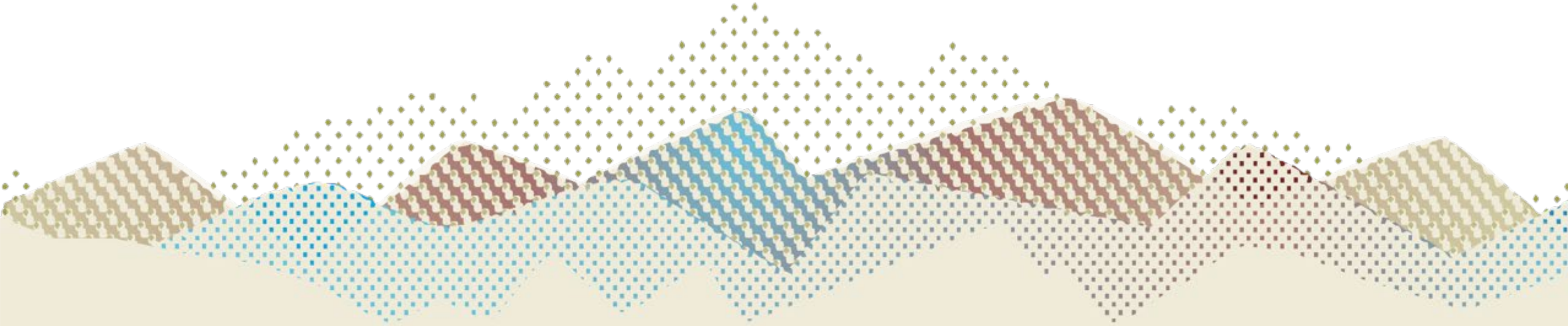
Hospital Quality Incentive Program 2026 Six-Month Measure Set Kickoff Webinar

Troy Foster, Program Manager II
Hospital and Perinatal Quality Incentive Programs



Objectives

- Hospital Quality Incentive Program Background
- 2026 Six-Month Bridge Timeline
- 2026 Six-Month Bridge Hospital Quality Incentive Program
- Questions and Answers

About Us

Mission:

To help our members, and the communities we serve, be healthy.

Vision:

To be the most highly regarded managed care plan in California.

Hospital Quality Incentive Program (HQIP)

- The HQIP is a pay-for-performance program **supporting hospitals** serving Partnership members **to improve quality and health outcomes**.

