OMB Number: 0915-0387
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Office of Rural Health Policy: Rural Health
Community-Based Grant Programs

Performance Improvement and Measurement System (PIMS) Database

Small Health Care Provider Quality Improvement Grant Program

Table 1: ACCESS TO CARE

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 an interaction between a patient/client and a clinical or non-clinical health professional. Please include the number of patients served through this program, funded by Federal Office of Rural Health Policy (ORHP) 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 and
4) mailings/newsletters.
5) Other mass media (e.g., radio, television, social media)

1	**Direct Services** Please provide the number of patients or clients your organization serves through *direct services* (e.g., patient visits, counseling, and education)	**Number**
2	**Indirect Services** Please provide the number of individuals your organization reaches through the following *indirect services:* billboards, flyers, health fairs, mailings/newsletters, other mass media	**Number**

Table 2: POPULATION DEMOGRAPHICS

Table Instructions:
Please provide the total number of people served by race, ethnicity, and age. 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 in any category 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 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.)

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 primary health care coverage for children.
- 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.

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	**Unknown**	**Number**

Table 4: STAFFING

Table Instructions:

Please provide the number of clinical and non-clinical positions funded by this grant. Please indicate a numerical figure. There should not be a N/A (not applicable) response since all questions are applicable.

Clinical staff includes, but is not limited to, physician (general or specialty), physician assistant, nurse, nurse practitioner, dentist, dental hygienist, psychiatrist, social worker, pharmacist, technician (medical, pharmacy, laboratory, etc.), therapist (behavioral, physical, occupational, speech, etc.), health educator, community health worker, promotora, case manager, interpreter/translator.

Non-clinical staff includes management (CEO, CFO, CIO, etc.), support staff, fiscal and billing staff, information technology (IT).

NOTE: Please report each staff person who is funded by this program only once. In the case of an individual whose time is split between clinical and non-clinical activities, please report them in the category that reflects the majority of their time.

13	Number of positions funded by grant dollars	Full-Time (1.0 FTE)	Part-Time (less than 1.0 FTE)
	Clinical		
	Non-Clinical		

14	How many staff received continuing education or training?	Number

Table 5: SUSTAINABILITY

Table Instructions:

- The definition of sustainability is "programs or services continue because they are valued and draw support and resources".
- Select your sources of sustainability and sustainability activities.
- Please indicate if any of your program's activities will sustain after the grant period.
- Use HRSA's Economic Impact Tool provide the ratio for Economic Impact vs. HRSA Program Funding.

15	**Annual program award** Please provide the annual program award based on box 12a of your Notice of Award (NOA).	**Dollar amount**
16	**Annual program revenue** Please provide 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. Do not leave any sections blank.	**Dollar amount**
17	**Additional funding secured to assist in sustaining the project**	**Dollar amount**

18	**Sources of Sustainability** Select the type(s) of sources of funding for sustainability. Please check all that apply.	**Selection list**
	Network/Consortium 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	

19	**Sustainability Activities:** Which of the following activities have you engaged in to enhance your sustainability? Please select all that apply.	**Selection list**
	Local, State and Federal Policy changes	
	Media Campaigns	
	Community Engagement Activities	
	Other – Specify activity	
20	**Have you developed any of the following:** Please select all that apply.	**(Y/N)**
	Sustainability Plan	
	Business Plan	
	Communications Plan	
	Fundraising Plan	

21	**What is your ratio for Economic Impact vs. HRSA Program Funding?** Use the HRSA's Economic Impact Analysis Tool (http://www.raconline.org/econtool/) to identify your ratio.	**Ratio**
22	**Will the network/consortium sustain, if applicable?** If you are participating in this program as a network or consortium, please indicate if your current network/consortium will continue after the grant period is over	**(Y/N)**
23	**Will any of the program's activities be sustained after the grant period?**	**All/Some/None**

TABLE 6: CONSORTIUM/NETWORK (OPTIONAL)
Table Instructions:
If you are participating in this program as a network or consortium, please complete this section.

Please provide information about the consortium or network members, if applicable. A consortium or network is defined as collaboration between two or more separately owned organizations.

