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

Measures Overview

This section provides an overview of all performance measures.

SECTION 1: ACCESS TO CARE

1. Number of counties served in the project
2. Number of unique individuals served (direct/indirect services)
3. Number of unique individuals who received direct services
4. Total number of unique individuals in your target population during this reporting period

SECTION 2: POPULATION DEMOGRAPHICS

5. Number of individuals served by ETHNICITY
6. Number of individuals served by RACE
7. Number of individuals served, by AGE GROUP
8. Number of individuals by INSURANCE STATUS

SECTION 3: CONSORTIUM | COLLABORATION | SUSTAINABILITY

INFRASTRUCTURE
9. Type and number of organizations in the consortium
10. Consortium/network partners' contributing to direct service encounter data (Yes/No)
11. Number of consortium/network partners contributing direct service encounter data
BENEFITS
12. Benefits self-assessment: assess the benefits as a result of being in the consortium
SUSTAINABILITY
13. Sustainability self-assessment: select indicators of sustainability experienced by the consortium as a result of this funding.
14. Type of sustainability funding/sustainability funding plan. If selected "private, foundation, philanthropy" please answer: How and to what extend does the public-private partnership contribute to the sustainability of the program?

SECTION 4: LEADERSHIP AND WORKFORCE

15. Number of positions funded by this program during this budget period
16. List of health professional education/training to care coordination staff in this program

SECTION 5: CARE COORDINATION

17. Care Coordination Activities completed during this budget period?
HEALTH INFORMATION TECHNOLOGY (HIT)

18. Type of Health Information Technology (HIT) implemented, expanded, or strengthened during this budget period
19. Does your consortium have EHR installed and in use?
20. Does your consortium exchange clinical information electronically with other key providers/health care settings?
21. Does your consortium engage patients through health IT either through EHR or through other technologies?
22. Does your consortium use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?
23. 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?
TELEHEALTH
24. Did your organization use telehealth to provide remote clinical/non-clinical care services?
25. Number of consortium/network sites providing/using relevant telehealth services.
26. Number of unique individuals who received direct services by telehealth.
27. Number of providers trained and/or supported through telehealth.
28. Number of patients travel miles saved.

SECTION 6: CLINICAL MEASURES | IMPROVED OUTCOMES*

*BASELINE DATA WILL BE COLLECTED FOR THIS SECTION ONLY
1. Cardiovascular Disease (CMS347v3)
2. Diabetes Care (CMS122v8)
3. Body Mass Index (BMI) (CMS69v6)
4. Blood Pressure (CMS165v6)
5. Tobacco Use (CMS138v8)
6. Depression (CMS2v9)
7. Weight Assessment (CMS155v6)
8. Alcohol and Other Drug Dependence (CMS137v8)
9. 30-Day Hospital Readmission (NQF1789)
10. Medication Reconciliation (NQF 0097)
11. Chronic Obstructive Pulmonary Disease (COPD) (NQF 0102)
12. Medication Documentation (CMS68v9)

SECTION 1: ACCESS TO CARE

Table Instructions: This table collects information about an aggregate count of the number of people served through the program and the types of services that were provided during this budget period. Please report responses using a numeric figure. If the total number is zero (0), please put zero in the appropriate section. Do *not* leave any sections blank. There should *not* be an N/A (not applicable) response since all measures are applicable to all awardees.

Definitions:
- **First Year – Third Year:** Data that is collected after the end of the respective budget period.
- **Direct Services:** 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.
- **Indirect Services:** For the purposes of this data collection activity, indirect services will be limited to billboards, flyers, health fairs, mailings/newsletters, and other mass media (radio,

television, newspaper and social media). For radio, television and newspaper please report estimated total circulation. For social media, please report the reach (number of followers).

		Year I	Year II	Year III
1	**Number of counties served in the project** Note: This should be consistent with the figures reported in your grant application and should reflect your project's service area.			
2	**Number of unique individuals served** for by all activities, including direct and indirect services			
3	**Number of unique individuals who received direct services.** Please report the number of unique (i.e. unduplicated count) patients/clients that received *direct services* from your organization			
4	**Total number of unique individuals in your target population during this budget period.** Note: this is the unduplicated count of patients/clients from your target population			

Year 3 Measures – To be collected during Year 3 reporting period only	**Data across Year 1-3** **(September 1, 2020 – August 31, 2023)**
1	**Number of counties served in the project**	
2	**Number of unique individuals served**	
3	**Number of unique individuals who received direct services.**	
4	**Total number of unique individuals in your target population across the project period (all three years).**	

SECTION 2: POPULATION DEMOGRAPHICS

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 served** reported in the previous section. 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. 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).