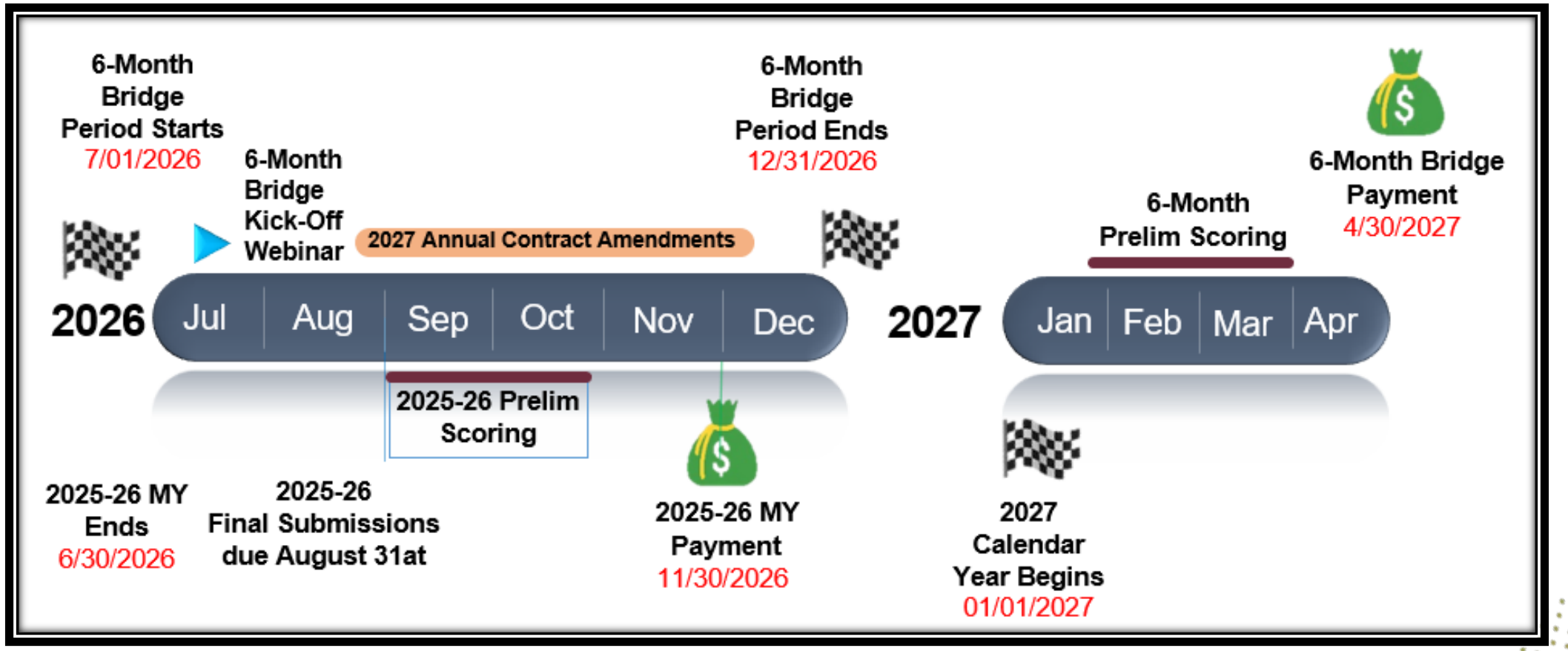
- Hospitals Earn Substantial Financial Incentives: Approximately **$7** million was awarded among **33 hospitals in the 2024-2025** measurement year.

- Measures are spread over six domains: Readmissions, Advance Care Planning, Clinical Quality (OB / Newborn / Pediatrics), Patient Safety, Patient Experience, and Operations and Efficiency

Guiding Principles

1. Where possible, pay for outcomes instead of processes
2. Actionable measures
3. Feasible data collection
4. Collaboration with providers in measure development
5. Simplicity in the number of measures
6. Representation of different domains of care
7. Align measures that are meaningful
8. Stable measures

Six-Month Bridge Transition Timeline



Six-Month Bridge Transition Timeline

- Starting in 2027, the HQIP will run on a calendar year. To transition to a calendar year, the HQIP will have an abbreviated 6-month bridge measure set from July 1 through December 31, 2026. Payment for this period will be sent by the end of April 2027.
- Organizations are required to sign an annual contract amendment agreeing to participate in the QIPs as defined in provided measure summaries. Partnership plans for earlier engagement in this process during 2026. Amendments have already been signed that cover the 6-month bridge sets.

Health Information Exchange and Emergency Department Information Exchange Participation

Health Information Exchange (HIE) and Emergency Department Information Exchange (EDIE) implementation and maintenance is a prerequisite to participating in the Hospital QIP. To have the potential to earn 100% of your hospital's HQIP incentive dollars, all the items below must be met.

Admissions, Discharge, Transfer (ADT)

plus HL7 or XDS interface with either:

Sac Valley Med Share

North Coast Health Information Network (Humboldt County Only)

ADT interface with EDIE

Link to one of the following national HIE networks:

CareQuality,

eHealth Exchange, or

Commonwell

Requirements for Capitated Hospitals

Capitated Hospitals also have the additional requirements below that impact the percent amount of HQIP incentive dollars they can earn.

From July 1, 2026, to December 31, 2026, Hospitals must utilize **PointClickCare's EDIE** for their capitated members to alert their internal utilization Management team to out of network admissions. PointClickCare will report usage data to Partnership confirming routing (month-by-month) utilization of the module via responsiveness to previously established alerts.

Delegation Reporting

To receive the full Hospital QIP incentive payment capitated hospitals must submit timely and accurate delegation deliverables to Partnership according to deadlines outlined in your hospital's Utilization Management Delegation Agreement. Timely submission percentages can be reviewed on page 6 of the measurement set specifications document.

