OMB Number: 0906-0102
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Federal Office of Rural Health Policy: Rural Health

Community-Based Programs

Performance Improvement and Measurement Systems (PIMS) Database

Public Burden Statement: The purpose of this collection is to collect information on grantee activities for the Small Health Care Provider Quality Improvement (SHCPQI) Program. 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 information collection is 0906-0102 and it is valid until 8/31/2027. This information collection is required to obtain or retain a benefit (Government Performance and Results Act of 1993, P.L. 103-62, Section 1116). Data will be kept private to the extent allowed by law. Public reporting burden for this collection of information is estimated to average 13.5 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 Information Collection Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857 or paperwork@hrsa.gov. Please see https://www.hrsa.gov/about/508-resources for the HRSA digital accessibility statement.

Small Health Care Provider Quality Improvement Grant Program

SECTION 1: ACCESS TO CARE *(applicable to all grantees)*

This section collects information about 1) the number of individuals served from your grant project's targeted patient population (full patient panel) and 2) the types of services provided, by your grant project during the reporting period. Please reference the following guidance for instructions about how to complete responses to these measures.

Instructions - Measure 1, 1a, 1b &2:

- All sections must be completed. Responses left blank will result in a form validation error.
- Responses should be consistent with figures indicated in your project's awarded grant application, and/or most recent HRSA approved work plan.
- A justification, provided in the section's form comment box, is required for any deviations from the awarded grant application figures reported.
- Please also include, in the section's form comment box, any applicable information pertinent for accurate interpretation of responses provided.
- All measure definitions for this section can be found in Appendix A. Section 1.

1	Target Population	Year 1	Year 2	Year 3	Year 4
	Number of counties served in project *Note:* This number should be consistent with the figures reported in your grant application and should reflect your project's service area. **Please specify the names of the counties served. (Text box entry)**				

	Number of people in the target population *Note*: This number should be consistent with the number of individuals in your organization's general target population at large. This should be consistent with the figures reported in your grant application.				
	Number of people in the Full Patient Panel *Note:* This number should be consistent with the number of individuals identified to receive direct services from your organization's funded grant project intervention for the duration of the four year funding period.				
	Changes to Target Population Measures Were there were any changes to the number of counties served, the number of people in the target population and/or the number of people in the full patient panel for your grant project during the budget period?	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**
	Justification for Changes If yes, a justification supporting the rationale for changes to any of these measures is required. Please include your response in the designated text box provided.	**Text field response**	**Text field response**	**Text field response**	**Text field response**
1a	**Direct Service Encounters**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Number of unique (i.e. unduplicated count) patients/clients that received direct services during this budget period. *Note:* Direct Services is defined for this measure as a documented interaction between a patient/client and a clinical or non-clinical health professional that has been funded with FORHP grant dollars during the grant budget period. Examples of direct services include (but are not limited to) patient visits, counseling and education.				
1b	**Direct Service Encounters Provided by Partner Organizations**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Number of *project partner sites* contributing to the number of unique (i.e. unduplicated count) patients/clients that received direct services during this budget period. *Note:* This is applicable *only* to projects who are working across more than one project site to implement project activities and/or provide direct services reported in PIMS.				
2	**Type of Direct Service Encounters *(Select All That Apply)*** Using the selection list, please select the type of grant funded direct services provided during the grant budget period.	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Chronic Disease Management				
	Chronic Disease Prevention				
	Medication Management				
	Nutrition Education and/or Counseling				
	Physical Exercise Education and/or Counseling				
	Substance and/or Other Drug Use Disorder Treatment and/or Education				
	Other Mental/Behavioral Health Treatment and/or Education *(non-substance or other drug use disorder services)*				

	Care Coordination/Transition of Care Services *(include referrals)*				
	Other (*Please specify)*				

SECTION 2: POPULATION DEMOGRAPHICS *(applicable to all grantees)*

This section collects information about the number of individuals served by your funded grant project during the reporting period categorized by race, ethnicity, age and health insurance status.

Instructions - Measures 3-4:

- All sections must be completed. Responses left blank will result in a form validation error.
- Response totals reported for each measure in this section must equal the total ***number of individuals who received direct services*** reported for measure 1 reported in the previous section.
- Please refer to the specific definitions for each field below for additional measure guidance and instructions. All measure definitions for this section can be found in Appendix A. Section 2.

Measure 3: Number of Individuals Served by Race and Ethnicity

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.

	Number of Individuals Served by Race and Ethnicity					
	Line	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 received direct services

	Number of Individuals Served by Age Group	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Children (0-12)				
	Adolescents (13-17)				

	Adults (18-64)				
	Elderly (65 and over)				
	Unknown				
	Total *(Automatically calculated. Equal to the total of the number of unique individuals who received direct services)*				

Instructions - Measures 5: Number of Individuals by Health Insurance Status

- Please include Medicare Advantage coverage under "private insurance" as a private plan purchased through Medicare for the purposes of this reporting.
- If a patient is active duty military or obtaining health care under the Indian Health Service, please include in "other" for the purposes of this reporting.
- Medicare Plus Supplemental counts individuals covered by Medicare Plus Supplemental *only*.

