**SMALL RURAL HOSPITAL IMPROVEMENT GRANT PROGRAM (SHIP)**

**Hospital Grant Application for Fiscal Year 2015 (FY15)**

**September 1, 2015 – May 31, 2016**

Due back to State Office of Rural Health (SORH) by:**Thursday, February 19, 2015**

**EMAIL TO NITA HAM:** **nham@dch.ga.gov** **OR FAX TO:  229-401-3084**

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**.** This form must be completed and returned to the SORH for inclusion in the FY15 SHIP application.

**A. Hospital Information:**

**Hospital Name:**

**Address:**

**City:**       **State:**       **Zip:**       **County:**

**Phone:**       **Fax:**

**Administrator/CEO Name:**       **E-mail:**

**SHIP Project Director Name:**       **E-Mail:**

(Individual responsible for managing SHIP-funded project for the hospital)

**CAH status**: Yes [ ]  No [ ]

**(Check one)** Returning SHIP hospital(funded in FY14) [x]  **Or**New SHIP hospital (not funded in FY14) [ ]

If returning hospital, please answer the following questions:

Is there a change in hospital name since FY14 SHIP application? Yes [ ]  No [ ]

Is there a change in hospital address since FY14 SHIP application? Yes [ ]  No [ ]

Is there a change in Administrator/CEO information since FY14 SHIP application? Yes [ ]  No [ ]

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

Cost Reporting Period of most recently filed Medicare Cost Report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Attach part I of Worksheet S-3 from most recently filed Medicare Cost Report (PPS Hospitals only).**

***\*Note:*** *If hospital reports a licensed bed count greater than 49 on Line 14 but staffs 49 beds or fewer, you may certify eligibility 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.*

**B. Planned FY15 (September 1, 2015 – May 31, 2016) Expenditures:**

Indicate the percent and dollar amount that will be used to support activities listed on the SHIP Purchasing Menu (page 3). **Total Requested** **Budget estimate = $9,000 per hospital.**

**Please follow these instructions/priorities:**

1. Hospitals may select more than 1 category to participate if priorities are followed and available funds exist.
2. Please check applicable investments and measures on the SHIP Purchasing Menu.
3. SHIP funded purchases are prioritized as follow :
	1. 1st Priority– Activities relating to **MBQIP** implementation and reporting (if that hospital has yet to register and transmit MBQIP data). Non-CAHs are exempt from this provision;
	2. 2nd Priority – **HCAHPS and/or ICD-10** activities if that hospital is not in the process of implementing both systems. In no particular order, hospitals may select one or both; and
	3. 3rd Priority – If a hospital is already participating in all three of these activities, **MBQIP, HCAHPS, and ICD-10,** then that hospital may select a different activity listed on the SHIP Purchasing Menu.
	4. If a hospital has already completed **ALL** pre-selected investments (equipment and/or services) listed on the SHIP Purchasing Menu, that hospital may identify an alternative piece of equipment and/or service PROVIDED: a) this purchase will optimally affect a hospital’s transformation into an accountable care organization, increase value based purchasing objectives, and/or aid in the adoption of ICD-10; and b) that hospital receives pre-approval from both their state SHIP director and the appropriate Federal Office of Rural Health Policy project officer.

Please answer the following investment questions:

*Questions for CAHs only:*

My hospital has signed-up for MBQIP Yes [ ]  No [ ]

*Questions for all hospitals:*

My hospital has begun to implement or has implemented HCAHPS: Yes [ ]  No [ ]

My hospital has begun to implement or has implemented ICD-10: Yes [ ]  No [ ]

