**Small Rural Hospital Improvement Grant Program (SHIP)
Hospital Grant Application of Fiscal Year (FY) 2017
June 1, 2017 - May 31, 2018**

Due back to State Office of Rural Health (SORH) by \_\_\_\_\_\_\_\_\_\_\_\_\_\_

To help facilitate the awards process, the SORH will submit one SHIP application on behalf of all eligible hospital applicants to the Health Resources and Services Administration, Federal Office of Rural Health Policy (FORHP). This form must be completed and returned to the SORH for inclusion in the FY17 SHIP application.

**Hospital Contact Information**

**Hospital Name:** *Click here to enter text.*

**Address:** *Click here to enter text.*

**City:** *Click here to enter text.*

**State:** *Click here to enter text.*

**Zip Code:** *Click here to enter text.*

**County:** *Click here to enter text.*

**Phone Number:** *Click here to enter text.*

**Fax Number:** *Click here to enter text.*

**Administrator/Chief Executive Officer (CEO) Name:** *Click here to enter text.*

**Administrator/CEO Email:** *Click here to enter text.*

**Hospital SHIP Project Director Name:** *Click here to enter text.*

**Hospital SHIP Project Director Email:** *Click here to enter text.*

**Enter CMS Certification Number (CCN): \_\_\_\_\_\_\_\_\_**

**Hospital and SHIP Eligibility Information**

**Indicate which of the following applies to your hospital:**

[ ] Returning SHIP Hospital (funded in FY16) [ ]  New SHIP Hospital (not funded in FY16)

If your hospital is a returning hospital, please answer the following questions:

**Is there a change in your hospital name since the FY16 SHIP application?**

[ ]  Yes [ ]  No

**Is there a change in your hospital address since the FY16 SHIP application?**

[ ]  Yes [ ]  No

**Is there a change in Administrator/CEO information since the FY16 SHIP application?**

[ ]  Yes [ ]  No

**Is there a change in hospital SHIP project director since the FY16 SHIP application?**

[ ]  Yes [ ]  No

Please answer the following SHIP eligibility questions:

**Is your facility a critical access hospital (CAH)?**

[ ]  Yes [ ]  No

**Number of beds per Line 14 of the most recently filed Medicare Cost Report\*:**

*Click here to enter text.*

\*Note: If hospital reports a licensed bed count greater than 49 on Line 14 but staffs 49 beds or fewer, eligibility may be certified by submitting a written statement to the SORH that includes: 1) the number of staffed beds at the time of the most recent cost report submission, 2) the cost reporting period of the most recently filed cost report and 3) the signature of the certifying official.

**Has your hospital implemented ICD-10?**

[ ]  Yes [ ]  No

**Is your hospital conducting HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)?** [ ]  Yes [ ]  No

**If yes, is your hospital’s HCAHPS data publicly reported on Hospital Compare?**

[ ]  Yes [ ]  No

**Returning SHIP hospitals: Progress of FY16 Investments / Activities**

Are the FY16 activities conducted in a network or consortium? [ ]  Yes [ ]  No

**Indicate the Progress of the FY16 investment / activities (check one of the boxes that applies)**

[ ]  To be initiated [ ]  In process [ ]  Completed [ ]  Incomplete

If activities are **to be initiated**, (hospital has not started the activity, but is actively planning to begin project in near future), then what is the timeline to begin and complete investment / activities?

*Click here to enter text.*

If the activity is **in progress** (hospital is in process of currently and actively working to implement the investment / activities with good faith to complete it), then what is the timeline and anticipated impact?

*Click here to enter text.*

If the investment / activities are **complete (**hospital implemented investment / activities and able to evaluate the effect of the intervention), then what is the impact and/or measurable outcome?

*Click here to enter text.*

If activities are **incomplete**, (hospital has abandoned the activity and is not working on the project), then what is inhibiting the hospital from moving forward to finish the investment / activity? If the hospital plans to continue in the future, what is the timeline?

*Click here to enter text.*

**FY17 SHIP Purchasing Menu - Instructions**

Indicate which activities your hospital plans to participate in from the purchasing menu on the next page following these instructions/priorities:

1. Hospitals may select more than 1 category to participate in if priorities are followed and available funds exist
2. Hospitals must be able to demonstrate and report measurable outputs/outcomes to the SORH
3. SHIP funded investments must be prioritized as follows:
* First Priority: HCAHPS (CAHs) and ICD-10 (all hospitals) - both of these must be fully implemented and HCAHPS must be publicly reported to Hospital Compare before your hospital can select any other investment options. Priority is not given to one over the other. Your hospital may choose both
* Second Priority: If your hospital is already participating fully in HCAHPS and ICD-10, you may select a different investment listed on the SHIP purchasing menu
* Third Priority: If your hospital has already completed ALL investments listed on the SHIP purchasing menu, your hospital may identify an alternative piece of equipment and/or service ONLY IF: a) the purchase will optimally affect your hospital's transformation into an accountable care organization, increase value-based purchasing objectives and/or aid in the adoption of ICD-10; and b) your hospital receives pre-approval from both your state SHIP Coordinator and the appropriate FORHP project coordinator

