STATE HEALTHCARE INNOVATION PLAN (SHIP)
Application of Interest

Please view the SHIP website at www.ship.idaho.gov for additional information before completing and submitting this application of interest.

CLINIC INFORMATION

Clinic Name:				Phone:
Street Address:				Fax:
City:	State: ID		Zip:	Website:
Tax ID #				Organization NPI #

Corporate Ownership or System Affiliation (if applicable):

Organization Type:

- ☐ Private Practice
- ☐ FQHC
- ☐ RHC
- ☐ Hospital Owned Clinic
- ☐ Other: _____

Predominant Specialty

- ☐ Family Practice
- ☐ Internal Medicine
- ☐ Pediatrics
- ☐ Multi-Specialty
- ☐ Other: _____

Please indicate number of providers by type and specialty:

Provider Type (full-time FTEs):

___ Physicians
___ Doctors of Osteopathic Medicine
___ Nurse Practitioners
___ Physician Assistants
_____ Other Providers

Provider Specialty (full-time FTEs):

___ Family Practice
___ Family Practice
___ Pediatrics
___ OB/GYN
___ Psychiatry
___ Psychology
___ Social Work
___ Diet/ Nutrition
_____ Other Practice Staff

Clinic contact person for questions regarding this application of interest:

Name:
Phone:
Email:

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PROPOSED TRANSFORMATION TEAM

Engaged leadership and an effective transformation team are critical to the success of implementing and sustaining the PCMH model. Please list your proposed Transformation Team members below:

Physician Champion:	Name:	Title:	Email:
Clinic Administration, if applicable (CEO, CFO, etc.):	Name:	Title:	Email:
Office Manager:	Name:	Title:	Email:
Other Key Leaders:	Name:	Title:	Email:
	Name:	Title:	Email:

NATIONAL PCMH ACCREDIATION/ RECOGNITION STATUS

Please indicate if your clinic has achieved national PCMH recognition or accreditation, the organization(s) it was received from, and level of recognition (if from NCQA). *Recognition is not required to apply or to participate in the SHIP.*

- ☐ AAAHC Date Accredited:
- ☐ JCAHO Date Accredited:
- ☐ NCQA Date Recognized: Level of Recognition:
- ☐ URAC Date Certified:

HEALTH INFORMATION TECHNOLOGY (HIT) CAPABILITIES

Does your clinic have an electronic medical record system? ☐ Yes ☐ No

If yes, what system?

How long has your clinic utilized this system?

Is your clinic currently connected to the IHDE (Idaho Health Data Exchange)? ☐ Yes ☐ No

Do you receive HIT incentive dollars, and if so what level of Meaningful Use (MU) are you currently striving for?

BEHAVIORAL HEALTH

What level of mental health and/or substance services do you provide and/or coordinate for our patients?

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QUALITY IMPROVEMENT ACTIVITIES

Does your clinic conduct formal quality improvement activities? ☐ Yes ☐ No

If yes, specify the tools used (e.g. Six Sigma, Lean, PDSA cycles):

PCMH PROGRAM INCENTIVE HISTORY

Has your clinic ever participated in any of the following?

- ☐ Safety Net Initiative
- ☐ IMHC Pilot
- ☐ Other PCMH Programs (CHIC, ect).

If other, please list:

CLINIC VISION AND INTENTIONS

Please describe what your clinic intends to achieve by participating in the SHIP. Include in your response how your intentions will align with the SHIP goals to improve health outcomes, reduce healthcare costs and improve provider and patient experience. Please limit your response to 100 – 500 words.

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By signing this application, we are demonstrating our intention to apply as a SHIP clinic. We understand SHIP in-service training will be required as part of the formal application process to occur Fall, 2015.

_____

Applicant's Signature

_____

Print Applicant's Name

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