Federal Office of Rural Health Policy (FORHP)
Office for the Advancement of Telehealth (OAT)

Performance Improvement and Measurement System (PIMS) Database

Telehealth Network Grant Program

TABLE 1: ACCESS TO CARE

Table Instructions:

Information collected in this table provides an aggregate count of the number of people served through the program. Please refer to the detailed definitions and guidelines in answering the following measures. Please indicate a numerical figure.

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.

1	**Direct Services** Please provide the number of unique patients/clients your organization serves through *direct services* (i.e. clinical patients) encounters	**Number**
	Number of telehealth encounters for each of the following clinical services:	
	• **Behavioral health**	
	• **Mental health service**	
	• **Asthma**	
	• **Obesity reduction and prevention**	
	• **Diabetes**	
	• **Oral health**	

TABLE 2: POPULATION DEMOGRAPHICS

Table Instructions:

Please provide the total number of people served by race, ethnicity, age and veteran status. The total for each of the following questions should equal to the total of the number of people served through Direct Services provided in the previous section. If the total number that is Hispanic or Latino is zero (0), 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.

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.)

2	**Gender**	**Number**
	Male	
	Female	
3	**Number of people served by ethnicity:**	**Number**
	Hispanic or Latino	
	Not Hispanic or Latino	
	Unknown	
4	**Number of people served by race:**	**Number**
	American Indian or Alaska Native	
	Asian	
	Black or African American	
	Native Hawaiian or Other Pacific Islander	
	White	
	More than one race	
	Unknown	
5	**Number of people served, by age group:**	**Number**
	Children (0-12)	
	Adolescents (13-17)	
	Adults (18-64)	
	Elderly (65 and over)	
	Unknown	

Table 3: INSURANCE STATUS/COVERAGE

Table Instructions:

Please respond to the following questions based on these guidelines:

- Uninsured is defined as those without health insurance.
- Medicare is defined as Federal insurance for the aged, blind, and disabled (Title XVIII of the Social Security Act).
- Medicaid is defined as State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act.
- The Children’s Health Insurance Program (CHIP) provides health coverage to eligible children and is administered by the states, according to federal requirements.
- Other state-sponsored or public assistance program includes State and/or local government programs.
- Private insurance is health insurance provided by commercial and not for profit companies. Individuals may obtain insurance through employers or on their own.
- Health Insurance Marketplace

Each patient should be counted once. The total for this table should equal to the total number of people served through Direct Services.

6	**Number of uninsured people**	**Number**
7	**Number of people covered through Medicare**	**Number**
8	**Number of people covered through Medicaid**	**Number**
9	**Number of people covered through the Children's Health Insurance Program (CHIP)**	**Number**
10	**Number of people covered through other state-sponsored insurance or public assistance program**	**Number**
11	**Number of people covered by private insurance**	**Number**
12	**Health Insurance Marketplace**	**Number**
13	**Unknown**	**Number**

Table 4: 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 and Medicaid 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 Partnership for Patients is a public/private partnership focused on making hospital care safer, more reliable, and less costly through two goals: reducing preventable hospital-acquired conditions and improving care transitions. (http://partnershipforpatients.cms.gov/)
- Million Hearts is a national initiative to prevent 1 million heart attacks and strokes by 2017. (http://millionhearts.hhs.gov/index.html)
- 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).

(http://www.hrsa.gov/ruralhealth/about/hospitalstate/medicareflexibility_.html)

14	**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	
	Advance Payment ACO Model	
	Pioneer ACO Model	
	Next Generation ACO Model	
	Other - specify	
15	**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	
16	**Care Coordination Activities**	**Yes/No (Selection List)**
	Referral tracking system	
	Patient support and engagement	
	Integrated care delivery system (agreements with specialists, hospitals, community organizations, etc. to coordinate care)	
	Case management	
	Care plans	
	Medication management	
	Other – specify	
17	**Participation in Partnerships for Patients**	**Yes/No**
18	**Participation in Million Hearts**	**Yes/No**
19	**Critical Access Hospitals: Participation in Medicare Beneficiary Quality Improvement Project (MBQIP)**	**Yes/No**

TABLE 5: 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. Please indicate a numerical figure or N/A for not applicable for your specific grant activities.

Measure 1

Numerator: Patient's screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented.
Denominator: All patients aged 12 years and older.

Measure 2

Numerator: Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
Denominator: Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN.

Measure 3

Numerator: The percentage of adolescents who turned 13 years of age in the measurement year who had a blood pressure screening with results.
Denominator: The number of patients who turned 13 years of age in the measurement year.

	Clinical Measures	**Numerator (Number)**	**Denominator (Number)**	**Percent (Automatically calculated by system)**
1	NQF 0418: Screening for clinical depression: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.			
2	NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: - Body mass index (BMI) percentile documentation - Counseling for nutrition - Counseling for physical activity.			
3	NQF 1552: Blood Pressure Screening by 13 Years of Age: The percentage of adolescents who turn 13 years of age in the measurement year who had a blood pressure screening with results.			