	Number of Individuals by Health Insurance Status	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Private Insurance ***(Employer and/or Individual Health Insurance)***				
	None/Uninsured				
	Dual Eligible *(Covered by both Medicaid and Medicare)*				
	Medicaid/CHIP *(only)*				
	Medicare Plus Supplemental				
	Medicare *(only)*				
	Other Third Party				
	Unknown				
	Total *(Automatically calculated. Equal to the total of the number of unique individuals who received direct services)*				

SECTION 3: SUSTAINABILITY *(applicable to all grantees)*

This section collects information/data about your grant project's sustainability. Please select the type(s) of sources of funding for sustainability and include the dollar amount obtained by each source, if known.

Instructions – Measures 6-8:

- If applicable and data is available, include information pertaining to funding stream sources contributing to your organization's grant project, accrued during the budget period.
- Please refer to Appendix A. Section 3 for the definitions of all terminology included under this section.

6	**Source of Sustainability**	**Program Revenue/Funding Sources** *(Dollar Amount)*
	In-kind Contributions	
	Membership Fees/Dues	
	Fundraising/ Monetary Donations	
	Contractual Services	
	Other Grants	
	Fees Charged to Individuals for Services	
	Product sales	
	Government (non-grant)	
	Private Insurance Company Incentives	
	Other – specify type	

	Accountable Care Organization (ACO) Participation Incentives	
	Medicare Service Reimbursement	
	Transitional Care Management (TCM)	
	Chronic Care Management (CCM)	
	General Behavioral Health Integration (BHI)	
	Psychiatric Collaborative Care Model (CoCM)	
	Advanced Care Planning (ACP)	
	Annual Wellness Visit (AWV) *(includes Initial Preventive Physical Examination)*	
	Other Medicare Service Reimbursement *(please specify)*	

Measures 7 & 8: ***Measures 8 & 8a for Year 4 Reporting Only***

Sustainability		**Year 1**	**Year 2**	**Year 3**	**Year 4**
7	**What is your ratio for Economic Impact vs. HRSA Program Funding?** *Note:* Use the HRSA's Economic Impact Analysis Tool **https://www.ruralhealthinfo.org/econtool** to identify your ratio. Reponses should reflect the ratio for the annual economic impact for your grant's budget year funded for your project's ***annual*** reporting period.	**Ratio**	**Ratio**	**Ratio**	**Ratio**
8	**What is your ratio for Economic Impact vs. HRSA Program Funding?** *Note:* Use the HRSA's Economic Impact Analysis Tool **https://www.ruralhealthinfo.org/econtool** to identify your ratio. Reponses should reflect the ratio for the ***cumulative economic impact across the duration of your grant's full four-year funding cycle.***	**n/a**	**n/a**	**n/a**	**Ratio**
8a	**Will any of the program's activities be sustained after the project period?**	**n/a**	**n/a**	**n/a**	**(Some/ None/All)**

SECTION 4: CONSORTIUM/NETWORK *(For network and/or consortium partner participation in the implementation of funded grant projects **only)***

Instructions - Measure 9a-9b:

- ***Only*** applicable to grant projects that involve participation of network and/or consortium partners for the implementation of funded grant project activities and/or services.
- If applicable, responses should reflect the total number of network and/or consortium member partners for each type of organization listed in the table. If an organization type for your grant project's network and/or consortium member partners is not listed in the table, please select "other" and specify the type (s) of other organization(s) in the text box provided.
- If a network and/or consortium member partner is more than one organizational type (e.g. faith-based long-term care facility, etc.), please select the appropriate boxes and notate this information in the form comment box for this section additionally.
- Please refer to Appendix A. Section 4 for definitions of all terminology included under this section.

9a	Number of Member Organizations in the Consortium/Network	Number
	Area Agency on Aging	
	Area Health Education Center (AHEC)	
	Business	
	Community Health Center/ Federally Qualified Health Center (FQHC)	
	Critical Access Hospital	
	Emergency Medical Service	
	Faith-Based Organization	
	Health Department	
	HIT Regional Extension Center	
	Hospice	
	Hospital, not Critical Access	
	Long Term Care Facility	
	Mental Health Center	
	Pharmacy	
	Private Practice (Medical and/or Dental)	
	Professional Association	
	Public Health Department	
	Rural Emergency Hospital (REH)	
	Rural Health Clinic	
	School District	
	Social Services Organization	
	Tribal Entity	

University/College/Community College/Technical College	
Other – Specify Type:	

SECTION 5: QUALITY IMPROVEMENT *(applicable to all grantees)*

This section focuses on elements specific to quality improvement occurring as part of grant funded project implementation.

Instructions – Measures 10a-b

- Please select from the lists below all responses that apply to your grant funded quality improvement project implementation.
- Please refer to Appendix A. Section 5 for definitions of all terminology included under this section.

