

**Healthcare Associated Venous Thromboembolism (HA-VTE)
Prevention Challenge
Nomination Form**

Contact information

Provide the contact information for the individual submitting the nomination.

Name: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____ Business E-mail: _____

Nominee information

Provide the following information for the organization being entered into the Challenge.

Name: _____

Business Address: _____

Business Phone: _____ Business E-mail: _____

Check the box which best represents the nominee:

☐ Hospital, single

☐ Multi-hospital system

☐ Hospital Network / Managed Care
Organization (MCO)

Designation

☐ U.S. non-federal

☐ U.S. Federal

☐ International

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0390. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Region Served

- ☐ Northeast
☐ Midwest

- ☐ South
☐ West

Location

- ☐ Urban
☐ Rural

- ☐ Both

Number of staffed beds: _____

Number of patient admissions (2014): _____

If your organization has more than one location providing inpatient medical care, provide the number of hospitals or facilities: _____

Describe the following demographics that support the organization:

Percent of patients who are:

White (non-Hispanic): _____

Black (non-Hispanic): _____

Hispanic: _____

Percent of patients whose primary language is not English: _____

Percent of patients who are enrolled in Medicaid: _____

Description of HA-VTE Prevention Initiative

Please submit a 2-3 page executive summary of your HA-VTE Prevention Strategy. Please include the following sections:

- **Background:** Include the need for HA-VTE prevention in your organization and the overall strategy for improving HA-VTE prevention.
- **Objectives:** State the objectives of your prevention initiative. Please include the purpose and desired outcomes of your strategy and intervention(s).
- **Methods:** Describe how you improved HA-VTE prevention within your organization (How, when, and among whom). Please include a description of relevant methods including implementation and

monitoring, populations of interest, case definitions for outcomes and metrics, periods of observation, and resources and staff required.

- **Results:** Describe the observed improvement in HA-VTE Prevention. Please include number of patients observed, periods of observation, pre and post-implementation HA-VTE prevention metrics and measures of effectiveness and, if data are available, any associated reduction in HA-VTE rates or increases/decreases in adverse events. Additional data tables and figures may be submitted along with the summary. Please ensure that all measures are fully defined in the methods or results sections.
- **Conclusions:** Describe the overall impact of the HA-VTE prevention initiative including keys to success, challenges, and the sustainability and scalability of the program.

Agreement to Participate

Please enter your name below to indicate that you, as the nominee, agree to the following:

If you are not the nominee, please enter your name below assuring that you have consulted with the nominee, and the nominee agrees to the following:

- All information provided is true and accurate to the best of your knowledge.
- To participate in a data verification process if selected as a candidate for champion.
- Consent to a background check if selected as a candidate for champion.
- To be recognized by provider or practice name and location if selected as a champion, to participate in recognition activities, and to share best practices for the development of publically available resources.
- To assume any and all risks and waive claims against the Federal Government and its related entities, except in the case of willful misconduct, for any injury, death, damage, or loss of property, revenue, or profits, whether direct, indirect, or consequential, arising from my participation in this prize contest, whether the injury, death, damage, or loss arises through negligence or otherwise.
- To indemnify the Federal Government against third party claims for damages arising from or related to competition activities.”

Thank you for participating.