

**Federal Office of Rural Health Policy: Rural Health Network Development  
Community-Based Division Grant Programs  
Performance Improvement and Measurement System (PIMS) Database**

**SECTION I: NETWORK**

**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.

<b>1</b>	<b>Identify the types and number of organizations in the consortium or network for your project:</b>	
	<b>Type of Member Organizations in the Consortium/Network</b>	<b>Number</b>
	Area Health Education Center	
	Behavioral/Mental Health Organization	
	Community College	
	Community Health Center	
	Critical Access Hospital	
	Emergency Medical Service	
	Faith-based Organization	
	Federally Qualified Health Center	
	Free Clinic	
	Health Department	
	Home Health Care Agency	
	Hospice	
	Hospital	
	Long Term Care Facility	
	Migrant Health Center	
	Private Practice Primary Care	

	Private Practice Specialty Care	
	Rural Health Clinic	
	School District	
	Social Services Organization	
	Tribal Organization	
	University	
	Other – Member Organization	
	Total	

**Table 2: Network Benefits**

**Table Instructions:** Please select the benefits realized by network members as a result of being in the network.

Please refer to the following definitions of “network benefits”:

**Financial Cost Savings:** A reduction in historical or projected cost that may occur from a change to plans regarding frequency, volume, or policy that reduce the expense associated with a business activity. Examples may include: reduced operational costs, cost sharing, and reduced cost of services.

**Efficiencies:** A streamlined process or procedure that produces the least amount of waste of time and effort; competency in performance.

**Quality Improvement:** A systematic, formal approach to the analysis of practice performance and effort to improve performance.

**Access to Educational Opportunities:** Educational experience where new knowledge is acquired. Examples may include: webinars, conferences, workshops.

**Access to Equipment:** Newly acquired ability to utilize equipment. Examples may include: access to shared software, in kind use of equipment,

**Branding/Marketing:** To make the products and services provided by the network recognized and known by community members, network members, and other stakeholders.

**Development of Workforce that is Change Ready and Adaptable:** Creation of a workforce that is able to react and comply with changes in the provision of services; including rules, regulations, processes and services.

**Knowledge Sharing:** Dissemination of knowledge or expertise across staff members, such as through meetings, educational opportunities or access to subject matter experts.

**Understanding of Community Health Needs:** Ability to assess the health needs of the targeted community, through the use of data, surveys, focus groups, and other methods that provide insight into the unique health needs of the community.

**Opportunities for Innovation:** Ability to create innovative products and services, resulting from supportive management, understanding of needs of the network members and the community, efficiencies, adequate revenue streams, expertise, or other factors that promote and facilitate innovation.

<b>2</b>	<b>During the current budget year, assess the following overall benefits realized by the network members as a result of being in the network (check the benefit(s) that apply):</b>	
	<b>Type of Network Benefit</b>	<b>Select if Applicable</b>
	Financial Cost Savings	
	Efficiencies	
	Quality Improvement	
	Access to Educational Opportunities	
	Access to Equipment	
	Branding/Marketing	
	Development of Workforce That is Change Ready and Adaptable	
	Knowledge Sharing	
	Understanding of Community Health Needs	
	Opportunities for Innovation	
	Other network benefit(s) (Please Specify):	

**Table 3: Network and Program Sustainability**

**Table Instructions:** Please provide network and program sustainability information.

<b>3</b>	Will the network continue to collaborate after this grant funding?	Yes/No
<b>4</b>	Will the programs created through this grant funding continue to sustain after this grant funding?	All (100%) Most (50-99%)

	Some (less than 50%) None (0%)
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**Table 4: Indicators of Network and Program Sustainability**

**Table Instructions:** Please select the following indicators of sustainability experienced by the network as a result of this grant funding, as applicable.

5	Sustainability Indicator	Select if Applicable
	Ability of the network to adapt to regional or national healthcare trends	
	Collaboration across traditional and non-traditional healthcare members within the network	
	Incorporation of the health needs of the community into the network’s decision making strategies	
	Creation of diverse products and services that meet the needs of the target population and network members	
	Creation of diverse revenue streams that include member dues, fee for services and product sales	
	Utilization of an evaluation plan to assess progress towards program goals and objectives	
	Absorption of the services provided from this grant funding into the routine operations of network members, without requiring additional funding support	
	Other	

**Table 5: Impact**

**Table Instructions:** Information collected in this table provides an aggregate count of the number of people targeted within the service area, which may or may not be the total population residing within the service area. Please indicate a numerical figure or DK for do not know, if applicable

Number of people in target population

- Denotes the number of people your program is trying to serve (not necessarily the number of people who availed themselves of your services). For example, if the network focuses its mission on serving a particular population such as migrant and seasonal farm workers, then the migrant and seasonal farm workers may be a subset of the total population within the service area.