**SHIP Purchasing Menu: Planned FY2017 (June 1, 2017 - May 31, 2018) Expenditures**

Following the instructions/priorities on the previous page, indicate which activities your hospital plans to participate in, selecting from the purchasing menu below. In the final box, indicate the dollar amount that will be used to support the activities selected by investment category. **Total Requested Budget Estimate = $9,000**

| **Value-Based Purchasing (VBP) Investment Activities**Activities that support improved data collection to facilitate quality reporting and improvement. | **Selected Activity(ies)** |
| --- | --- |
| A. Quality reporting data collection/related training (e.g. eCQM implementation) | [ ]  |
| B. HCAHPS data collection process/related training | [ ]  |
| C. Efficiency or quality improvement training/project in support of VBP related initiatives | [ ]  |
| D. Provider-Based Clinic Quality Measures Education | [ ]  |
| E. Alternative Payment Model and Merit-Based Incentive Payment training/education | [ ]  |

| **Accountable Care Organization (ACO) or Shared Savings Investment Activities**Activities that support the development or the basic tenets of ACOs or shared savings programs. | **Selected Activity(ies)** |
| --- | --- |
| A. Computerized provider order entry implementation and/or training | [ ]  |
| B. Pharmacy services implementation  | [ ]  |
| C. Disease registry training and/or software/hardware | [ ]  |
| D. Efficiency or quality improvement training/project in support of ACO or shared savings related initiatives | [ ]  |
| E. Systems performance training | [ ]  |
| F. Mobile health equipment installation/use | [ ]  |
| G. Community paramedicine training and/or equipment installation/use  | [ ]  |
| H. Health Information Technology Training for Value and ACOs  | [ ]  |

| **Payment Bundling (PB) or Prospective Payment System (PPS) Investment Activities**Activities that improve hospital financial processes. | **Selected Activity(ies)** |
| --- | --- |
| A. ICD-10 software | [ ]  |
| B. ICD-10 training | [ ]  |
| C. Efficiency or quality improvement training/project in support of PB or PPS related initiatives | [ ]  |
| D. S-10 Cost Reporting training/project  | [ ]  |
| E. Pricing Transparency Training  | [ ]  |

| **Investment Category** | **Budget Requested** |
| --- | --- |
| VBP Investment Activities | *Enter Amount* |
| ACO or Shared Savings Investment Activities  | *Enter Amount* |
| PB or PPS Investment Activities | *Enter Amount* |
| Total Budget Requested | $9,000.00 |

**Grant and Funding Information**

**If your hospital received funds in FY16 (June 1, 2016 – May 31, 2017), did the hospital expend over 90% of the funds?**

[ ]  Yes [ ]  No [ ]  Our hospital did not receive funds in FY16

**If not, please explain why:**

*Click here to enter text.*

**Indicate if your hospital is participating in the following Centers for Medicare and Medicaid Services (CMS) programs:**

Medicare Shared Savings Program [ ]  Yes [ ]  No

Pioneer Accountable Care Organization Model [ ]  Yes [ ]  No

Other Accountable Care Organization Model ☐ Yes ☐ No

Hospital Inpatient Quality Reporting Program [ ]  Yes [ ]  No

Hospital Compare [ ]  Yes [ ]  No

**PPS Hospitals Only:**

Hospital Value-Based Purchasing Program [ ]  Yes [ ]  No

**Is your hospital pooling SHIP funds with other hospitals in the form of a network or consortium?**

[ ]  Yes [ ]  No

**Please provide any recommendations you have for improving SHIP.**

*Click here to enter text.*

**Signature**

By signing this document, you are affirming that your hospital:

1. Has selected menu investment(s) based upon the specific selection priorities listed in the SHIP Purchasing Menu Instructions. Hospitals that do not follow the purchase priorities and/or purchase equipment/services that are not listed on the SHIP Purchasing Menu will be subject to penalties including suspension from the next SHIP funding opportunity.
2. Has selected menu investment(s) for which the hospital will be able to demonstrate measurable outputs/outcomes and that your hospital will report those measures and progress to the SORH upon request and at the end of the program year.

Note: Prior approval from your state SHIP Coordinator/SORH is required before changing investments; no changes can be made after the mid-year point.

**Administrator/CEO Signature:**  **Date:**

**Hospital SHIP Project Director Signature: Date:**

(E-signatures are acceptable.)