10a	**Approaches to Quality Improvement** Please select from the lists below all responses which best reflect the quality improvement approaches utilized as part of your grant funded quality improvement project implementation. More than one selection can be made for each section.	
	Health Technology	**Selection list**
	Computerized Provider Order Entry (CPOE)	
	Electronic Entry of Prescriptions/E-Prescribing	
	Health Information Exchange (HIE)	
	Population Health Management Software	
	Electronic Patient or Disease Registry	
	Certified Electronic Health Record System (CEHR)	
	Electronic Patient Portal System	
	Remote Patient Monitoring	
	Telehealth or Telemedicine	
	Mobile Technology	
	Other Health Technology *(please specify)*	**Selection list & Text box**
	Patient Care/Service Delivery	**Selection list**
	Patient Referral Management /Tracking System	
	Health Literacy	
	Individualized Patient Care Plans/Case Management	
	Patient Safety *(specific patient safety processes and/or strategies in place)*	
	Integrated Care Delivery System *(agreements with specialists, hospitals, community organizations, ambulatory services, etc. to coordinate care)*	
	Multidisciplinary Care Team(s)	
	Healthcare Professional Continuation Education and/or Training *(includes training for providers and mid-level practitioners)*	

	Other *(please specify)*	**Selection list & Text box**
	Quality Improvement Methodology	**Selection list**
	Lean Model *(Includes Lean Six Sigma)*	
	Model for Improvement *(with PDSA)*	
	PDSA only	
	Chronic Care Model	
	Other *(please specify)*	**Selection list & Text box**
	Organizational Positioning	**Selection list**
	Value-Based Care (VBC) Program Participation *(Specific to the Centers for Medicare and Medicaid Services (CMS) value-based programs)*	
	Accountable Care Organization (ACO) Participation	
	Patient Centered Medical Home Model (PCMH) Participation	
	Quality Ambulatory Care Accreditation *Note:* For projects seeking any form of organizational quality accreditation as part of funded grant project activities. This also includes accreditation for any grant project partner organizations. Please also specify the respective accrediting body(s) in the text field, if known.	**Selection list & Text box**
	Other *(Please Specify)*	**Selection list & Text box**
10b	**Agency for Healthcare Research and Quality (AHRQ)** Please select, from the list below, all responses which best reflect the utilization of any AHRQ resources, tools, guidelines, measures, etc. as part of your grant funded quality improvement project implementation, as applicable.	**Yes/No**
	AHRQ Clinical Guidelines and/or Recommendations	
	AHRQ Toolkits	
	AHRQ Evidence-Based Models	
	AHRQ Measures/Indicators	
	Other *(please specify)*	

Instructions -- Measure 11a-c:

- Applicable *only* to funded grant projects that include activities and/or services focusing on the integration of mental/behavioral health into the primary care setting.
- If applicable, please complete responses using the table provided by indicating a selection that corresponds best to the status of your funded grant project's *Healthcare Service Delivery & Organizational Practice Domains* accomplished during the reporting period of performance.
- Please refer to the table and Appendix A. Section 5 for definitions of all terminology included under this section.

Integration of Mental/ Behavioral Health into the Primary Care Setting

11a Healthcare Service Delivery & Organizational Practice Domains	Not Implemented/Not Integrated	Partially Implemented/Partially Integration	Fully Implemented/Fully Integrated
Care Team Expertise The team is tailored to the needs of particular patients and populations—with a suitable range of expertise and roles.			
Clinical Workflow Utilization of shared operations, workflows, and protocols to facilitate collaboration are in place. Clinical protocols and workflows are clearly documented for integration of care. Operational workflows, processes, and quality control processes to support integrated behavioral health care are specified and documented.			
Patient Identification The team employs systematic methods to identify and prioritize individuals in need of integrated care.			
Patient and Family Engagement Patients and family are engaged (as appropriate) as active members in the integrated care team and in shared care plans. Protocols or workflows for patient and family engagement are documented for care teams and in care plans.			
Treatment Monitoring Systematic measurement of patient outcomes is implemented, adjusting treatment over time, as needed, to meet desired patient outcomes identified.			
Leadership Alignment Explicit, shared values with a visible leadership commitment to establish and maintain collaborative integrated behavioral health care exists.			
Business Model Sustainability A business model that is sustainable for the practice, its providers, and its patients is in place. Financial performance of the integrated behavioral health aspect of the practice is monitored and modified, as needed, to ensure or improve sustainability of behavioral health			
Data Collection and Use Practice-wide systems to collect and use data for data-driven quality improvement are expected and present. This includes the monitoring and documentation of patients' clinical outcomes to assess impact of integration of care.			

Other *(please specify)*				
Number of Mental/Behavioral Healthcare	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Please provide the number of new mental/behavioral healthcare providers successfully hired and/or contracted to provide mental/behavioral healthcare services in the primary care setting as a result of funded grant project activities during the reporting period?				
How many total full-time equivalent (FTE) hours of mental/behavioral healthcare provider personnel positions have been allocated to provide mental/behavioral healthcare services in the primary setting as a part of grant funded project activities during				
Number of Mental/Behavioral Healthcare Direct Service Encounters	**Year 1**	**Year 2**	**Year 3**	**Year 4**
Please provide the number of unique individuals who received mental/behavioral healthcare direct services in the primary care setting as a result of funded grant activities during the budget reporting period.				

