

**Outpatient Services Award**

**2021-2022**

**Application Form**

**Award Description**The Outpatient Services Award is available to critical access hospitals in Illinois. The intent of this award is to provide funding to assist CAHs to improve care provided in outpatient and emergency department settings through identification of new service lines, high risk or high volume needs or other various outpatient services. Due to the nature of the funding for this award, only critical access hospitals can apply for this award.

**Award Project Suggestions:**

Outpatient case management

Telemedicine or mobile health

Electronic Medical Record for outpatient rehab and home health service

Fitness, Health & Wellness Services

Aquatic Therapy

Concussion Management Services

Cardiac Rehab Services

Pulmonary Rehab Services

Laboratory Outreach Services

**Project Period: September 1, 2021–June 30, 2022**

**Amount: $5,000 maximum for each recipient. There are approximately 6 awards available.**

**Application Deadline: end of business, Friday, November 12th, 2021**

**Contact:**

**Laura S. Fischer, Flex Grant Project Manager**

**Illinois Critical Access Hospital Network**

[**lfischer@icahn.org**](mailto:lfischer@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. Only one application per hospital per category will be accepted.

Please send completed application electronically to [lfischer@icahn.org](mailto:lfischer@icahn.org). Applications are to be submitted as a Word document 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.



**Outpatient Services Award**

**2021-2022**

**Application Form**

*Due back to the Illinois Critical Access Hospital Network by November 12th, 2021*

|  |  |
| --- | --- |
| ***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. |

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

Outpatient case management

Telemedicine or mobile health

Electronic Medical Record for outpatient rehab and home health service

Fitness, Health & Wellness Services

Aquatic Therapy

Concussion Management Services

Cardiac Rehab Services

Pulmonary Rehab Services

Laboratory Outreach Services

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Baseline Award Information**

Outpatient revenues to total hospital revenues \_\_\_\_\_\_

Number of outpatient registrations\_\_\_\_\_\_\_\_\_\_

Number of patients transferred out of Emergency Department\_\_\_\_\_\_\_\_

Number of inpatient admissions from the Emergency Department\_\_\_\_\_\_\_\_

1. **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.**
2. **Describe the need for this project and how it relates to the overall goal of improving outpatient services. Use data to support the need for this project.**
3. **Describe your hospital’s current efforts in the identified program/project area and any challenges or successes the hospital has had in its current efforts.**
4. **If the project involves the local community, detail local involvement, evidence of community support and any cost to the community.**
5. **If this award is to support an ongoing project, please detail the plans for sustaining the service beyond the scope of the project award.**
6. Project Goals—Creation of **SMART** Goals

**List 2 goals for your project. Be as SPECIFIC as possible.**

**How will you MEASURE if each of the goals listed above is achieved? What are the metrics and milestones that need to be met for this project to be a success?**

**What other resources will you need to ACHIEVE your goals and for this project to be a success? These may include such things as: additional funding support from the hospital, or if outside expert consultants are needed—describe their qualifications and experience.**

**If key hospital personnel will be needed to manage the project and ACHIEVE your goals—describe their qualifications, experience, and the amount of time they will be able to dedicate to the project.**

**How are the proposed project goals RELEVANT to strengthening the outpatient health services in the service area?**

**Detail the major steps in your work plan. What is needed for project completion and the projected TIMELINE for the proposed project. (Included major steps from planning to implementation to final measurement)**

1. **How will the program/project improve the overall hospital environment? Will this project impact your facilities market share in the community?**

|  |  |  |  |
| --- | --- | --- | --- |
| **2021-2022 Proposed Award Budget—$5,000** | | | |
| **Category** | **Award Funds** | **Hospital Matching Funds** | **Total Funds to Complete Project** |
| Consultant’s Fees |  |  |  |
| Contracted Services |  |  |  |
| Communications/Marketing |  |  |  |
| Education/Training |  |  |  |
| Equipment/Supplies |  |  |  |
| Hardware/Software |  |  |  |
| Employee Salaries |  |  |  |
| **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. (No direct patient care, purchase of vehicles, or use of funds to purchase or improve real property).

Consultant’s Fees

Contracted Services

Communications/Marketing

Education/Training

Equipment/Supplies

Hardware/Software

Employee Salaries

**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?