**SHIP Purchasing Menu: Planned FY15 (September 1, 2015 – May 31, 2016) Expenditures**

Select (check) applicable investments and indicate the dollar ($) amount and percent (%) of FY15 requested budget that will be used to support the selected investments up to $9000.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Category** | **Value-Based Purchasing (VBP)** | **Accountable Care Organizations or Shared Savings (ACOs)** | **Payment Bundling/PPS (PB/PPS)** | **Care Transitions** |
| **Description** | Activities that support improved data collection to facilitate quality reporting. | Activities that support the development of ACOs. | Activities that improve the revenue cycle process. | Activities that reduce hospital readmissions. |
| **Investments** | [ ] A. Training specific to coordinating the collection of **MBQIP** measure(s’) data and/or software that would enable the collection of data [ ] B. **HCAHPS** Software or Hardware [ ] C. Training Specific to **HCAHPS** implementation or further application [ ] D. Efficiency Training (Six Sigma or Lean) in 1 of the following areas: patient satisfaction, improving ER efficiency (ies), or efficiencies to clinical care delivery areas  | [ ] A. Computerized Provider Entry [ ] B. Pharmacy Services [ ] C. Hardware/Software Related to Purchase of Disease Registry [ ] D. Efficiency Training (Six Sigma or Lean) in 1 of the following areas: non-clinical operations, board organization/operation, or multi-hospital/network projects[ ] E. Baldrige or systems performance training☐F. Quality Health Indicator (QHi) or other quality improvement training | [ ] A. **ICD-10** Software [ ] B. **ICD-10** Training [ ] C. QI or Efficiency Training (Six Sigma or Lean) in 1 of the following areas: financial improvement, operational multi-hospital/network projects [ ] D. Purchase of Six Sigma and/or Lean software [ ] E. Revenue Cycle Management[ ] F. S-10 Cost Reporting | [ ] A. Emergency Department transfer communication improvement[ ] B. Training to reduce readmissions and/or infections [ ] C. Medical provider quality improvements[ ] D. Telemedicine or mobile health equipment[ ] E. Community Paramedicine equipment and/or training [ ] F. HIE subscription within state or region or adding direct address  |
| **Budget** | **% $** | **% $** | **100 % $ 9000** | **% $** |

**Measures: By selecting an investment above you are agreeing to report on the measure corresponding to the investments.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Corresponding****Measures** | A. Training completed related to MBQIP data collectionB. Installation of HCAHPS software or hardware C. Implementation and completion of HCAHPS training D. Completion of Efficiency training and project implementation with identification of a specific measure selection and target  | A. Implementation and/or training completed regarding use of a computerized provider entry system B. Implementation of a pharmacy service with selection of a process measure to improve upon C. Implementation and/or training completed regarding use of a disease registryD. Completion of efficiency training, with identification of a specific measure selection and targetE. Completion of Baldrige or systems performance trainingF. Implementation and use of QHi or quality improvement training | A. Installation and use of ICD-10 softwareB. Implementation of ICD-10 trainingC. Implementation of an efficiency project , with identification of a specific measure selection and targetD. Installation of Six Sigma or lean softwareE. Completion of Revenue Cycle Management training or equipment purchaseF. S-10 Cost Reporting improvement | A. Implementation and/or training regarding ED transfer communications B. Complete training for reducing readmissions and/or infections C. Implementation and/or training of a medical provider quality improvement projectD. Installation/use of telemedicine or mobile health equipment E. Installation/use of community Paramedicine equipment and/or completion of training F. Installation/use of state or region HIE or direct address **Overall Outcome Measure**: Decrease in hospital readmission rate over last year  |

**C. Reporting on most recently completed funding cycle FY13 (September 1, 2013 – August 31, 2014)**

If you received SHIP funds in FY13, did you expend over 90% of funds?  Yes [x]  No [ ]

If not, please explain:

**D. Indicate if your hospital is participating in the following CMS programs:**

a. Medicare Shared Savings Program Yes [ ]  No [ ]

b. Pioneer Accountable Care Organization Model Yes [ ]  No [ ]

c. Hospital Inpatient Quality Reporting Program Yes [ ]  No [ ]

d. Hospital Compare Yes [ ]  No [ ]

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

**E. Network Participation**

Is your hospital affiliated with a rural health network? Yes [x]  No [ ]

 If yes, network name: HomeTown Health

**Award preference:**

**□** My hospital would like to allocate SHIP funds (check one: full □, or partial □) in the amount of $\_\_\_\_ for membership in the following Consortium\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 [x]  My hospital would like all grant funds awarded directed to my hospital. We are participating in the HomeTown Health Revenue Cycle Program

**F. Recommendations**

Please list any recommendations you may have to improve the Small Hospital Improvement Program:

 Please expedite grant Execution so that we may receive services for the full grant year beginning 9-1-2015

**G. Signatures**

By signing this document, you are affirming:

1. That your hospital has selected menu investment(s) based upon the specific selection priorities listed on page 2. Hospitals that do not follow 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 year’s Small Hospital Improvement Program.
2. That you are not only selecting an investment, but also a measure that correlates to your purchase. Your hospital will be expected to report to your State Office of Rural Health regarding progress at the end of the 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.*

**CEO Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SHIP Project Director Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Individual responsible for managing SHIP-funded project for the hospital)