number of clinical and non-clinical positions funded by this grant during this budget period. If you are not sure who is funded by this grant, please refer to the staffing plan and budget narrative that was submitted with your grant application. Please report a numeric figure. There should not be a N/A (not applicable) response since all measures are applicable to all grantees.

Please report each staff person who is funded by this program only once. Clinical staff includes, but is not limited to, physician (general or specialty), physician assistant, nurse, nurse practitioner, dentist, dental hygienist, psychiatrist, social worker, pharmacist, therapist (behavioral, physical,

occupational, speech, etc.), health educator, community health worker, promotora, case manager, interpreter/translator, care coordinator. Clinical staff are individuals that directly interact with patients/clinics.

Non-clinical staff includes management (CEO, CFO, CIO, etc.), support staff, fiscal and billing staff, information technology (IT). Non-clinical staff are individuals that do not directly interact with patients/clients.

		End of Budget Period
7	**Number of positions funded by grant dollars during this budget period**	
	Total number of new clinical staff	
	Total number of new non-clinical staff	
	Total number of in-kind staff	
	Total number FTE amount of all staff paid via grant	0.0 Format

SECTION 4: SUSTAINABILITY

Table Instructions: This table collects information/data about the grant's programmatic sustainability. There should not be a N/A (not applicable) response since the measures are applicable to all grantees. For the purposes of this report, sustainability efforts will be reported on at the end of each budget period (once per year).

In Year 3 of grant funding, grantees will need to report on the additional measures:

- Question #11 - The ratio impact for Economic Impact vs. HRSA Program Funding using HRSA's Economic Impact Analysis Tool (https://www.ruralhealthinfo.org/econtool)
- Question #12 - If your current consortium/network will sustain after the grant project period is over
- Question #13 - If any of the activities will sustain after the grant project period is over

		End of Budget Period
8	**Annual program revenue** Please report the amount of annual program revenue made through the services offered through the program. Program revenue is defined as payments received for the services provided by the program that the grant supports. These services should be the same services outlined in your grant application work plan. Please do not include donations. If the total amount of annual revenue made is zero (0), please put zero in the appropriate section.	**Dollar amount**
9	**Sources of Sustainability** Select the type(s) of sources of funding for sustainability. Please	

	check all that apply.	
	Program revenue	
	In-kind Contributions (In-Kind contributions are defined as donations of anything other than money, including goods or services/time.)	
	Membership fees/dues	
	Fundraising/ Monetary donations	
	Contractual Services	
	Other grants	
	Fees charged to individuals for services	
	Reimbursement from third-party payers (e.g. private insurance, Medicare, Medicaid)	
	Product sales	
	Government (non-grant)	
	Other – specify type	
	None	
10	Which of the following activities have you engaged in to enhance your sustained impact? Check all that apply.	**Selection list**
	Local, State and Federal Policy changes	
	Media Campaigns	
	Community Engagement Activities	
	Other – Specify activity	
11	**What is your ratio for Economic Impact vs. HRSA Program Funding?** Use the HRSA's Economic Impact Analysis Tool (https://www.ruralhealthinfo.org/econtool) to identify your ratio. Please attach the online generated Economic Impact Report.	**Ratio**
12	**Will the consortium/network sustain after the project period?**	**Y/N**
13	**Will any of the program's activities be sustained after the project period?**	**(Some/None/All)**

SECTION 5: HEALTH INFORMATION TECHNOLOGY

Table Instructions: Health Information Technology (HIT)
Please select all types of technology implemented, expanded or strengthened through this program.

14	**Type(s) of technology implemented, expanded or strengthened through this program:** (Please check all that apply)	**Selection list**
	Computerized provider order entry (CPOE)	
	Electronic entry of prescriptions/e-prescribing	
	Electronic medical records/electronic health records	

	Health information exchange (HIE)	
	Patient/disease registry	
	Telehealth/telemedicine	
	None	
	Other – please specify	

SECTION 6: QUALITY IMPROVEMENT

Table Instructions:
Please report on quality improvement activities and initiatives implemented, expanded or strengthened through this program.