6	Number of people in target population	Number
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7	<b>Number of people in the target population who received or participated in a new or expanded program/area of service this year as a result of network activities funded by the Rural Health Network Development Program</b>	<b>Number</b>
8	<b>Number of new programs/areas of service implemented or enhanced by the network this year - as a result of grant funding from the Rural Health Network Development Program</b>	

9	<b>Type(s) of new and/or expanded service area(s) provided by the network as a result of the Rural Health Network Development grant funding</b>	<p><b>Please check <input checked="" type="checkbox"/></b></p> <p><b>Please check any boxes below that apply to any new and/or expanded services provided as a result of Network Development grant funding.</b></p> <p><b>NOTE:</b> Please check at least one box.</p>
	<b>Health and Wellness:</b>	
	Cardiovascular Disease	
	Chronic Obstructive Pulmonary Disease	
	Diabetes / Obesity Management	
	Elderly / Geriatric Care	
	Emergency Medical Service (EMS)	
	Health Education	
	Health Insurance Enrollment	
	Health Literacy/Translation Services	
	Health Promotion/Disease Prevention	
	Maternal and Child Health	
	Mental/Behavioral Health	
	Nutrition	

	Oral Health	
	Pharmacy	
	Primary Care	
	Specialty Care	
	Substance Abuse Treatment	
	Transportation	
	Workforce	
	<b>Care Coordination:</b>	
	Care Coordination	
	Care Transitions	
	Case Management	
	<b>Quality Improvement:</b>	
	Accountable Care Organization	
	Medical Home or Patient Centered Medical Home	
	<b>Health Information Technology:</b>	
	Attestation of Meaningful Use Stage 1, 2 or 3	
	Electronic Medical Records/Electronic Health Records	
	Health Information Exchange	
	Telehealth/Telemedicine	
	Patient/Disease Registry	
	<b>Other, please specify.</b>	open-ended response
	<b>None- Explain</b>	open-ended response

<b>10</b>	<b>What is your ratio for Economic Impact vs. HRSA Program Funding?</b> Use the HRSA's Economic Impact Analysis Tool ( <a href="https://www.ruralhealthinfo.org/econtool">https://www.ruralhealthinfo.org/econtool</a> ) to identify your	Ratio
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	ratio.	
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## SECTION II: DEMOGRAPHICS – ALL PROGRAM ACTIVITIES

**Table 6: Demographics- Number of People Served by the Program**

**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:** It is expected that each grantee organization will collect baseline data, and then again report at the end of the budget period.

### **Hispanic or Latino Ethnicity**

- Column A (Hispanic/Latino): Report the number of persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, broken down by their racial identification and including those Hispanics/Latinos born in the United States. Do not count persons from Portugal, Brazil, or Haiti whose ethnicity is not tied to the Spanish language.
- Column B (Non-Hispanic/Latino): Report the number of all other people except those for whom there are neither racial nor Hispanic/Latino ethnicity data. If a person has chosen a race (described below) but has not made a selection for the Hispanic /non-Hispanic question, *the patient is presumed to be non-Hispanic/Latino*.
- Column C (Unreported/Refused to Report): Only one cell is available in this column. Report on Line 7, Column C only those patients who left the entire race and Hispanic/Latino ethnicity part of the intake form blank.

People who self-report as Hispanic/Latino but do not separately select a race must be reported on Line 7, Column A as Hispanic/Latino whose race is unreported or refused to report. Health centers may not default these people to “White,” “Native American,” “more than one race,” or any other category.

### **Race**

All people must be classified in one of the racial categories (including a category for persons who are “Unreported/Refused to Report”). This includes individuals who also consider themselves to be Hispanic or Latino. People who self-report race, but do not separately indicate if they are Hispanic or Latino, are presumed to be non-Hispanic/Latino and are to be reported on the appropriate race line in Column B.

