E-mail

Print

Membership Application

Center Name _____

Address 1 _____

Address 2 _____

City _____ State _____ Zip _____

Country _____ NICU phone number _____

Year NICU opened/first accepted patients _____

Please fill out all contact fields below

TEAM LEADER

This contact is responsible for overseeing all activities involved in Vermont Oxford Network (VON) participation by:

- *coordinating data submission, reporting, education, and quality improvement activities*
- *ensuring the appropriate staff fulfill critical VON roles*
- *serving as your center's primary advocate for data science and quality improvement*
- *encouraging your center's staff to fully utilize VON information and tools*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

REPORT CONTACT

This contact should be a member of your center's peer review committee and be active in quality improvement activities. The Report Contact is responsible for:

- *receiving a printed copy of your center's Annual Report and electronic copies of other Vermont Oxford Network (VON) reports*
- *sharing reports and findings with the applicable team members at your center*
- *ensuring that the appropriate staff are aware of and have access to the Nightingale reporting tool*
  - *Report Contacts are automatically granted access to VON Members Area - Data Management and issued a VON Web Services Login*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

DATA CONTACT

This contact is responsible for collection and submission of all infant data to Vermont Oxford Network (VON) by:

- *establishing and overseeing procedures for data collection and submission*
- *developing an Eligibility Verification Plan and monitors its implementation*
- *collecting and submitting infant data to VON or, depending on the size of your center, supervising the data collection and submission tasks*
- *verifying that all eligible infants are included in your center's data submissions*
- *receiving all Network correspondence regarding data status, submission, and errors*
- *confirming that the data conform to all definitions and conventions of the VON database*
  - *Data Contacts are automatically granted access to VON Members Area - Data Management and issued a VON Web Services Login*

Contact Name _____

Address _____

City _____ State WA Zip _____

Country _____ Email _____

Phone _____ Fax _____

FINANCIAL CONTACT

This contact's responsibilities include:

- *handling Vermont Oxford Network (VON) membership agreements*
- *ensuring VON membership payment*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

NEONATOLOGIST

This contact supports your center's Vermont Oxford Network (VON) membership by:

- *answering medical questions from your center's Data Collector pertaining to the VON data definitions*
- *receiving, evaluating, and distributing information from VON about ongoing clinical trials, research projects, and quality improvement collaboratives*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

QUALITY LEADER

This contact is the person in your center who is responsible for:

- *assessing quality indicators, and providing information to and ideally participating in quality and healthcare improvement projects*
  - *if not part of your team, this person may be at the Program, Division, or Organizational level*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

APPLICATIONS CONTACT

This contact is on your IT team and is an Applications Analyst or someone who is similarly qualified. The Applications Contact is responsible for:

- *planning for the integration, hosting, and support of VON software for your organization*
- *serving as an effective communicator between VON and your center's team members who have advanced technical skills and/or final decision making authority*
  - *applications may include software hosted on VON's web site, software hosted at your organization, and potential integration with third party medical record applications*

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

SENIOR LEADER

This contact should be a member of your center's executive management team (CEO, CNO, CQO).

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

NICU MANAGER

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

CHIEF OF NEONATOLOGY

Contact Name _____

Address _____

City _____ State _____ Zip _____

Country _____ Email _____

Phone _____ Fax _____

DATABASE CHOICE / PARTICIPATION START DATE

Your reports will be of greatest value if you submit a complete calendar year of data (Jan. 1 to Dec. 31)

☐ Very Low Birth Weight Database ☐ Expanded Database (includes VLBW)

First year of participation _____

YOUR CENTER'S FINANCIAL STRUCTURE

Is your center:

- ☐ Wholly owned and managed
- ☐ Leased
- ☐ Contract managed
- ☐ A subsidiary of another corporate organization
- ☐ Other (please specify)

_____

Are any of the actions or financial decisions of your organization overseen or approved by another corporate entity?

☐ Yes ☐ No

If so, please identify the entity. _____

YOUR CENTER'S OWNERSHIP STRUCTURE

- ☐ Government (federal or non-federal)
- ☐ Non-government, not for profit (nfp) (church operated or other not-for-profits including nfp corporations)
- ☐ Investor owned, for profit (individual, partnership, or corporations)
- ☐ Other (please specify)

_____

Is your center part of a hospital system (owned, leased, sponsored, or managed by a central organization)?

☐ Yes ☐ No

If yes, please identify which system you are part of:

_____

YOUR CENTER'S NETWORKS

Is your center part of a hospital network (a group of hospitals, physicians, other providers, insurers, and/or community agencies that voluntarily work together to coordinate and deliver health services?)

☐ Yes ☐ No

If yes, please identify which network(s).

_____

_____

Does your center participate in state or regional improvement collaboratives?

☐ Yes ☐ No

If yes, please identify which collaboratives(s).

_____

_____

Is your NICU staffed by a contracted physician group?

☐ Yes ☐ No

If yes, please identify which group. _____

Is your center a free-standing children's hospital?

☐ Yes ☐ No

INFORMATION TECHNOLOGY AND ELECTRONIC HEALTH RECORDS

Who provides your information technology (IT) support?

☐ An internal IT staff

☐ IT staff at network or parent organization

☐ An external vendor

Are you using an electronic medical record in the NICU?

☐ Yes ☐ No

If yes, who provides your primary EHR/EMR? _____

Will you use your EHR/EMR to electronically submit data to VON, either through eNICQ6 or VON EDS?

☐ Yes, file import to eNICQ6

☐ Yes, file submitted directly to VON EDS

☐ No

Thank you. We look forward to working with you.