SECTION 6: UTILIZATION *(optional)*

Instructions – Measure 12:

- Please respond using the table provided under this section, if applicable.
- Hospital utilization tracking should be specific to your funded grant project full patient panel population identified to be tracked for your project.
- Please refer to Appendix A. Section 6 for specific calculation instructions for completion of measure responses and for definitions of all terminology included under this section.

12	**Hospital Utilization**	**Numerator**	**Denominator**	**Calculation (%)**
	Emergency Department (ED) Utilization Rate			
	30-Day Emergency Department (ED) Re-Admission Rate			
	30-Day Hospital Re-Admission Rate			

SECTION 7: TELEHEALTH *(applicable to grantees utilizing telehealth services)*

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 grant project utilized telehealth during the reporting period, please fill out the table below as follows.

- If this measure section *is applicable* (i.e. telehealth was a grant funded activities completed during the budget period), please proceed in referring to the section's instructions for completion of the measure.
- If this measure *is applicable* (i.e. telehealth was a grant funded activities completed during the budget period) but the requested information is unable to be reported, please select this option for your response to this section and complete the required text field with a statement indicating why the requested information is unable to be reported.
- If this measure is *not applicable* (i.e. telehealth was *NOT* a grant funded activities completed during the budget period), please select this option for your response to this section and proceed to the next section.

Instructions – Measure 13:

- Download the Excel spreadsheet to help you total these numbers. To download, right click with your mouse on the link above and choose "Save Target As..." then choose a location and filename on your computer which makes sense to you.
- 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.

- Please refer to Appendix A. Section 7 for definitions of all terminology included under this section.
- All responses should reflect services provided to your funded grant project's target patient population during the budget period.

Question 13					
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 8: CLINICAL MEASURES *(applicable to all grantees)*

Instructions Measures 14-19:

This section collects information about measures for clinical outcomes relating to certain direct services provided to the **unique individuals who received direct services funded by this grant during this budget period**. The denominator for all measures should be based only on the population of unique persons (i.e., an unduplicated count of persons) who received direct services through this grant during this budget period.

- Please refer to the specific definitions for each field provided in the tables below. For additional details and clarification, please consult each measure's hyperlink and/or your assigned HRSA Project Officer.
- Responses should be provided as a numerical value
- Please select the selection box labeled "not applicable" if a measure is not applicable to report for your grant project. An explanatory justification is required for all measures indicated as "not applicable" and must be completed in the corresponding measure's text field box for form completion.
- Please use the form comment box for this section to provide any additional information needed to interpret the values reported.

14	**Measure 1: Cardiovascular Disease** CMS347v6 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		
	Number (Denominator) Total number of patients in the funded grant project target patient population considered at high risk for cardiovascular events *(met one or more of the measure criteria)* during the budget period	**Number (Numerator)** Number of patients in the funded grant project target patient population actively using or received a prescription for statin therapy during the budget period	**(%)**
15	**Measure 2: Diabetes Care - Hemoglobin A1c (HbA1c) Poor Control** NQF 0059/CMS122v11 Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period		
	Number (Denominator) Total Patients 18 through 75 Years of Age with Diabetes in the funded grant project target patient population during the budget period	**Number (Numerator)** Patients with HbA1c >9% in the funded grant project target patient population during the budget period	**(%)**
16	**Measure 3: Body Mass Index (BMI) Screening and Follow-Up** NQF 0421/CMS69v11 Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters (Normal Parameters: Age 65 years and older BMI > or = 23 and < 30; Age 18 – 64 years BMI > or = 18.5 and < 25)		
	Number (Denominator) Total Patients Aged 18 and Older in the funded grant project target patient population during the budget period	**Number (Numerator)** Number of Patients in the funded grant project target patient population with BMI Outside Normal Parameters and Follow-Up Plan documented during the encounter or during the previous twelve months of the encounter.	**(%)**
17	**Measure 4: Blood Pressure** NQF 0018/CMS165v11 Percentage of patients 18-85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90mmHg) during the measurement period.		
	Number (Denominator) Total Patients 18 through 85 Years of Age in the funded grant project target patient population who had a diagnosis of Hypertension during the budget period	**Number (Numerator)** Number of Patients in the funded grant project target patient population whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the budget period.	**(%)**
18	**Measure 5: Tobacco Use NQF 0028** CMS138v11 Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, *and* (2) if identified to be a tobacco user received cessation counseling intervention.		
	Number (Denominator) All patients aged 18 years and older in the funded grant project target patient population seen for at least two visits or at least one preventive visit during the budget period.	**Number (Numerator)** Number of Patients in the funded grant project target patient population Screened for Tobacco Use* *and* who received tobacco cessation counseling intervention during the budget period** 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.*	**(%)**

19	**Measure 6: Depression Screening** CMS2v12 Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool *and*, if screening was positive, (2) had a follow-up plan documented.		
	Number (Denominator) Total Patients Aged 12 and Older in the funded grant project target patient population during the budget period	**Number (Numerator)** Patients screened for clinical depression using an age appropriate standardized tool AND, if screening was positive, had a follow-up plan documented during the budget period	**(%)**

SECTION 9: OPTIONAL CLINICAL MEASURES *(optional)*

Instructions – Optional Measures 20-25:
This optional section collects information, if it is applicable to your funded grant project, about measures for clinical outcomes relating to certain direct services provided to the **unique individuals who received direct services funded by this grant during this budget period**. For any applicable measures selected in this section to report, the denominator should reflect the population of unique persons (i.e., an unduplicated count of persons) who received direct services through this grant during this budget period.