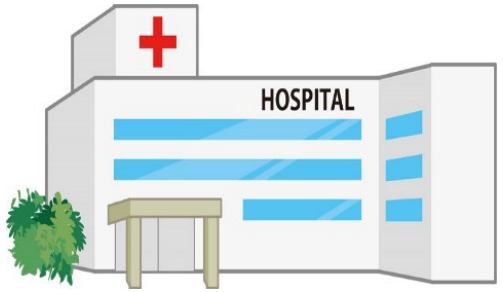
All reporting submissions and written Utilization Program Structure may be sent to: DelegationOversight@partnershiphp.org.

2026 Six-Month Bridge HQIP Measure Set

2026 Six-Month Bridge HQIP Measure Set
1. Risk Adjusted Readmissions Rate (RAR)
2. 7-day Clinical Follow-up Visit
3. Palliative Care Capacity
4. Elective Delivery
5. Exclusive Breast Milk Feeding
6. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate
7. Vaginal Birth After Cesarean
8. Expanding Delivery Privileges
9. Doula Support
10. Increasing Screening Mammogram Capacity
11. Vaccines For Children Program Enrollment
12. Patient Safety Organization Participation
13. Substance Use Referral
14. Hospital Quality Improvement Platform

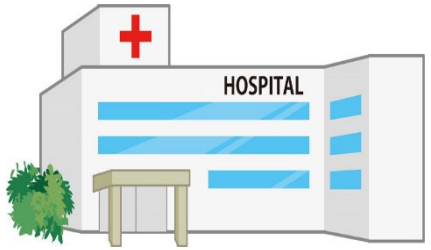
Hospital Size	Max Points
X-Large with OB	100
Large with OB	100
Small with OB	95
Very Small	55

Hospital Size Designations



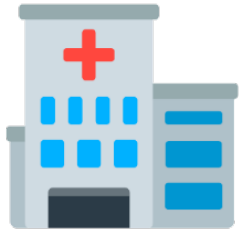
X-Large Hospitals

≥ 100 licensed general acute beds



Large Hospitals

≥ 50 licensed general acute beds



Small Hospitals

< 50 licensed general acute beds

Very Small Hospitals

< 25 licensed general acute beds

1. Risk Adjusted Readmissions

Measure Summary

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

- Count of Index Hospital Stays* (denominator)
- Observed Readmissions: Count of 30-Day readmissions (numerator)
- Expected Readmissions: Sum of adjusted readmission risk (numerator)
- Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year

Large & X-Large Size Hospitals Targets	Small & Very Small Size Hospitals Targets
<1.0 Full Points = 10 Points	**<1.0 Full Points = 5 Points**
≥1.0 - 1.2 for Partial Points = 5 Points	**≥1.0 - 1.2 for Partial Points = 2.5 Points**

1. Risk Adjusted Readmissions

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between July 1 and December 1 of the measurement year by members age 18 to 64 years of age continuously enrolled for at least 90-days prior admission date and 30 days after admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 3 and December 31 of the measurement year by Partnership members included in the denominator.

RAR Calculations

30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between July 1 and December 1 of the measurement year by Partnership members included in the denominator.

Calculation: Observed 30 Day Readmissions Rate $= \frac{\textbf{Observed 30 Day } \textbf{\textit{Readmissions}}}{\textbf{Total Count of Index Hospital } \textbf{\textit{Stays}}}$

Expected 30-Day Readmission: An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

Calculation: Expected 30 Day Readmissions Rate $= \frac{\textbf{Expected 30 Day } \textbf{\textit{Readmissions}}}{\textbf{Total Count of Index Hospital } \textbf{\textit{Stays}}}$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

2. Seven-Day Follow-up Clinical Visits

For assigned members 18 to 64 years of age, the percentage of acute inpatient stays for which the member received follow-up within seven calendar days of discharge. Follow-up visits may include in person, telephone, and telehealth visits done at the hospital or outpatient setting. Clinical visits by a qualified medical professional include those with a patient's primary care provider, other specialist, mental health professional, PA, NP, RN, CNM, or a hospitalist/hospital-based clinician in a hospital discharge visit. Visits with a case manager (non-RN) would not count towards the numerator for this measure.

