Illinois Critical Access Hospital Network

*2020 Flex Grant Reporting Form*

***Population Health Award***

|  |  |
| --- | --- |
| **Hospital:** | |
| **Person Completing Report:** | |
| **Date of Report:** | **Phone:** |
| **Authorized Signature:** | |

*Please complete the following information and return with accompanying budget evaluation form to Laura S. Fischer at* [*lfischer@icahn.org*](mailto:lfischer@icahn.org) *no later than* ***July 31, 2020.***

|  |
| --- |
| 1. **Which category did you use the funds for:**   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 and Fitness Promotion Program  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Describe your grant program/project and how it was implemented.**    **Did this program/project do the following:**  1) Strengthen existing services  Yes  No  Not Applicable  2) Improve Care Coordination  Yes  No  Not Applicable  3) Add new services to your facility  Yes  No  Not Applicable  4) Improve Community Health Knowledge  Yes  No  Not Applicable |
| 1. **Explain how you achieved the outcomes defined in the application for this grant. If outcomes were not achieved, explain what factors kept you from achieving them**.  |  |  | | --- | --- | | Short term outcomes (less than 6 months) |  | | 1. |  | | 2 |  | |  |  | | Long term outcomes (6 months or greater) |  | | 1. |  | | 2. |  | | 3. |  | |
| **3. Were there any changes to the planning process for the program/project?**  Yes  No  **If yes, please describe**. |
| 1. **Explain how you measured the success of the program/project.**  |  |  | | --- | --- | | Measure 1 |  | | Measure 2 |  | | Measure 3 |  | | Measure 4 |  |   **Was there an increase in patients using the service**?  Yes  No If no, why not?  **Was there overall satisfaction with the service**?  Yes  No If no, why not?  **Did the service improve your market share**?  Yes  No If no, why not?  **Was patient care improved in the identified setting**?  Yes  No If no, why not? |
| 1. **Please describe any changes to the original budget request and the reasons for the change**. |
| 1. **Please describe any changes to the original timeline or deliverables. Explain the reason(s) for the change. Describe in detail the plans for the completion of the project.** |
| 1. **Was an audit completed of the Organization’s most recent fiscal year-end by an independent Certified Public Accountant**?   Yes  No  **If an audit was completed, what type of audit opinion was issued on the financial statements**?  Unqualified  Qualified  Adverse |
| 1. **Was a single audit completed of the Organization’s most recent fiscal year-end? (A single audit is required if more than $500,000 of federal funding is expended in a given fiscal year.)**   Yes  No  **If a single audit was completed, did the Organization have any findings or questioned costs**?  Yes  No  **If findings or questioned costs were in existence, please attach the single audit package for ICAHN’s review.** |

***Budget Evaluation***

**Did you receive your grant award funds?**  Yes  No

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Grant Amount Received** | **Applicant Contribution** | **Total** |
| Consultant’s Fees |  |  |  |
| Contracted Services |  |  |  |
| Communications/Marketing |  |  |  |
| Education/Training |  |  |  |
| Equipment/Supplies |  |  |  |
| Hardware/Software |  |  |  |
| **Total** |  |  |  |

**Budget Narrative** (Please provide detail of the amounts listed in budget evaluation section above.) **No food expenses are allowed.**

Consultant Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software