



## Participation Agreement

### HSAG Hospital Quality Improvement Contract (HQIC) Partnership

***Please complete and return this Participation Agreement***

Your hospital was selected by The Centers for Medicare & Medicaid Services (CMS) based on specific criteria in order to qualify for the HQIC Partnership. HSAG requests your hospital leadership's commitment to engage and participate in the HQIC Partnership through 2024.

**CMS awarded Health Services Advisory Group (HSAG) the HQIC to support specific hospitals in meeting the following goals:**

- *Decrease opioid related adverse events, including deaths, by 7 percent with a focus on Medicare beneficiaries using opioids.*
- *Reduce all-cause harm in hospitals by 9 percent or more, including adverse drug events.*
- *Reduce hospital readmissions by 5 percent.*

**My organization commits to participate as a partner with HSAG.  
(September 2020–September 2024)**

Executive Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Organization Name: \_\_\_\_\_ CMS Certification # (CCN): \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Please provide the following information for your organization's point of contact:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Direct Telephone: \_\_\_\_\_

**Return via email to [hospitalquality@hsag.com](mailto:hospitalquality@hsag.com) or fax to 602.665.6166..**

**For more information, please visit [www.hsag.com/hqic](http://www.hsag.com/hqic).**

**Use Attachment A to enroll multiple sites (page 2 of this document).**

## Attachment A: Facility List for Multiple Sites

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

Corporation: \_\_\_\_\_

Facility Name: \_\_\_\_\_ CCN: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ CCN: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_ CCN: \_\_\_\_\_

Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone Number: \_\_\_\_\_