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Federal Office of Rural Health Policy
Community-Based Division
Rural Health Network Development Program (RHND)
Performance Improvement and Measurement Systems (PIMS) Database

MEASURES

Instructions: Please review and respond to each question listed below. Provided answers should only reflect information that has resulted from your network's use of the Rural Health Network Development (RHND) funding. Do not leave any question blank, if a question does not pertain to your program, please reply with N/A. Unless otherwise noted, please answer each of the below questions using data collected from the most recent grant funding year.

Section 1: Network/Collaboration

1) ***Table Instructions:*** Please identify the types and number of network members who are participating in the RHND Grant. 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. Network members do not include other partner organizations who are playing a role in the grant but who are not member. If the organization type is not applicable, please insert N/A. DO NOT leave any space blank under the current budget year for your grant. If you mark "Other", please specify the type of member organization in the comment section below.

Type of Member Organizations	**Year I**	**Year II**	**Year III**
Area Health Education Center			
Accountable Care Organization			
Behavioral/Mental Health Organization			
Community College			
Community Health Center			
Critical Access Hospital			
Emergency Medical Service			
Federally Qualified Health Center			
Faith Based Organizations			
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			
Public or Private Payers			
Rural Health Clinic			
School District			
Social Services Organization			
Tribal Organization			
University			
Other			
Total	Automatically calculated by system	Automatically calculated by system	Automatically calculated by system

2) ***Table Instructions:*** Assess the overall benefits realized by network members as a result of being in the network during the current budget year**.** Select all that apply**.** Do not leave any space blank; if one of the benefits does not apply, insert N/A. Definitions of each type of network benefit can be found below in the RHND Program Reference Guide. Please provide any specific network benefit examples you wish to share in the comment section below.
Note: Only assess the below benefits for the network funded by the RHND grant.

Type of Network Benefit	**Year I**	**Year II**	**Year III**
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			
Policy Development			
Other Capacity Building: Please specify			
Other: Please specify			

3) ***Table Instructions***: Indicate the funding strategy that your network currently utilizes and the percent of total network budget. If you select "Other", please specify the funding type and percent of your network budget. You may select as many funding strategies as apply. Do not leave any space blank, if the network does not utilize a type of funding, respond N for No.

Type of Funding	Year I	Year II	Year III
Indirect Funding/In-kind Contributions	y/n and %		
Reimbursement from Third Party Payers			
Fees for Services, Events, Consulting; Products Sales			
Membership Fees			
Donations			
Grants			
Government Budgets			
Other (Specify)			

4) **ONLY YEAR 3**: What percent of the future cost of network operations do you project will be covered by grant funds after the RHND grant is complete (June 30, 2023)?
   All (100%)
   Most (50-99%)
   Some (Less than 50%)
   None (0%)

5) **ONLY YEAR 3**: Please indicate the percent of programs created or enhanced through this grant funding that will continue to sustain after the funding ends.
   More (Expanded)
   All (100%)
   Most (50-99%)
   Some (Less than 50%)
   None (0%)

6) **ONLY YEAR 3**: Will the formal network continue after this grant funding? **Y/N**
   a. Please explain the factors that will contribute to your formal network sustaining or ending after this grant**.**

7) ***Table Instructions***: Please review the following components of network sustainability and indicate where your network falls on the scale. Definitions for the sustainability components can be found below. If you mark "other", please specify in the comment section below, otherwise, please leave blank.

Sustainability Component	Never	Sometimes	Often	Always	Don't Know
Strategic Vision					

Collaboration					
Leadership					
Relevance and Practicality					
Evaluation and ROI					
Communication					
Efficiency and Effectiveness					
Capacity					
Other: Please specify					

Section 2: Demographics and Services

8) ***Table Instructions:*** This table collects information about an aggregate count of the people served by race, ethnicity, and age. The total for *each* of the following questions **should equal the total of the number of unique individuals who received direct services**. This number represents the total number of people served by all of the activities outlined in your work plan and includes all direct clinical (if applicable) and non-clinical people served by the program. 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 this grant. Examples of direct services include but are not limited to patient visits, counseling, and education. Please do ***not*** leave any sections blank. There should not be a N/A (not applicable) response since the measures are applicable to all awardees. 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). Response totals reported for each measure in this section must equal the total ***number of individuals who received direct services (Question 12).*** Please refer to the specific definitions for each field below for additional measure guidance and instructions.