- Please refer to the specific definitions for each field provided in the tables below. For additional details and clarification, please consult each measure's hyperlink and/or your assigned HRSA Project Officer.
- Responses should be provided as a numerical value
- For measures in this section not selected to report, please select the selection box labeled "not applicable"
- Please use the form comment box for this section to provide any additional information needed to interpret the values reported.

20	**Optional Measure 1: Weight Assessment and Counseling for Children/Adolescents** NQF 0024/CMS155v11 Percentage of patients 3–17 years of age with a body mass index (BMI) percentile *and* counseling on nutrition *and* physical activity documented.		
	Number (Denominator) Total number of patients 3-17 years of age in the funded grant project target patient population with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the budget period	**Number (Numerator)** Total patients aged 3 through 17 in the funded grant project target patient population who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the budget period: • patients who had height, weight, and BMI percentile documentation • patients who had counseling for nutrition • patients who had counseling for physical activity	**(%)**
21	**Optional Measure 2: Alcohol and Drug Dependence Treatment** CMS137v11 Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence and treatment services		

	Number (Denominator) Number of patients age 13 years of age and older in the funded grant project target patient population who were diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency during the budget period.	**Number (Numerator)** Number of patients in the funded grant project target patient population who initiated treatment within 14 days of the diagnosis during the budget period AND the number of patients in the funded grant project target patient population who initiated treatment and who had two or more additional services with an alcohol, opioid, or other drug abuse or dependence diagnosis within 30 days of the initiation visit during the budget period.	**(%)**
22	**Optional Measure 3: 30-Day Hospital-Wide All-Cause Unplanned Readmission** NQF 1789 Hospital-level, risk-standardized rate of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge for patients aged 18 and older.		
	Number (Denominator) Total Number of All-Cause Hospital Admissions for Patients 18 years and Older in the funded grant project target patient population during the budget period	**Number (Numerator)** Number of Unplanned All-Cause 30-Day Hospital Readmissions for patients in the funded grant project target patient population during the budget period	**(%)**
23	**Optional Measure 4: Chronic Obstructive Pulmonary Disease (COPD)** NQF 0102 Percentage of patients aged 18 years and older with a diagnosis of COPD, have FEV1/FVC < 70% and symptoms who were prescribed a long acting inhaled bronchodilator.		
	Number (Denominator) Total number of patients aged 18 years and older in the funded grant project target patient population with a diagnosis of COPD, who have an FEV1/FVC <70% and have symptoms (e.g., dyspnea, cough/sputum, wheezing) during the budget period	**Number (Numerator)** Total number of COPD Patients in the funded grant project target patient population Prescribed an Inhaled Bronchodilator during the budget period	**(%)**
24	**Optional Measure 5: Care Coordination (Medication Documentation)** NQF0419e/CMS68v12 Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician 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.		
	Number (Denominator) Total Number of Visits for Patients aged 18 years and older in the funded grant project target patient population during the budget period	**Number (Numerator)** Total Number of Current Patient Medication Documentations, Updates, or Reviews using all immediate resources available on the date of the encounter for patients in the funded grant project target patient population during the budget period.	**(%)**

25	**Other Clinical Quality Measures (CQM)**	**Year 1**	**Year 2**	**Year 3**	**Year 4**
	Did your grant project track a Clinical Quality	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**

	Measure (CQM) during the grant budget period that is not provided in the table above? If yes, please use the text field table below to complete the measure title, number, numerator and denominator your grant project has measured as part of funded grant project activities for your grant project's target population during the budget period.				
	Clinical Quality Measure Title (allows for up to five open text fields)	**Numerator**	**Denominator**	**Percent**	

Appendix A
Section Definitions

Definitions Section 1: Access to Care

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. This includes both face-to-face in-person encounters as well as non face-to-face encounters.

Targeted Patient Population: Refers to the target patient population (full patient panel) identified in your grant project's application proposal to receive the proposed project activities and/or service and tracked across the four year performance period to demonstrate improvements in health outcomes as a result of the funded grant project.

General Patient Population: number of unique individuals in the entire population of patients served by organizations directly engaged in grant funded activities.

Full Patient Panel: number of unique individuals served by the grant project intervention receiving grant funded services and/or activities that is being tracked and measured across the four years of the grant period to show impact of funded project on patient health outcomes.