Definitions:
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 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.

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 (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: 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**
5	**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*	*(Automatically calculated by*	*(Automatically calculated by*

		system)	*system)*	*system)*
6	**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)*
7	**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)
8	**Number of individuals by INSURANCE STATUS:**			
	Self-pay			
	Uninsured			
	Dual Eligible (covered by both Medicaid and Medicare)			
	Medicaid/CHIP only			
	Medicare only			
	Medicare plus supplemental			
	Other third party			
	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)*

SECTION 3: CONSORTIUM | COLLABORATION | SUSTAINABILITY

Table: Infrastructure

Table Instructions: Please provide information about the network/consortium members and operations. 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/consortium.

	Identify the types and number of organizations in the consortium/network for your project:			
	Type of Member Organizations in the Consortium/Network	**Year I** (Number)	**Year II** (Number)	**Year III** (Number)
	Health Education			
	Behavioral/Mental Health Organization			
	Community Health Center			
	Critical Access Hospital			
	Faith-based organization			
	Foundation/Philanthropy			
	Free Clinic			
	Health Department			
	Home Health Agency			
	Hospice			
	Hospital			
	Migrant Health Center			
	Private Practice Primary Care			
	Private Practice Specialty Care			
	Rural Health Clinic			
	School District			
	Social Services Organization			
	University/College			
	Other – (Please Specify):			
	Total	(Automatically calculated by system)	(Automatically calculated by system)	(Automatically calculated by system)
10	**Are all consortium/network partners contributing to direct service encounter data?** *If no, please indicate the contributing partner sites in the question below.* Please indicate whether all funded partner sites are contributing to the direct service encounter values included for the purposes of this reporting.	(Yes/No)	(Yes/No)	(Yes/No)

11	**Number of consortium/network partners contributing direct service encounter data.** Please provide the total number of funded network partner sites contributing to the direct service encounter values included for the purposes of this reporting.	(Number/NA)	(Number/NA)	(Number/NA)

Table: Benefits Assessment

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

Definitions:
- **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.

12	**Assess the following overall benefits realized by the members as a result of being in the network/consortium (check the benefit(s) that apply):**			
	Type of Network Benefit (Select if Applicable)	**Year I**	**Year II**	**Year III**
	Financial Cost Savings			

	Efficiencies			
	Quality Improvement			
	Access to Educational Opportunities			
	Access to Equipment			
	Influence/Authority			
	Branding/Marketing			
	Development of Workforce That is Change Ready and Adaptable			
	Knowledge Sharing			
	Understanding of Community Health Needs			
	Opportunities for Innovation			
	Other benefit(s) (Please Specify):			

Table: Sustainability Assessment

Table Instructions: Please select the following indicators of sustainability experienced by the network/consortium as a result of this funding.

13	Sustainability Indicator (Select if Applicable)	Year I	Year II	Year III
	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 funding into the routine operations of network members, without requiring additional funding support			
	Participation in the Rural Health Public-Private Partnership and/or Rural Health Aligned Funding Initiative			
	Other indicator(s) (Please Specify):			

Table Instructions: Please fill out this table for project years 1-3 only. No baseline data needed.
If applicable and data is available, include information pertaining to funding stream sources contributing to your organization's project, accrued during the budget period.

14	Type of Sustainability (Program Revenue/Funding Sources *(Dollar Amount)*	Year I	Year II	Year III
	Medicare service reimbursement			
	Other federal (i.e. Medicaid)			
	State			
	Private (i.e. foundation/philanthropy)			
	Other (Please Specify):			

14) If selected "Private (i.e. foundation/philanthropy)". We are interested in learning more about your public private partnerships through this program. Please elaborate on how and to what extend does the public-private partnership contribute to the sustainability of the program.

Comment box:

Year 3 Sustainability Measures – To be collected during Year 3 reporting period only		
	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**
	Will the network/consortium sustain after this federal funding period? • Yes, the network and/or activities of the network are expected to operate after the period of performance. • No, the network is not expected to continue after the period of performance.	(Y/N)

SECTION 4: LEADERSHIP AND WORKFORCE

Table Instructions: The following tables collect information about an aggregate number of clinical and non- clinical positions funded and education/training provided to these positions by this award during this budget period. If you are not sure who is funded by this award, please refer to the staffing plan and budget narrative that was submitted with your grant application. Please report a numeric figure. There should not be a N/A (not applicable) response since all measures are applicable to all awardees.

It is important to understand the current state of workforce training and different staffing models to better support recruitment and retention of health professionals. Targeted training to staff improves capacity for care coordination. This section includes a series of questions on health center workforce.