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- An Accountable Care Organization (ACO) is a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to Medicare patients.
- A Medical Home is defined as comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes. To become a medical home an organization generally gains a level of certification from an accrediting body.
- Care coordination is defined as the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services.
- The Medicare Beneficiary Quality Improvement Project (MBQIP) is a Flex Grant Program activity within the core area of quality improvement for Critical Access Hospitals (CAH). (https://www.ruralcenter.org/tasc/mbqip)

15	**Participation in Accountable Care Organization (ACO)** Is your organization participating in an ACO? (If yes, please check all that apply)	**Yes/No** **(Selection List)**
	Medicare Shared Savings Program	
	Advanced Payment ACO Model	
	Pioneer ACO Model	
	Other – specify	
16	**Participation in Medical Home** Is your organization participating in a Medical Home or Patient Centered Medical Home (PCMH) initiative?	**Yes/No**
	If yes, have you achieved or are you pursuing certification or recognition? (If yes, please check all that apply)	**Yes/No** **(Selection List)**
	National Committee for Quality Assurance (NCQA)	
	Accreditation Association for Ambulatory Health Care (AAAHC)	
	The Joint Commission	

	State/Medicaid Program	
	Other – specify	
17	**Critical Access Hospitals: Participation in Medicare Beneficiary Quality Improvement Project (MBQIP)**	**Yes/No**
18	**Other – please specify**	

SECTION 7: CARE COORDINATION

Table Instructions: This table collects information about care coordination activities as a direct result of the Care Coordination grant.
If your grant did support one or more of the care coordination activities, but you do not know the information, then select/enter DK (do not know). If your grant did not support one or more these care coordination activities, then select/enter N/A (not applicable).

19	**Care Coordination Activities: Have you done these activities this budget period?**	**Yes/No (Selection List)**
	Referral tracking system	
	Facilitate transitions across settings	
	Patient support and engagement	
	Integrated care delivery system (agreements with specialists, hospitals, community organizations, etc. to coordinate care)	
	Case management	
	Care plans	
	Linkage to community resources	
	Medication management	
	Hiring care coordinator(s)	
	Other – specify	

SECTION 8: CLINICAL MEASURES

Table Instructions:
Please use your health information technology system to extract the clinical data requested. Please refer to the specific definitions for each measure (PQRS Measures list, etc.).

If your project focused on Type 2 diabetes, you are required to report on four out of the five outcome measures listed in the table below at a minimum. All of the Diabetes measures below are capturing Type 2 Diabetes measures (not type 1). If you did not focus on Type 2 diabetes, put N/A.

If your project focused on Congestive Heart Failure (CHF), you are required to report on four out of the four outcome measures listed in the table below at a minimum. If you did not focus on CHF, put N/A.

If your project focused on Chronic Obstructive Pulmonary Disease (COPD), you are required to report on four out of the five outcome measures listed in the table below at a minimum. If you did not focus on COPD, put N/A.

All care coordination grantees are to report on the Care Coordination Measures section.

		Numerator	Denominator	Percent
	Type 2 Diabetes			
1	PQRS 0313: Diabetes: Hemoglobin A1c Poor Control: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period			
2	PQRS 2: Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL): Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the measurement period			
3	PQRS 117: Diabetes: Eye Exam: Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period			
4	PQRS 119: Diabetes: Medical Attention for Nephropathy: The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period			
5	PQRS 163: Diabetes: Foot Exam: Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period			
	Congestive Heart Failure (CHF)			
1	PQRS 5: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD): Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital			

	discharge			
2	PQRS 8: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD): Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge			
3	PQRS 7: Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%): Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have prior MI OR a current or prior LVEF < 40% who were prescribed beta-blocker therapy			
4	PQRS 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.			
	Chronic Obstructive Pulmonary Disease (COPD)			
1	PQRS 51: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation: Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry results documented			
2	PQRS 52: Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy: Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 60% and have symptoms who were prescribed an inhaled bronchodilator			
3	PQRS 110: Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.			
4	PQRS 111: Pneumonia Vaccination Status for Older Adults: Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.			

5	PQRS 226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.			

	Care Coordination Measures			
1	CMS 4: Chronic Care ACSC Composite Measure: Rate of risk-adjusted hospitalizations for the three chronic care ACSC measures (diabetes composite; COPD or asthma; or heart failure), expressed as discharges per 1,000 Medicare beneficiaries with diabetes, COPD or asthma, or chronic heart failure attributed to a physician or group of physicians (based on AHRQ's PQIs)			
2	NQF 0097/PQRS 046: Medication Reconciliation Post-Discharge: The percentage of discharges from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years and older of age seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record. This measure is reported as three rates stratified by age group: • Reporting Criteria 1: 18-64 years of age • Reporting Criteria 2: 65 years and older • Total Rate: All patients 18 years of age and older			
3	NQF 0326: Advance Care Plan (NCQA) Description: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.			