People sometimes categorized as “Asian/Other Pacific Islander” in other systems are divided into three separate categories:

- Line 1, Asian: Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Indonesia, Thailand, or Vietnam
- Line 2a, Native Hawaiian: Persons having origins in any of the original peoples of Hawaii
- Line 2b, Other Pacific Islander: Persons having origins in any of the original peoples of Guam, Samoa, Tonga, Palau, Truk, Yap, Saipan, Kosrae, Ebeye, Pohnpei or other Pacific Islands in Micronesia, Melanesia, or Polynesia
- Line 2, Total Native Hawaiian/Other Pacific Islander: Must equal lines 2a+2b

American Indian/Alaska Native (Line 4): Persons who trace their origins to any of the original peoples of North and South America (including Central America) and who maintain Tribal affiliation or community attachment.

More than one race (Line 6): “More than one race” should not appear as a selection option on your intake form. Use this line only if your system captures multiple races (but not a race and an ethnicity) and the person has chosen two or more races. This is usually done with an intake form that lists the races and tells the person to “check one or more” or “check all that apply.” “More than one race” must not be used as a default for Hispanics/Latinos who do not check a separate race. They are to be reported on Line 7 (Unreported/Refused to Report), as noted above.

<b>11</b>	<b>Line</b>	Number of People Served By Race	Hispanic/Latino (a)	Non-Hispanic/ Latino (b)	Unreported/ Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
	1	Asian				
	2a.	Native Hawaiian				
	2b.	Other Pacific Islander				
	2.	Total Native Hawaiian/Other Pacific Islander  (Sum lines				
	3.	Black/African American				
	4.	American Indian/Alaska Native				
	5.	White				

	6.	More than one race				
	7.	Unreported/Refused to report race				
	8.	Total of individuals served (Sum Line 1+2+3 to 7)				Equal to the total number of unique individuals who receive direct services

### SECTION III: HEALTH INFORMATION TECHNOLOGY

**Table 7: Summary of Care Record**

**Table Instructions:** If your RHND grant program is an EHR/HIT or Care Coordination program and any member of your network has achieved Meaningful Use Stage II or Stage III, please indicate “yes/no” to the following questions.

	Summary of Care Record	Yes/No
12	Is your program using a certified EHR technology (CEHRT) to create a summary of care record?	
13	If yes, does your program submit this summary to a receiving provider for more than 10 percent of transitions of care referrals?	
14	What percentage of care transitions between organizations receive an electronic care summary (if available)?	open-ended response

**SECTION IV: TELEHEALTH**

**Table 8: Patient Travel Miles Saved**

**Table Instructions:** Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. If your RHND grant program utilizes telehealth please fill out the following table.

In the table, enter the names of each consultant site (hub site) in column 1 and each originating site (patient data site) in column 2. For many programs, the telehealth provider site will be serving all your remote sites. We ask that you still list the telehealth provider (hub) site in column 1.

Estimate the distance between the two (in miles) and enter this number into column 3. This information can be obtained by using Google maps (<https://www.google.com/maps>) or other mapping resources.

Enter the number of patient care sessions between the two locations in column 5. For group sessions/clinics, each patient should be counted separately, as each would have had to travel for these sessions. For simplicity reasons (and to avoid collecting information from each patient) the distance a patient travels from their home to the remote site is intentionally omitted. Home patients should be excluded from this entire reporting sheet. Patients being stabilized prior to transport should be excluded as well, as their travel is not averted, only delayed.

Columns 4 and 6 will fill in automatically. You do not need to enter anything into these cells.

**Definitions:**

**Consultant Site/Hub site:** Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.

**Originating Site/Patient Data Site:** Site at which the patient is located or where patient data is collected at the time the service is provided via telecommunications system.

**Patient-Care Sessions:** Include therapy and counseling (including nutritional, group, etc.) but NOT didactic education, community meetings or administrative sessions.

1	2	3	4	5	6
Consultant Site	Patient/Patient-data Site	Distance Between (miles)	Miles Roundtrip ('column 3' X 2)	# Patient Care Sessions	Miles Saved ('column 4' X 'column 5')
			0		0
			0		0
			0		0
			0		0
			0		0
Total:			0	0	0

**SECTION: V DIRECT CLINICAL SERVICES (IF APPLICABLE)**

**Table 9: Number of People Receiving Direct Clinical Services (If applicable)**

**Table Instructions:** Please provide information on the number of unique (i.e. unduplicated count) patients/clients that received direct clinical services from your organization.