		Year I	Year II	Year III
15	**Number of positions funded by grant dollars during this budget period**			
	Total number of clinical staff			
	Total number of non-clinical staff			
	Total number FTE amount of all staff paid			

		Year I	Year II	Year III
	via grant (0.0 Format)			

		Year I	Year II	Year III
16	**Did you provide health professional education/training to staff funded by this program?** (Yes/No) Health professional education/training does not include continuing education units.			
	If yes, provide a list of education/training and number of care coordinators (clinical or non-clinical) trained			

SECTION 5: CARE COORDINATION

Table Instructions: This table collects information about care coordination activities as a direct result of the Care Coordination Program.

If your award did support one or more of the care coordination activities, but you do not know the information, then select/enter DK (do not know). If your award did not support one or more these care coordination activities, then select/enter N/A (not applicable)

17. Care Coordination Activities: Have you done these activities this budget period?	Year I	Year II	Year III
	Yes/No (Selection List)	**Yes/No (Selection List)**	**Yes/No (Selection List)**
Referral tracking system			
Facilitate transitions across settings			
Patient support and engagement			
Integrated care delivery system (agreements with specialists, hospitals, community organizations, etc. to coordinate care)			
Case management			
Care plans			
Linkage to community resources			
Medication management			
Hiring care coordinator(s)			
Other – specify			

Table Instructions: *Health Information Technology (HIT):* This table collects information about HIT activities as part of the Care Coordination Program.

Coordinating care across consortium partners may often involve navigating multiple Electronic Health Records (EHR) systems.

18	Type(s) of Health Information Technology implemented, expanded or strengthened through this program: (Please check all that apply) (Selection list)	Year I	Year II	Year III
	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 – specify			

19	Does your consortium have an EHR installed and in use? (Please select one answer)	Year I	Year II	Year III
	If yes, a. Yes, installed at all consortium members' sites and used by all providers b. Yes, but only installed at some members' sites and used by some providers If no, a. No, members will install the EHR system in 3 months b. No, members will install the EHR system in 6 months c. No, members will install the EHR system in 1 year or more d. No, members have not planned on installing the EHR system			
20	Does your consortium exchange clinical information electronically with other key providers/health care settings such as hospitals, emergency rooms, or subspecialty clinicians? (Yes/No/Not Sure)			
21	Does your consortium engage patients through health IT such as patient portals, kiosks, secure messaging (i.e., secure email) either through the EHR or through other technologies? (Yes/No/Not Sure)			
22	Does your consortium use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when			

	requested? (Yes/No/Not Sure)			
23	**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?** (Yes/No/Not Sure)			

Table Instructions: Telehealth: This table collects information about telehealth activities as part of the Care Coordination 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.

24	**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:			
25	**Number of consortium/network sites providing/using relevant telehealth services.** Note: if telehealth services are no longer available at any of the network sites please detail this in the form comment box.	(Number)	(Number)	(Number)
26	**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.			
27	**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.			

Table Instructions: This table collects information on Patient Travel Miles Saved.
In this table, enter the names of each originating site in column 1 and the specialty in column 2.
Originating Site is defined as the site at which the patient is located or where patient data is collected at the time the service is provided via telecommunications system.

For column 4, estimate the distance between the Originating Site ('column 1') to the location where the patient would have been referred in the absence of telehealth ('column 3') (in miles). Use Google maps or similar program to determine the shortest travel miles by car one way. If the patient will be accessing telehealth from their home or work, then enter "0". If the patient will be accessing telehealth from a clinic location then enter the miles from the patient's home to that clinic. If the patient will not be using telehealth then enter the miles from the patient's home to the location where they will be receiving the majority of their services.

Enter the number of encounters in column 6. For group sessions/clinics, each patient should be counted separately, as each would have had to travel for these sessions. Columns 5 and 7 will fill in automatically. You do not need to enter anything into these cells.

When filling this table, please note the following:
- Information to answer this table should be determined at intake/baseline. Locations may change in the course of treatment; use the location planned at the time of intake only.
- The provider or staff completing the intake/baseline should make this determination and does not need to ask the patient.

28. Patient Travel Miles Saved

1	2	3	4	5	6	7
Originating Site	**Specialty**	**Name of location where patient would have been referred in absence of telehealth**	**Estimated Miles from Originating (patient) Site ('column 1') to the location where patient would have been referred in the absence of telehealth ('column 3')**	**Miles Roundtrip** ('column 4' X 2)	**Total Encounters**	**Miles Saved** ('column 5' X 'column 6')
			#	0	#	0
			#	0	#	0
			#	0	#	0
			#	0	#	0
			#	0	#	0
			Total:	0	0	0

SECTION 6: CLINICAL MEASURES/IMPROVED OUTCOMES

BASELINE DATA WILL BE COLLECTED FOR THIS SECTION ONLY

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 program.