Definitions Section 2: Population Demographics Insurance Status/Coverage

Private Insurance (Employer and/or Individual Health Plan): Health insurance provided by commercial and not for profit companies. Individuals may obtain insurance through employers or on their own.

Uninsured: Those without health insurance.

Medicare (Only): Federal insurance for the aged, blind, and disabled (Title XVIII of the Social Security Act). For the purposes of this reporting, coverage reported under Medicare, should also be inclusive of all Medicare coverage (other than dual eligible and Medicare supplemental coverage including Medicare Advantage as well as beneficiaries with supplemental coverage such as Medigap, employer sponsored or Veteran's Administration (VA) coverage).

Medicare Plus Supplemental: A Medicare Supplement Insurance (Medigap) policy helps pay some of the health care costs that. Original Medicare doesn't cover, like copayments or coinsurance. Coverage including Medicare Advantage as well as beneficiaries with supplemental coverage such as Medigap, employer sponsored or Veteran's Administration (VA) coverage.

Medicaid: is defined as State-run programs operating under the guidelines of Titles XIX (and XXI as appropriate) of the Social Security Act. For the purposes of this reporting, insurance coverage under Children's Health Insurance Program (CHIP) should be included within the reporting for this category.

Dual Eligible: Covered by both Medicaid and Medicare

Children's Health Insurance Program (CHIP): Jointly funded state and federal government program which provides health coverage to eligible children, through both Medicaid and separate CHIP programs administered by states, in accordance to federal requirements. For the purposes of this reporting, please report Medicaid (not including CHIP) separately from those including CHIP under Medicaid.

Other Third Party: Includes coverage through state and/or local government programs such as state-sponsored or public assistance programs only.

Definitions Section 3: Sustainability

Annual Program Revenue: Payments received for the services provided by the program that the grant supports. These services should be the same services outlined in your grant application work plan. Please do not include donations. If the total amount of annual revenue made is zero (0), please put zero in the appropriate section.

Additional Funding: Funding already secured to assist in sustaining the project. Donations should be included in this section.

In-Kind Contributions: Donations of anything other than money, including goods or services/time.

Accountable Care Organization (ACO): A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to Medicare patients.

Transitional Care Management: Transitional Care Management, under Medicare Part B, refers to coordination and management services for a patient's care the first 30 days following an inpatient stay.

Chronic Care Management: Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

General Behavioral Health Integration (BHI): Refers to General Behavioral Health Integration (BHI) Services reimbursable under Medicare through the Centers for Medicare & Medicaid Services (CMS).

Psychiatric Collaborative Care Model (CoCM): Refers to Psychiatric Collaborative Care Model (CoCM) services reimbursable under Medicare through the Centers for Medicare & Medicaid Services (CMS) and reflective of a model of behavioral health integration that enhances "usual" primary care by

adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving.

Advanced Care Planning: Advanced Care Planning, covered under Medicare Part B as part of the yearly wellness visit, is planning for care when patients become ill and unable to speak for themselves through an advance directive, a written document stating how a patient would like medical decisions to be made if ability to make them decisions for themselves is lost. This pay also include a living will and a durable power of attorney for health care.

Annual Wellness Visit: Annual Wellness Visit (AWV) is a Medicare covered yearly appointment to discuss plan of preventive care in the coming year.

Definitions Section 4: Consortium/Network

Consortium/Network: A consortium or network is defined as collaboration between two or more separately owned organizations. For the purposes of this reporting, this may include accountable care organizations (ACO) and other integrated health system structures and/or partnerships.

Definitions Section 5: Quality Improvement

Computerized Provider Order Entry (CPOE): CPOE is the process of a medical professional entering orders for medications, diagnostic studies, imaging studies, therapeutic services, nutrition and food services, nursing services, and other orderables to be supplied into a computer system application. For the purposes of this reporting, CPOE systems instituted as either a module or component of an integrated information system or electronic health record (EHR), or as a standalone system that is interfaced or integrated through a clinical data repository in addition to physician offices or clinic are included. Modules may also not necessarily be called CPOE by name, but have a similar functionality embedded in their EHR.

Electronic Entry of Prescriptions/E-Prescribing: Electronic entry of prescriptions, or e-prescribing**,** is a technology framework that allows physicians and other medical practitioners to write and send prescriptions to a participating pharmacies electronically instead of using handwritten, faxed notes or calling in prescriptions. For the purposes of this reporting, this measure includes both standalone e-prescribing systems as well as e-prescribing systems that are part of an EHR system.

Health Information Exchange (HIE): Electronic health information exchange allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care. Definition is inclusive of all three current key forms of HIE including:

- ***Directed Exchange*****:** ability to send and receive secure information electronically between care providers to support coordinated care
- ***Query-Based Exchange:*** ability for providers to find and/or request information on a patient from other providers, often used for unplanned care
- ***Consumer Mediated Exchange:*** ability for patients to aggregate and control the use of their health information among providers

Population Health Management Software: Population health management tools help providers aggregate and analyze data to create a comprehensive, actionable clinical picture of each patient. Using

the information generated by these tools, providers can track and improve clinical outcomes — and lower health care costs.