24	**Number of member organizations in the Consortium/Network**	**Number**
	Area Agency on Aging	
	Area Health Education Center (AHEC)	
	Business	
	Community Health Center/ Federally Qualified Health Center (FQHC)	
	Critical Access Hospital	
	Emergency Medical Service	
	Faith-Based Organization	
	Health Department	
	HIT Regional Extension Center	
	Hospice	
	Hospital, not Critical Access	
	Long Term Care Facility	
	Mental Health Center	
	Migrant Health Center	
	Pharmacy	
	Private Practice (Medical and/or Dental)	
	Professional Association	
	Public Health Department	
	Rural Health Clinic	
	School District	
	Social Services Organization	
	Tribal Entity	
	University/College/Community College/Technical College	
	Other – Specify Type:	

Table 7: HEALTH INFORMATION TECHNOLOGY
Table Instructions: Health Information Technology (HIT)
Please select all types of technology implemented, expanded or strengthened through this program.

25	**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	
26	**Have your organization and/or any of your organization's providers attested to Meaningful Use?** If yes, please select all that apply.	**Y/N**
	Stage 1	
	Stage 2	
	Stage 3	
	If no, is your organization and/or providers planning to attest in the next 12 months?	
	If yes, have your organization and/or providers received incentive payments?	

Table 8: 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 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)

27	**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	
28	**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	
29	**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	
30	**Participation in Partnership for Patients**	**Yes/No**
31	**Participation in Million Hearts**	**Yes/No**
32	**Critical Access Hospitals: Participation in Medicare Beneficiary Quality Improvement Project (MBQIP)**	**Yes/No**
33	**Other – please specify**	

Table 9: 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.

Measure 1: The percentage of patients 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.
Numerator: Patients whose HbA1c level is <8.0% during the measurement year.
Denominator: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Measure 2: The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent LDL-C test is <100 mg/dL during the measurement year.
Numerator: Patients whose most recent LDL-C test is <100 mg/dL during the measurement year.
Denominator: Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

Measure 3: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25)
Numerator: Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters
Denominator: All patients aged 18 years and older

Measure 4: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.
Numerator: The number of patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.
Denominator: Patients 18 to 85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.

Measure 5: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user
Numerator:
Patients who were screened for tobacco use* at least once during the two-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user
*Includes use of any type of tobacco

** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy
Denominator: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the two year measurement period

Measure 6: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented
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 7: 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
Numerator: Patients who received an influenza immunization OR who reported previous receipt* of an influenza immunization
*Previous receipt can include: previous receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measures is applied (typically, prior vaccination would include influenza vaccine given since August 1st).
Denominator: All patients aged 6 months and older seen for a visit between October 1 and March 31

		Numerator	Denominator	Percent
1	**NQF 0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%): The percentage of patients 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.**			
2	**NQF 0064: Comprehensive Diabetes Care: LDL-C Control <100 mg/dL: Percent of adult patients, 18- 75 years of age with diabetes (type 1 or type 2) who had LDL-C less than 100 mg/dL**			
3	**NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up: Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.**			

4	**NQF 0018: Controlling High Blood Pressure: The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.**			
5	**NQF 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user**			
6	**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**			
7	**NQF 0041: 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**			

OPTIONAL CLINICAL MEASURES
The following clinical measures are OPTIONAL. You are encouraged to include them, especially if your program has a focus on pediatric populations.

Please use your health information technology system to extract the data requested. Please refer to the specific definitions for each measure.

Optional Measure 1: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
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.

Optional Measure 2: Hemoglobin A1c (HbA1c) Testing for Pediatric Patients
Numerator: Patients who had an HbA1c test performed during the measurement year.
Denominator: Patients aged 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemic/antihyperglycemics for at least 12 months.

Optional Measure 3: Blood Pressure Screening by 13 Years of Age
Numerator: Children who had documentation of a blood pressure screening and whether results are abnormal at least once in the measurement year or the year prior to the measurement year.
Denominator: Children with a visit who turned 13 years old in the measurement year.

		Numerator	Denominator	Percent
1	**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**			
2	**NQF 0060: Hemoglobin A1c (HbA1c) Testing for Pediatric Patients: Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.**			
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**			