- Please refer to the specific definitions for each field below and consult each measure's weblink provided for additional measure guidance and instructions. See definitions in Appendix A.
- Please indicate a numerical figure or N/A for not applicable for your specific grant activities.
- All responses reported should be reflective of grant project target intervention patient population values only. **The denominator should equal the total of the number of unique individuals served in section one: access to care.**

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.

Clinical Measures				
		Baseline, Year I, Year II, Year III		
Measure Number	Clinical Measure	Numerator (Number)	Denominator (Number)	Percent *(Automatically calculated by system)*

Measure 1: Cardiovascular Disease	(CMS347v3) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period.			
Measure 2: Diabetes (HbA1C)	NQF 0059 (CMS122v8): *Comprehensive Diabetes Care:* Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.			
Measure 3: Body Mass Index (Screening and Follow-Up)	NQF 0421 (CMS69v6): *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. (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25).			
Measure 4: Blood Pressure	NQF 0018 (CMS138v8): *Controlling High Blood Pressure:* The number of patients 18 to 85 years of age who has a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year.			
Measure 5: Tobacco Use	NQF 0028 (CMS165v6)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.			

Measure 6: Depression	NQF 0418 (CMS2v9):Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan: Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow up plan documented.			
Measure 7: Weight Assessment	NQF 0024 (CMS155v6): 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			

Clinical Measures				
		Baseline, Year I, Year II, Year III		
Measure Number	Clinical Measure	Numerator (Number)	Denominator (Number)	Percent (Automatically calculated by system)
Measure 8: Alcohol and Other Drug Dependence	NQF 0004 (CMS137v8): Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported: 1) Percentage of patients who initiated treatment within 14 days of the diagnosis. 2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.			
Measure 9: 30-Day Hospital Readmission	NQF1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR): Hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.			
Measure 10: Medication Reconciliation	NQF 0097 Medication Reconciliation Post Discharge: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation			

	facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.			
Measure 11: Chronic Obstructive Pulmonary Disease (COPD)	NQF 0102 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 70% and have symptoms who were prescribed a long acting inhaled bronchodilator.			
Measure 12: Medication Documentation	NQF 0419 (CMS68v9) : Documentation of Current Medications in the Medical Record Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.			
Upload an attachment of at least 3 Project-Specific Measures	*[Awardees will provide project-specific measures, including:* • *Description of numerator* • *Description of denominator* • *Data Sources and Collection* *These measures are to follow for the entire duration of the program. Refer to Attachment 12 of the application for more information]*			

Appendix A: Definitions

The following questions related to the Rural Health Care Coordination Program PIMS measures for 3 reporting years:
As of September 1, 2020   = **Baseline**   PIMS Reporting Period: November 1, 2020
Sept 1, 2020-Aug 31, 2021 = **Year 1**   PIMS Reporting Period: Sept 1-30, 2021

Sept 1, 2021-Aug 31, 2022 = **Year 2**   PIMS Reporting Period: Sept 1-30, 2022
Sept 1, 2022-Aug 31, 2023 = **Year 3**   PIMS Reporting Period: Sept 1-30, 2023

Definitions Section 5: CARE COORDINATION

Care Coordination: The Agency for Healthcare Research and Quality (AHRQ) defines care coordination 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".[1] Care coordination connects primary care physicians, specialists, hospitals, behavioral health providers, other health care organizations, and non-health social service organizations, including schools, housing agencies, correctional facilities, and transportation organizations. All of these entities work together to communicate information and organize patient's care to make it safer, more appropriate, and more effective.[2] Care coordination creates smooth transitions as a patient interacts with various providers and services and allows for holistic patient care and patient engagement in care management.[3]

Care coordination, or care management, encompasses a cultural shift from a focus on periodic, acute care visits to a more comprehensive view of managing care for those with chronic disease and complex conditions. Care coordination often includes use of staff as care coordinators to specifically work with and support individual patients.[4]

Care **Coordination**	Care **Coordinator**
A function	A person
Based on a population and their needs	Individualized action and support for a patient
A deliberate, systematic organization of patient car	Could involve case management, coaching, advocacy
Infrastructure, policies, communication, and resources	May be clinical or non-clinical
A function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites that are met over time	A person in charge of coordinating client care in a clinical or health care setting, typically responsible for developing care plans, arranging and tracking appointments, educating clients/patients, and coordinating other aspects of clients' well-being