Electronic Patient or Disease Registry: A tool for tracking the clinical care and outcomes of a defined patient population automated and/or calibrated electronically. Disease/immunization registries are often used to support patients with chronic diseases, such as diabetes, coronary artery disease, or asthma.

Certified Electronic Health Record System (CEHR): Certification of health IT assures purchasers and other users that an electronic health record system, or other relevant technology, offers the technological capability, functionality, and security to help them meet the meaningful use criteria established for a given phase.

Electronic Patient Portal: A patient portal is a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information.
Electronic Patient Portal System.

Remote Patient Monitoring (RPM): Remote patient monitoring uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

Telehealth or Telemedicine: Telehealth / telemedicine is the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Mobile Technology (mHealth): mHealth (mobile health) is a general term for the use of mobile phones and other wireless technology in medical care. The most common application of mHealth is the use of mobile phones and communication devices to educate consumers about preventive health care services.

Patient Referral Management/Tracking System: A comprehensive institutional framework, agreements, system, processes and/or strategies that connects various health care facilities and professionals with well-defined processes for effective coordination of provided recommended patient care referrals.

Individualized Patient Care Plans/Case Management: A document developed with a purpose to maximize improvement of individual patient health outcomes following an initial patient assessment which identifies patient-specific care goals and objectives relative to the individual patient's specific diagnoses, intervention, medication, referral and care needs. The plan typically also includes an operative timeframe for accomplishment and evaluation and formulated with input from the patient and the patient's family.

Patient Safety: Patient safety is a discipline that emphasizes safety in health care through the prevention, reduction, reporting, and analysis of medical error that often leads to adverse effects.

Integrated Care Delivery System: For the purposes of this reporting, integrated care delivery systems refers to agreements with specialists, hospitals, community organizations, etc. to coordinate care of patients. This definition is inclusive of integration across different levels of service, multiple care sites

and/or across policy-making and management that bring together decisions about different parts of the health services, at different levels.

Health Literacy: Health Literacy refers to the degree of which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Lean Model: This model defines value by what a customer (i.e., patient) wants. It maps how the value flows to the customer (i.e., patient), and ensures the competency of the process by making it cost effective and time efficient.

Six Sigma: Six Sigma is a measurement-based strategy for process improvement and problem reduction. It is completed through the application of the QI project and accomplished with the use of two Six Sigma models: 1) DMAIC (define, measure, analyze, improve, control), which is designed to examine existing processes, and 2) DMADV (define, measure, analyze, design, verify) which is used to develop new processes.

Lean Six Sigma: Combined practice of Six Sigma and Lean models

Plan Do Study Act (PDSA): The Plan-Do-Study-Act cycle is a methodology utilized for testing a change as part of the Institute for Healthcare Improvement Model for Improvement. The cycle involves assessment of change specifically through the scientific method, used for action-oriented learning by planning, implementing, observing results, and acting on what is learned.

Model for Improvement: This model focuses on three questions to set the aim or organizational goal, establish measures, and select changes. It incorporates Plan-Do-Study-Act (PDSA) cycles to test changes on a small scale.

Chronic Care Model: There are six fundamental aspects of care identified in the Care Model, which creates a system that promotes high-quality disease and prevention management. It does this by supporting productive interactions between patients, who take an active part in their care, and providers, who have the necessary resources and expertise.

Value-Based Care Programs: Refers to the Centers for Medicare & Medicaid Services (CMS) value-based care programs which are designed to reward health care providers with incentive payments for the quality of care they give to people with Medicare.

Accountable Care Organization (ACO): Medicare Shared Savings Program (Shared Savings Program) ACOs are a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to Medicare patients. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, the ACO may be eligible to share in the savings it achieves for the Medicare program (also known as performance payments).

Patient-Centered Medical Home: Comprehensive and continuous medical model of care that puts patients at the forefront of care with the goal of obtaining maximized health outcomes, improve quality and the patient experience, and increase staff satisfaction while reducing health care costs. To become a medical home an organization generally gains a level of certification from an accrediting body.

Ambulatory Care Accreditation: Ambulatory care accreditation assesses health organizations' quality and patient safety. It also evaluates them against standards of quality improvement, quality assurance, risk management, and performance improvement.

Definitions for Levels of Integration Table:
Healthcare Service Delivery & Organizational Practice Domains

***Care Team Expertise*:** The team is tailored to the needs of particular patients and populations—with a suitable range of expertise and roles.

Clinical Workflow: Utilization of shared operations, workflows, and protocols to facilitate collaboration are in place. Clinical protocols and workflows are clearly documented for integration of care. Operational workflows, processes, and quality control processes to support integrated behavioral health care are specified and documented.

Patient Identification: The team employs systematic methods to identify and prioritize individuals in need of integrated care.

Patient and Family Engagement: Patients and family are engaged (as appropriate) as active members in the integrated care team and in shared care plans. Protocols or workflows for patient and family engagement are documented for care teams and in care plans.

Treatment Monitoring: Systematic measurement of patient outcomes is implemented, adjusting treatment over time, as needed, to meet desired patient outcomes identified.