Target

All Size Hospitals:

Full Points: 10 points: ≥ 35% of members with a follow-up visit within seven calendar days of hospital discharge.

Partial Points: 5 points: 30 – 34.9% of patients with a follow-up visit within seven calendar days of hospital discharge.

2. Seven-Day Follow-up Clinical Visits

Denominator

The number of acute inpatient and observation visits on or between July 1 and December 31 of the measurement year by members' age 18 to 64 years of age continuously enrolled from the date of discharge through 30 days after discharge (31 days)

Numerator

The number of members in the denominator who had a follow-up visit within seven calendar days of hospital discharge.

Exclusions

Discharges for death, Pregnancy & Perinatal conditions, SNF transfers, Out-Patient in Bed

3. Palliative Care

Measure Requirements for X-Large Hospitals with > 100 beds

Required to provide the following to Partnership:

Part 1. Hospitals must submit a report summarizing the number of palliative care consults per month for the measurement year July 1, 2026 - December 31, 2026.

Part 2. Rate of consults who have completed an Advance Care Directive or have a signed POLST to be included in the report described in Part 1:

Numerator: Anyone with an Advance Directive or POLST status in the hospital's inpatient EMR and on the palliative care service at either the time of consult ***or*** the time of discharge.

Denominator: Patients with a palliative care consult recorded in the hospital's inpatient EMR and on the palliative care service, discharged alive from July 1, 2026 - December 31, 2026.

3. Palliative Care

Part 3. Submit Attestation form Appendix II showing inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician

X-Large Full Points Target (5 points)	X-Large Partial Points Target (2.5 points)
Part 1: Minimum of 10 patient consults per month, **and**	Part 1: Minimum of 5-9 patient consults per month, **and**
Part 2: ≥ 40% of patients with a completed AD or signed POLST, **and**	Part 2: ≥ 40% of patients with a completed AD or signed POLST, **and**
Part 3: Pay for reporting Palliative Care Capacity Attestation Form	Part 3: Pay for reporting Palliative Care Capacity Attestation Form

Palliative Care in Large and Small Size Hospitals

Measure Requirements for Large Hospitals with 50-99 Beds

Hospitals 50-99 beds: Inpatient palliative care capacity: at least two trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician (option for hospitals with less than 100 beds).

Large Hospital Target

Pay for reporting Palliative Care Capacity Attestation Form found in Appendix III of the specification manual; including the information listed under Measure Requirements above.

Large Hospital Full points = 5 points. No partial points are available for this measure.

Palliative Care in Large and Small Size Hospitals

Measure Requirements for Hospitals with Small <50 Beds

Hospitals <50 beds: Dedicated inpatient palliative care team: one Physician Champion, one trained* Licensed Clinical Social Worker or trained* Licensed Clinician (RN, NP, or PA), and an arrangement for availability of either video or in-person consultation with a Palliative Care Physician (option for all hospitals). *Training must total 4 CE or CME hours. Training options include ELNEC, EPEC, the CSU Institute for Palliative Care, or other approved Palliative Care Training. Training valid for 4 years.

Small Hospital Target

Pay for reporting Palliative Care Capacity Attestation Form, Appendix III including the information listed under Measure Requirements above.

Small Hospital Full points = 5 points. No partial points are available for this measure.

Exclusions

Hospitals with < 25 general acute beds are excluded from this measure.

Reporting

Reports & Attestations are due by February 28, 2027.

Maternity Measures (Applicable to OB Hospitals Only)

Data Submission Instructions

Hospitals must submit timely* data to California Maternal Quality Care Collaborative (CMQCC). Hospitals must authorize PHC to receive data from CMQCC by completing the authorization form available on the Maternal Data Center.

For hospitals new to CMQCC:

- Legal agreement: due September 30
- First data submission for July - October: due December 15.
- Timely data submission after that, starting January.

For hospitals already participating in CMQCC:

- 12 months of timely data submission for each month during the measurement year.

