

**Population Health Award**

**2019-2020**

**Application Form**

**Award Description**The Population Health Award is available to critical access hospitals in Illinois. The intent of this award is to provide funding to for CAHs to develop strategies for engaging with community partners and targeting specific health needs to enhance population health. The CAHs should utilize the award monies to conduct community outreach projects based upon needs identified in Community Health Needs Assessment (CHNA).

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**Award Project Suggestions:**

* Create Hospital Care Coordination Program
* Implement Community Health Education Program
* Implement Hospital Care Management/Case Management Program
* Telemedicine or Mobile Health Projects
* Consortium development with local healthcare providers to reduce readmissions
* Implement an evidence-based health program to address chronic conditions
* Implement an employee or community based wellness program
* Implement a Drug and/or Alcohol Dependence Prevention Programs
* Healthy Diet & Fitness Promotion Program

**Project Period: September 1, 2019 – June 30, 2020**

**Amount: $7,500 maximum for each recipient. There are approximately 12 awards available.**

**Application Deadline: December 6, 2019**

**Contact: Brian Ashpole, Data and Grant Project Coordinator**

 **Illinois Critical Access Hospital Network**

 **1945 Van’s Way**

 **Princeton, IL 61356**

 **Phone: (815) 875-2999**

**bashpole@icahn.org**

**Application Instructions**

All application fields/sections must be completed. Applications with blank fields/sections will be considered non-responsive and will not be considered for award. Applicants must be in compliance with all previous awards in order to be eligible. One application per hospital per category will be accepted. Only one application per hospital per category will be accepted.

Please send completed application to the above address no later than Friday, December 6, 2019. Applications may also be sent electronically to Brian Ashpole bashpole@icahn.org. The application can be accessed electronically at [www.icahn.org](http://www.icahn.org). Applications are to be submitted in a word processing format or PDF. Handwritten applications are no longer accepted. Fields may be expanded to suit the space requirements of the response; however, all fields must be included, i.e., do not delete any fields or fail to respond to information sought in each field.



**Population Health Award**

**2019-2020**

**Application Form**

*Due back to the Illinois Critical Access Hospital Network by December 6, 2019*

|  |  |
| --- | --- |
| ***Hospital Name*** | ***Date*** |
| ***Address*** | ***Contact Person*** |
| ***Phone Number*** | ***Email Address*** |
| ***FEIN (Federal Employee Identification Number)*** | ***IDHR # (Illinois Department of Human Rights)*** |

*\*Blank fields may result in application being considered non-responsive.*

***Hospital Ownership (please mark one):***

**[ ] For Profit; [ ] Not for Profit; [ ] Government**

 **Authorized Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROGRAM NARRATIVE**

|  |
| --- |
| Please respond to each question. Question fields left blank will result in application being considered non-responsive. Each question area should be expanded so sufficient detail can be provided. Additional pages may be attached as necessary.  |

**1. What do you plan to use the funds for? Please check one (1) or more areas this award program/project will address:**

[ ]  Create Hospital Care Coordination Program

[ ]  Implement Community Health Education Program

[ ]  Implement Hospital Care Management/Case Management Programs

[ ]  Implement Telemedicine or Mobile Health Project

[ ]  Consortium development with local healthcare providers to reduce readmissions

[ ]  Implement an evidence-based health program to address chronic conditions

[ ]  Implement an employee or community based wellness program

[ ]  Implement a Drug and/or Alcohol Dependence Prevention Program

[ ]  Healthy Diet & Fitness Promotion Program

[ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Describe the proposed program/project and the impact this project will have to strengthen existing services, improve operations, or add new services to the facility.**

**3. Describe your hospital’s current efforts in the identified program/project and how successful it has been.**

**4.** **Define the problem or issue you would like to address and how it relates to the overall goal of the award. What is not being accomplished and why is it not being accomplished?**

**5.** **Identify the desired outcomes you would like to achieve (example: affect certain number of individuals by the program).**

|  |  |
| --- | --- |
| **Short term outcomes (less than 6 months)** | **Long term outcomes (6 months or greater)** |
| **1.** | **1.** |
| **2.** | **2.** |
| **3.** | **3.** |

**How will these outcomes be achieved and how will they improve overall satisfaction?**

**6.** **Describe the planning process, education and implementation timetable for this program/project.** (Who is involved, and who is responsible for the project?)

**7. How will the program/project improve the overall hospital environment? Identify factors (external/environmental) that may impact your outcomes, including sustainability.**

**8.** **Describe the level of local commitment and the extent to which the project will contribute to your community.**

**9.** **Describe how you will measure/evaluate the value and effectiveness of the program/project for the hospital and community (example: participant listings).**

|  |  |
| --- | --- |
| **Measure 1** |  |
| **Measure 2** |  |
| **Measure 3** |  |
| **Measure 4** |  |

**What indicators will be used to evaluate the program/project and what milestones have you identified as being important?**

|  |
| --- |
| **2019-2020 Proposed Award Budget** |
| **Category** | **Award Funds** | **Matching Funds** | **Total Funds** |
| Consultant’s Fees |  |  |  |
| Contracted Services  |   |   |   |
| Communications/Marketing |   |   |   |
| Education/Training |   |   |   |
| Equipment/Supplies |   |   |   |
| Hardware/Software |   |   |   |
| **Total** |  |  |  |

**Budget Narrative** Provide detail of the amounts listed in budget section above**.** You may include additional materials to further support this Award Application. If documentation is not provided to explain expenses listed in each category your application will not be eligible for an award. Include consultant qualifications and level of expertise for the project. Please only include allowable expenses as identified in the state cost principles as part of uniform guidance.

Consultant’s Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software

**Review Criteria – Application Hints**

This Award Application will be reviewed by outside award reviewers and assigned awarding scores based on the following criteria:

1. Was all hospital information completed (including Federal Employee Identification Number, Illinois Department of Human Rights Number, and Hospital Ownership)?

2. How well did the applicant explain the problem/issue and how they were planning on addressing it?

3. Is the program/project clearly described?

4. Is information provided which supports the idea that the program/project will meet the identified outcomes?

5. Is the method of evaluating the effectiveness of the program/project reasonable?

6. Does the applicant provide enough budgetary detail to assess the likely success of the program/project?

7. Is the budget reasonable for this type of program/project?

8. Is there an indication that this program/project will continue in the future?

9. Does the program/project make sense? Is it valuable to the community? Does it improve the hospital? Is there community involvement?