Leadership Alignment: Explicit, shared values with a visible leadership commitment to establish and maintain collaborative integrated behavioral health care exists.

***Business Model Sustainability*:** A business model that is sustainable for the practice, its providers, and its patients is in place. Financial performance of the integrated behavioral health aspect of the practice is monitored and modified, as needed, to ensure or improve sustainability of behavioral health integration.

Data Collection and Use: Practice-wide systems to collect and use data for data-driven quality improvement are expected and present. This includes the monitoring and documentation of patients' clinical outcomes to assess impact of integration of care.

Definitions Section 6: Hospital Utilization

Emergency Department Utilization (ED) Calculation

Numerator / Denominator = Emergency Department Utilization (ED)

Numerator = Total number of patient ED admissions
Numerator Inclusion Criteria

- ED admissions are counted for patients within your *grant project's specified target patient population (full patient panel)* ***only***.
- ED admissions are to be counted with respect to your *grant project's specified related disease condition(s)* ***only*.** This is not intended to count all-cause admissions but count admissions specific to conditions addressed by the services and activities implemented for your funded grant project

- ED admission are counted as ED admissions that occurred within the current grant project reporting period of performance timespan
- Multiple ED admissions for the same patient *is* included in this value. Ex. Ms. Doe was admitted to the ED and then re-admitted two months later, both within the budget period timeframe. Ms. Doe's admissions would be counted as a total of two (2) for this numerator.

Denominator = Total number of unique individuals from your project's target patient population (full patient panel) who received direct services during this project performance period reporting.
Denominator Inclusion Criteria

- Value reported should be consistent with the same numerical value reported for the numerator reported for measure 1.
- The total number reported includes the total number of unique individual patients only. No patient should be counted more than once.

30-Day Emergency Department (ED) Re-Admission Calculation

Numerator / Denominator = 30-Day Emergency Department (ED) Re-Admission

Numerator **=** Total number of patient 30-Day ED re-admissions
Numerator Inclusion Criteria

- 30-day ED re-admission of patients include patients within your *project's specified target patient population (full patient panel)* ***only***.
- 30-day ED admissions are to be counted with respect to your *grant project's specified related disease condition(s)* ***only*****.** This is not intended to count all-cause admissions but count admissions specific to conditions addressed by the services and activities implemented for your funded grant project
- 30-day ED re-admissions that occurred within the current grant project reporting period of performance timespan
- Duplicate 30-day ED re-admission for the same patient *is* included in this value. Ex. Ms. Doe was admitted to the ED within 30 days on two different accounts within the budget period timeframe. Ms. Doe's 30-day ED re-admissions would be counted as a total of two (2) for this numerator.

Denominator **=** Total number of patient ED admissions
Denominator Inclusion Criteria

- ED admissions are counted for patients within your grant project's *specified target patient population (full patient panel)* ***only***.
- ED admissions are to be counted with respect to your *grant project's specified related disease condition(s)* ***only*****.** This is not intended to count all-cause admissions but count admissions specific to conditions addressed by the services and activities implemented for your funded grant project
- ED admission are counted as ED admissions that occurred within the current grant project reporting period of performance timespan
- Multiple hospital re-admissions for the same patient is included in this value. Ex. Ms. Doe was admitted to the ED and then re-admitted two months later, both within the budget period timeframe. Ms. Doe's admissions would be counted as a total of two (2).
- Value reported should be consistent with same value reported for the numerator used for the calculation of the Emergency Department Admission Rate in the previous measure.

30-Day Hospital Re-Admission Calculation

Numerator / Denominator = 30-Day Hospital Re-Admission

Numerator = Total number of patient 30-day hospital re-admissions
Numerator Inclusion Criteria

- 30-day hospital re-admission of patients include patients within your *grant project's specified intervention patient population* ***only***.
- 30-day hospital admissions are to be counted with respect to your *grant project's specified intervention focus* ***only*** (this is not intended to be all-cause re-admissions but specific to conditions related to grant project).
- 30-day hospital re-admissions that occurred within the current grant budget reporting period timespan.
- Duplicate 30-day hospital re-admission for the same patient *is* included in this value. Ex. Ms. Doe was admitted to the ED within 30 days on two different accounts within the budget period timeframe. Ms. Doe's 30-day hospital re-admissions would be counted as a total of two (2) for this numerator.

Denominator = Total number of patient hospital admissions
Denominator Inclusion Criteria

- Hospital admissions count patients within your grant project's *specified target patient population (full patient panel)* ***only***.
- Hospital admissions are to be counted with respect to your *grant project's specified related disease condition(s)* ***only*****.** This is not intended to count all-cause admissions but count admissions specific to conditions addressed by the services and activities implemented for your funded grant project
- Hospital admission are counted as hospital admissions that occurred within the current grant project reporting period of performance timespan
- Multiple hospital admissions for the same patient is included in this value. Ex. Ms. Doe was admitted to the hospital and then re-admitted two months later, both within the budget period timeframe. Ms. Doe's admissions would be counted as a total of two (2).

Definitions Section 7: Telehealth

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.