Source: Rural Policy Research Institute (RUPRI) and Stratis Health, 2014

1Agency for Healthcare Research and Quality. (2014). Chapter 2. What is Care Coordination? Available at: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html.
2 Rural Health Information Hub. (2018). Defining Care Coordination. Rural Care Coordination Toolkit. Available at: https://www.ruralhealthinfo.org/toolkits/care-coordination.
3 Stanek M, Hanlon C, Shiras T. (2014). Realizing Rural Care Coordination: Considerations and

Action Steps for State Policy-Makers. Robert Wood Johnson Foundation. Available at: https://www.shvs.org/wp-content/uploads/2014/04/RWJF_SHVS_Realizing-Rural-Care-Coordination.pdf.
4 Rural Policy Research Institute and Stratis Health. (2014). Care Coordination: A Self-Assessment for Rural Health Providers and Organizations. Available at: https://ruralhealthvalue.public-health.uiowa.edu/files/RHV%20Care%20Coordination%20Assessment.pdf.

Definitions Section 7: CLINICAL MEASURES

Baseline Data: Data that is collected prior to the start of the grant project or intervention. This data will be collected 60 days after the start of the project period. For the Rural Health Care Coordination Program, the baseline data should be as of September 1, 2020.

Measure 1: Cardiovascular Disease

(CMS347v3) Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period:
Adults aged >= 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR
Adults aged >= 21 years who have ever had a fasting or direct low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia; OR
Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL

Numerator: Patients who are actively using or who receive an order (prescription) for statin therapy at any point during the measurement period

Denominator: All patients who meet one or more of the following criteria (considered at high risk for cardiovascular events, under ACC/AHA guidelines):
1) Patients aged >= 21 years at the beginning of the measurement period with clinical ASCVD diagnosis
2) Patients aged >= 21 years at the beginning of the measurement period who have ever had a fasting or direct laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial or pure hypercholesterolemia
3) Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes and with an LDL-C result of 70-189 mg/dL recorded as the highest fasting or direct laboratory test result in the measurement year or during the two years prior to the beginning of the measurement period

Measure 2: Comprehensive Diabetes Care (HbA1C)

NQF 0059 ([CMS122v8):](#) Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%

Denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period.

Measure 3:   Body Mass Index (BMI) Screening and Follow-Up

NQF 0421 ([CMS69v6):](#) 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: Blood Pressure

NQF 0018 ([CMS165v6):](#) 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: Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Denominator: Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Measure 5: Tobacco Use

NQF 0028 ([CMS138v8):](#) 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 within 24 months AND who received tobacco cessation 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 6: Depression

NQF 0418 (CMS2v9): 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 depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Denominator: All patients aged 12 years and older.

Measure 7: Weight Assessment and Counseling for Children/Adolescents

NQF 0024 (CMS155v6): 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

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 8: Alcohol and Drug Dependence Treatment

NQF 0004 (CMS137v8): Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported:
1) Percentage of patients who initiated treatment within 14 days of the diagnosis.
2) Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Numerator 1: Patients who initiated treatment within 14 days of the diagnosis
Numerator 2: Patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit
Denominator: Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or drug dependency during a visit in the first 11 months of the measurement period

Measure 9: 30-Day Hospital Readmission

NQF1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR): Hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge (RSRR) for patients aged 18 and older.

Numerator: Unplanned all-cause 30-day readmission (readmission defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission). All readmissions are counted except those that are considered planned.

Denominator: This claims-based measure can be used in either of two patient cohorts: (1) admissions to acute care facilities for patients aged 65 years or older or (2) admissions to acute care facilities for patients aged 18 years or older.

Measure 10: Medication Reconciliation

NQF 0097 Medication Reconciliation Post Discharge: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.

Numerator: Patients who had a reconciliation of the discharge medications with the current medication list in the medical record documented.
Denominator: All patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care.

Measure 11: Chronic Obstructive Pulmonary Disease (COPD)

NQF 0102 Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC < 70% and have symptoms who were prescribed a long acting inhaled bronchodilator.

Numerator: Patients who were prescribed an inhaled bronchodilator

Denominator: All patients aged 18 years and older with a diagnosis of COPD, who have an FEV1/FVC <70% and have symptoms (e.g. dyspnea, cough/sputum, wheezing)

Measure 12: Care Coordination (Medication Documentation)

NQF 0419 (CMS68v9) : Documentation of Current Medications in the Medical Record Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

Numerator: Eligible professional attests to documenting, updating or reviewing the patient's

current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration.
Denominator: All visits occurring during the 12 month reporting period for patients aged 18 years and older before the start of the measurement period.