

Hospital Participation Agreement

Our hospital would like to participate in the Hospital Quality Improvement work. We understand the following expectations for this cooperative project, and agree to participate with Alliant Quality, the Medicare Hospital Quality Improvement Contractor (HQIC).

Benefits of Participating:

- Collaborative learning events offered throughout the year as well as technical assistance based on specific goals
- Sharing of best practices and strategies

We understand that this commitment requires support of hospital leadership to achieve reductions in the following areas over the next 4 years:

- Opioid prescribing (for prescriptions \geq 90MME)
- Opioid-related adverse events including deaths
- All-cause patient harm
- Readmission rates
- Adverse Drug Events (ADEs) (not included opioids)
- C.difficile rates

By signing this, our organization:

- Agrees Hospital Leadership is committed to support the goals of this work
- Agrees to remain an active participant through 2024 and to publicly disclose participation
- Attest that we are not participating with any other HQIC contractor performing this work
- Agrees to support development of strategies for overall quality within our hospital by working to:
 - Complete a baseline self-assessment that will capture current state and inform a gap analysis
 - Utilize a data-driven and proactive approach to quality improvement
 - Submit requested data
 - Actively participate in learning events
 - Share results, best practices and lessons learned

* Required Organizational Information (please print):

Hospital Name:		CCN #:	
Hospital Address:			
Corporate:	Yes No	Corporation Name:	CCN #:

* Required Hospital Leadership Signatures (please print):

CEO/COO/CNO:	
Email:	
Phone #:	
Signature: 	Date:

Primary Contact Name:	Secondary Contact Name:
Title:	Title:
Email:	Email:
Phone #:	Phone #:



Please complete and sign then email to: hospitalquality@alliantquality.org Thank you!

Attachment A: Facility List for Multiple Sites



You may email a company facility list in lieu of Attachment A if that is more convenient.

Corporation Name:

Facility Name:	CCN #:		
Address:	County:		
City:	State:	Zip:	
Name:	Title:		
Email:	Phone #:		

Facility Name:	CCN #:		
Address:	County:		
City:	State:	Zip:	
Name:	Title:		
Email:	Phone #:		

Facility Name:	CCN #:		
Address:	County:		
City:	State:	Zip:	
Name:	Title:		
Email:	Phone #:		