<b>15</b>	<b>Number of unique individuals who received direct clinical services during this budget period</b>	<b>Number:</b>
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**SECTION VI: CLINICAL MEASURES**

**Table 10: Clinical Measures**

**Table Instructions:** Please use your health information technology system to extract the clinical data monitored through this grant program. Please only report on data that is aligned with the activities funded through this grant program. Please refer to the specific definitions for each measure.

Detailed descriptions of NQF measures can be found at: <http://www.qualityforum.org/Home.aspx>

**Hospital Readmission:**

**Measure 1: NQF 1789: Hospital-Wide All Cause Readmission**

**Measure Description:**

*Numerator:* Number of readmission for patients 18 years or older as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission

*Denominator:* Number of admissions to acute care facilities for patients aged 18 years or older

**Behavioral/Mental Health:**

**Measure 2: NQF 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention**

**Measure Description:** *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 24 month 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 seen for at least two visits or at least one preventive visit during the measurement period

**Measure 3: NQF 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan**

**Measure Description:** *Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented*

**Numerator:** Patients screened for clinical depression using an age appropriate standardized tool AND follow-up plan is documented

**Denominator:** All patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool

**Diabetes:**

**Measure 4: NQF 0059: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%):**

**Measure Description:** *The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done during the measurement year.*

**Numerator:** Patients whose HbA1c level is >9.0% during the budget period.

**Denominator:** Patients 18-75 years of age by the end of the budget period who had a diagnosis of diabetes (type 1 or type 2) during the budget period.

**Obesity:**

**Measure 5: NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents**

**Measure Description:** *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

\*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

**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 during the measurement year.

**Measure 6: NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up**

**Measure Description:** *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

## Oral Health:

### **Measure 7: NQF 2508: Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk**

**Measure Description:** *Percentage of enrolled children in the age category of 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth within the reporting year.*

**Numerator:** Unduplicated number of enrolled children age 6-9 years at “elevated” risk (i.e., “moderate” or “high”) who received a sealant on a permanent first molar tooth as a dental service

**Denominator:** Unduplicated number of enrolled children age 6-9 years who are at “elevated” risk (i.e., “moderate” or “high”)

### **Measure 8: CMS74v7: Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists**

**Measure Description:** *Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period*

**Numerator:** Children who receive a fluoride varnish application

**Denominator:** Children, age 0-20 years, with a visit during the measurement period

## Care Coordination:

### **Measure 9: CMS50v6: Closing the referral loop: receipt of specialist report**

**Measure Description:** *Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred*

**Numerator:** Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred

**Denominator:** Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period

### **Measure 10: NQF 0097: Medication Reconciliation Post-Discharge**

**Measure Description:** *The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.*

**Numerator:** Medication reconciliation conducted by a prescribing practitioner, clinical pharmacists or registered nurse on or within 30 days of discharge

**Denominator:** All discharges from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) for patients 18 years 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.

		<b>Numerator</b>	<b>Denominator</b>	<b>Percent</b>
17	<b>Provide data on the NQFs monitored by and related to this grant program.</b>			
	<b>Hospital Readmission</b>			
	Measure 1: NQF 1789: Hospital-Wide All Cause Readmission			
	<b>Behavioral/Mental Health</b>			
	Measure 2: NQF 0028: Preventive Care & Screening: Tobacco Use			
	Measure 3: NQF 0418: Screening for clinical depression			
	<b>Diabetes</b>			
	Measure 4: NQF 0059: Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)			
	<b>Obesity</b>			
	Measure 5: NQF 0024: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
	Measure 6: NQF 0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up			
	<b>Oral Health</b>			
	Measure 7: NQF 2508: Prevention: Dental Sealants for 6-9 Year-Old Children at Elevated Caries Risk			
	Measure 8: CMS74v7: Primary Caries Prevention Intervention as Offered by Primary Care Providers, Including Dentists			
	<b>Care Coordination</b>			
	Measure 9: CMS50v6: Closing the referral loop: receipt of specialist report			
	Measure 10: NQF 0097: Medication Reconciliation			

Is your program addressing an NQF not provided in the table above	Yes	No
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**If your program IS addressing an NQF measure NOT provided in the table above, please provide the NQF number(s), numerator, denominator and percent in the table below.**

		Numerator	Denominator	Percent
	NQF:			
	NQF:			

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 0906-XXXX. Public reporting burden for this collection of information is estimated to average 6 hours 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, Room14N-39, Rockville, Maryland, 20857.