Hispanic or Latino Ethnicity

- 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.
- 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.*
- Unknown: Report on only individuals who did not provide information regarding their race or ethnicity.

Race

All people must be classified in one of the racial categories (including a category for persons who are "Unknown"). This includes individuals who also consider themselves 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.

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

- 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
- Native Hawaiian: Persons having origins in any of the original peoples of Hawaii
- 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
- American Indian/Alaska Native: 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: 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. "More than one race" must not be used as a default for Hispanics/Latinos who do not check a separate race.

		Year I	Year II	Year III
	Number of individuals served by ETHNICITY:			
	Hispanic or Latino			
	Not Hispanic or Latino			
	Unknown			
	Total (equal to the total of the number of unique individuals served)	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*
	Number of individuals served by RACE:			
	American Indian or Alaska Native			
	Asian			
	Black or African American			
	Native Hawaiian or Other Pacific Islander			

	White			
	More than one race			
	Unknown			
	Total (equal to the total of the number of unique individuals served)	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*
	Number of individuals served, by AGE GROUP:			
	Children (0-12)			
	Adolescents (13-17)			
	Adults (18-64)			
	Elderly (65 and over)			
	Unknown			
	Total (equal to the total of the number of unique individuals served)	*(Automatically calculated by system)*	*(Automatically calculated by system)*	*(Automatically calculated by system)*

9-13) ***Table Instructions***: Please fill out the following information about an aggregate number of people served through your project funded by the RHND Program during this budget period. Please provide numerical answers. If the total number is zero (0) please put zero in the appropriate section. Do not leave any sections blank or provide N/A (not applicable). All awardees must answer every question.

		Year I	**Year II**	**Year III**
9	Total number of counties where the target population resides. *Example: Your network has anticipated carrying out activities in 4 counties in this budget period.*			
10	Total number of counties served in the project during this budget period. *Example: Your network has carried out activities in 3 counties this budget period.*			
11	Number of people in the target population during this budget period.			
12	Number of unique individuals (i.e. unduplicated count) who received direct services that were funded with this grant.			
13	Number of unique individuals served for by all activities, including direct and indirect services.			

14) Table Instructions: Please indicate the types and number of new, continued, and/or expanded service areas provided by the network as a result of the RHND grant funding. Please mark all that apply, do not leave any section blank. If an area is not applicable, insert N/A.

Type(s) of new, continued, and/or expanded service area(s) provided by the network as a result of the RHND grant funding	**Year I**	**Year II**	**Year III**
Health and Wellness:			
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			
Care Coordination:			

Care Coordination			
Care Transitions			
Case Management			
Quality Improvement:			
Accountable Care Organization			
Medical Home or Patient Centered Medical Home			
Health Information Technology:			
Promoting Interoperability (previously known as attestation of Meaningful Use Stage 1, 2 or 3)			
Electronic Medical Records/Electronic Health Records			
Health Information Exchange			
Telehealth/Telemedicine			
Patient/Disease Registry			
Other, please specify.	open-ended response		
None- Explain	open-ended response		

14) What is your ratio for Economic Impact vs HRSA program funding?
Note: Please use the HRSA's Economic Impact Analysis Tool to identify your ratio https://www.ruralhealthinfo.org/econtool . Responses should reflect the ratio for the annual economic impact for your grant's budget year funded for your project's annual and cumulative reporting period.

	Year 1	Year 2	Year 3
What is your ratio for Economic Impact vs. HRSA Program Funding? **Yearly**	Ratio	Ratio	Ratio
What is your ratio for Economic Impact vs. HRSA Program Funding? **Cumulative**	n/a	n/a	Ratio

Section 3: Health Information Technology and Telehealth

15) **Table Instructions**: Please indicate if you used RHND grant funds to implement/install, use, or expand use of Health Information Technology. If your program did not use HIT, please mark "None" for the corresponding year.

	Year I	Year II	Year III
Implemented			
Use			
Expansion			
None			

16) **Table Instructions**: This table collects information about Health Information Technology (HIT) activities as part of the RHND Program. Coordinating care across network partners may often involve navigating multiple Electronic Health Records (EHR) systems. If your program did not use HIT, please mark "none" for the corresponding year, you do not need to indicate N/A for the types of HIT activities. Please indicate N/A if the type of HIT is not applicable to your program but your program did use some form of HIT program.

