

**Rural Health Network Development Planning Program
 Performance Improvement and Measurement System (PIMS) Form**

Table 1: Network Infrastructure

Table Instructions: Please provide information about the network members and network operations. Network members are defined as members who have signed a Memorandum of Understanding or Memorandum of Agreement or have a letter of commitment to participate in the network.

| Identify the types and number of organizations in the consortium or network for your project: | | | |
|--|-------------------------|---|--------------------------------------|
| | | Type of Member Organizations in the Consortium/Network | Number |
| | Non-Profit Organization | Area Health Education Center | |
| | | Behavioral/Mental Health Organization | |
| | | Community College | |
| | | Community Health Center | |
| | | Critical Access Hospital | |
| | | Faith-based organization | |
| | | Free Clinic | |
| | | Health Department | |
| | | Hospice | |
| | | Hospital | |
| | | Migrant Health Center | |
| | | Private Practice | |
| | | Rural Health Clinic | |
| | | School District | |
| | | Social Services Organization | |
| | | University | |
| | | Other – Specify type | |
| | | TOTAL for non-profit organization | (Automatically calculated by system) |
| | For-Profit Organization | Critical Access Hospital | |
| | | Hospice | |
| | | Private Practice | |
| | | Rural Health Clinic | |
| | | Other – Specify Type | |

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0384. Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-29, Rockville, Maryland, 20857.

| | | | | |
|---|--|-------------------------------|--------------------------------------|----------------|
| | | TOTAL for-profit organization | (Automatically calculated by system) | |
| 2 | Total number of NEW member organizations that joined the consortium/network during this project period: | | | Number |
| 3 | Indicate the total number of full-member (all members that signed MOU, MOA, or letters of commitment) network meetings conducted during the reported budget year by meeting type: | | | |
| | Meeting Type | Number | | |
| | Meeting conducted face-to-face | | | |
| | Meeting conducted via teleconference | | | |
| | Meeting conducted via webinar | | | |
| | Meeting conducted in a manner not listed above (please specify type) | | | |
| 4 | From the beginning of this budget year, assess the following overall Network changes (check one answer for each type of network change): | | | |
| | Type of Network Change | Increased | No Change | Reduced |
| | Financial Cost Savings | | | |
| | Access to Educational Opportunities | | | |
| | Access to Equipment | | | |
| | Access to Subject Matter Experts | | | |
| | Understanding of community health needs | | | |
| | Other (Please Specify): | | | |
| 5 | What area(s) was the network focusing on for this project period? (Check all that apply) | | | |
| | Cardiovascular disease | | | |
| | Care coordination | | | |
| | Care transition | | | |
| | Children's health | | | |
| | Diabetes | | | |
| | Elderly/Geriatric care | | | |
| | Emergency Medical Services | | | |
| | Health information technology | | | |
| | Health promotion/disease prevention | | | |
| | Increase access and/or quality of care | | | |
| | Mental/Behavioral health | | | |
| | Obesity | | | |
| | Primary care | | | |
| | Telehealth/telemedicine | | | |
| | Workforce | | | |
| | Other – Specify type | | | |

Table 2: Network Collaboration

Table Instructions: Please provide information about collaboration and/or integration among the network members. Refer to the activities listed in the project work plan for this project period.

| | | |
|----------|--|---------------|
| 6 | How many activities from the project work plan were <u>initiated</u> by at least two or more network members? | <i>Number</i> |
| 7 | How many activities from the project work plan were <u>completed</u> by at least two or more network members? | <i>Number</i> |
| 8 | Did the network develop the following (this does not include a needs assessment)? | |
| | Strategic Plan | <i>(Y/N)</i> |
| | Business Plan | <i>(Y/N)</i> |
| | Sustainability Plan | <i>(Y/N)</i> |
| | Other (please specify) | |
| 9 | What type of Network Planning activities were done during the project period (check all that apply): | |
| | Conduct needs assessment | |
| | Develop a plan (ex: strategic, business) | |
| | Develop network bylaws | |
| | Develop network mission statement | |
| | Develop network governance structure | |
| | Conduct community engagement activities | |
| | Conduct a SWOT analysis | |
| | Other (please specify) | |

Table 3: Sustainability

Table instructions: Please provide information about the contribution by network members and the network’s sustainability efforts.

| | | |
|-----------|---|--|
| 10 | Annual Program award Please provide the annual program award based on box 12a of your Notice of Award | |
| 11 | Additional funding secured to assist in sustaining the network Please provide the amount of additional funding that has already been secured during this current project period to sustain the program. | |
| 12 | Estimated amount of cost savings due to participation in the | |

| | | |
|-----------|--|--------|
| | network during this current project period | |
| 13 | Sources of Revenue (check all that apply) | |
| | Network revenue | |
| | In-kind contributions | |
| | Member Fees | |
| | Fundraising | |
| | Contractual Services | |
| | Other – specify type | |
| 14 | How many of the network members have provided the following in-kind services: | |
| | Goods (Ex: equipment, food) | Number |
| | Services (ex: meeting space) | Number |
| | Staff support | Number |
| | Expertise (ex: legal, business, website/marketing development) | Number |
| | Other (please specify) | |
| 15 | How many network policies or procedures were created during this budget period: | Number |
| 16 | How many network policies or procedures were amended during this budget period: | Number |
| 17 | How many network policies or procedures were implemented during this budget period: | Number |
| 18 | As a result of being part of the network, how many network member organizations were able to integrate joint policies/procedures within their respective organizations during this budget period? | Number |
| 19 | Will the activities of the Network/Consortium continue to operate after the Federal grant funding period? | Y/N |

Table 4: Network Assessment

Table instructions: Please provide information regarding the network’s assessment during this project period.

| | | |
|-----------|---|---------------------|
| 20 | Does the network include a process or tool to assess effectiveness of network performance? | Y/N |
| 21 | If yes, how is network performance assessed? | open-ended response |
| 22 | Does the network include a process or tool to assess effectiveness of network director? | Y/N |
| 23 | If yes, how is the network director assessed? | open-ended response |
| 24 | Did the network meet its program objectives? | Y/N |