Types of HIT Implemented, use, or expanded through this program (please check all that apply**)**	**Year I**	**Year II**	**Year III**
Computerized Order entry			
Electronic medical records/electronic health records			
Health information exchange			
Patient/disease registry			
Clinical Decision Tools			
Care Management Tools			
Summary of Care Records			
Other			
None			

17) Does your network exchange clinical information electronically with other key providers/health care settings such as hospitals, emergency rooms, or subspecialty clinicians?

18) Does your consortium use health IT to coordinate or to provide enabling services such as outreach, language translation, transportation, case management, or other similar services?

19) ***Table Instructions:*** *Telehealth:* This table collects information about telehealth activities as part of the Rural Health Network Development Program.

The term "telehealth" includes "telemedicine" services but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

a	**Did your organization use telehealth to provide remote clinical/non-clinical care services?** (Yes/No)	**Year I**	**Year II**	**Year III**
	If yes, then answer the following two questions:			
	i. Who did you use telemedicine to communicate with? (Select all that apply) a. Patients at remote locations from your organization (e.g., home telehealth, satellite locations) b. Specialists outside your organization (e.g., specialists at referral centers)			
	ii. What telehealth technologies did you use? (Select all that apply) a. Real-time telehealth (e.g., live videoconferencing) b. Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations) c. Remote patient monitoring d. Mobile Health (mHealth)			
	If no, then answer the following question:			
	If you did not have telehealth services, please comment why (select all that apply) a. Have not considered/unfamiliar with telehealth service options b. Policy barriers (Select all that apply) 1) Lack of or limited reimbursement Credentialing, licensing, or privileging 2) Privacy and security 3) Other (specify): c. Inadequate broadband/ telecommunication service (Select all that apply) 1) Cost of service 2) Lack of infrastructure 3) Other (specify): d. Lack of funding for telehealth equipment e. Lack of training for telehealth services f. Not needed g. Other - specify:			
b	**Number of consortium/network sites providing/using relevant telehealth services.**	(Number)	(Number)	(Number)

	Note: if telehealth services are no longer available at any of the network sites please detail this in the form comment box.			
c	**Number of unique individuals who received direct services by telehealth.** Note: this is a unique count of patients who receive a telehealth consult facilitated by the organization and/or network/consortium during the budget period.			
d	**Number of providers trained and/or supported through telehealth.** Note: providers are inclusive of anyone on the care coordination team. This is an unduplicated count of providers who were trained, educated or supported through telehealth/telemedicine during the budget period. For example, Project ECHO.			

Section 4: Direct Clinical Services (if applicable)

20) Number of unique individuals who received direct clinical services during this budget period

	Year I	Year II	Year III
Number of unique individuals who received direct clinical services during this budget period.			

21) ***Table Instructions:*** Please use your electronic patient registry and/or electronic health records system to extract the clinical data requested for patients served through the RHND program as applicable.

Please refer to the specific definitions for each field below and consult each measure's web link provided for additional measure guidance and instructions. Please indicate if this measure is applicable to your program or not. If it is applicable, provide the requested information. If it is not applicable to your program, please mark the first column "No". All responses reported should be reflective of grant project target intervention patient population values only. **The denominator should not be larger than the total of the number of unique individuals served in Question 20.**

Note: Please complete responses, as data/information is available to do so. If data/information is not available, please utilize the form comment box for provision of any additional necessary information needed for interpreting values reported in this section.

		Is this measure applicable to your	**Numerator**	**Denominator**	**Percent**

		program? (Yes/No)			
1	NQF 1789: Hospital-Wide All Cause Readmission				
2	NQF 0028e/ CMS138v8: Tobacco Use: Screening & Cessation Intervention				
3	NQF 0418e/ CMS2v9: Screening for Clinical Depression				
4	NQF 0059/CMS122v6: Comprehensive Diabetes Care				
5	NQF 0024/CMS155v6: Weight Assessment				
6	NQF 0421/ CMS69v6:Body Mass Index (BMI) Screening and Follow-Up				
7	CMS50v8: Closing the referral loop: receipt of specialist report				
8	NQF 0097: Medication Reconciliation Post-Discharge				
9	NQF 0018/CMS165v6: Controlling High Blood Pressure				
10	CMS137v8:Alcohol and other Drug Dependence				
11	NQF0102:Chronic Obstructive Pulmonary Disease (COPD)				
12	NQF0419e/CMS68v9:Medication Documentation				
13	CMS347v3: Cardiovascular Disease				

22) Please provide any additional NQF measures that your program is collecting. Indicate which measures you are collecting and provide the clinical data collected for each measure.