Per CMQCC, timely submissions are defined as those submitted within 45-60 days after the end of the month.

4. Elective Delivery before 39 Weeks

Description:

Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, where the delivery was elective within the measurement year.

Numerator:

The number of patients in the denominator who had elective deliveries.

Denominator:

Patients delivering newborns at ≥ 37 to < 39 weeks gestation.

Target:

- Full Points: ≤ 1.0% = 5 points
- Partial Points: > 1.0% - 2.0% = 2.5 points

5. Exclusive Breast Milk Feeding Rate

Description:
Exclusive breast milk feeding rate for all newborns during the newborn's entire hospitalization within the measurement year.

Numerator: The number of newborns in the denominator that were fed breast milk only since birth

Denominator: Single term newborns discharged alive from the hospital during the measurement year

Target:
- Full Points: ≥ 75.0% = 5 points
- Partial Points: 70.0% - < 75.0% = 2.5 points

6. Nulliparous Term, Singleton Vertex (NTSV) Cesarean Rate

Measure Summary

Rate of Nulliparous, Term, Singleton, Vertex Cesarean births occurring at each HQIP hospital within the measurement period.

Targets

All Size Hospitals

Full Points: < 22.0% NTSV cesarean rate = 5 points **Partial Points: ≥ 22.0% - 23.9% NTSV rate = 2.5 points**

Target thresholds determined considering the HealthyPeople2020 goal, and statewide and HQIP participant averages calculated using Cal Hospital Compare data.

Specifications
Joint Commission National Quality Care Measures Specifications v2018A used for this measure.

Numerator: Patients with cesarean births.
Denominator: Nulliparous patients delivered of a live term singleton newborn in vertex presentation.

7. Vaginal Birth After Delivery (X-Large Hospitals Only)

Description:
For hospitals with ≥ 100 beds that offer maternity services: Percent of patients who had a previous Cesarean delivery who deliver vaginally during the Measurement Year.

Numerator: Patients who deliver vaginally that have had a previous Cesarean delivery.

Denominator: Patients with a previous cesarean birth.

Target: Full Points: ≥ 5.0% VBAC Uncomplicated = 5 points

8. Expanding Delivery Privileges

Specifications

In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

Measure Requirements

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year starting July 1, 2025, and remains in Phase Two for this bridge period.

Phase Two Requirement:

Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges. Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.

8. Expanding Delivery Privileges

Target (5 Points)

Provide evidence* of recruitment during the measurement year and/or provider privileges list for those family physicians and midwives with privileges sent to Partnership by December 31, 2026.

Reporting

Evidence may include a list of family physicians and midwives with current privileges and/or other evidence of their privileges. If hospitals have actively recruited or completed outreach to midwives and physicians, but have not contracted with providers yet, they can submit evidence of recruitment and outreach for their submission. All documentation must be submitted to Partnership no later than December 31, 2026.

9. Doula Support

Measure Summary

This measure is intended to encourage hospitals to allow doulas to provide support during labor and delivery. Doulas can play a vital role during and after pregnancy as they support and comfort birthing parents. The benefit of doulas to the mother, baby, and birth outcomes is significant. These benefits include fewer interventions during delivery, being an advocate for the patient, providing extra attention and another set of hands, a person to help walk through difficult situations, offering additional coping skills as well as physical, emotional, and spiritual support, postpartum support, and a more satisfying birth experience.

Specifications

This measure will be implemented over multiple years, with **phase one** starting with the 2025-26 measurement year. In future years, hospitals will be required to work toward actively recruiting and allowing doulas to provide support during labor and delivery.

9. Doula Support

Measure Requirements

Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery. In future years, we anticipate a second phase of this measure to include evidence that doulas are being utilized in labor and delivery. Hospitals with existing bylaws and/or written policies that allow doulas to provide support during labor and delivery will get full points for the measure.

Target (5 Points)

Evidence* that approved policies and procedures are in place by December 31, 2026, and/or submission of the list of doulas used by the hospital.

Reporting

*Evidence may include written policy and procedure respective to the measure requirements above. Alternatively, a list of current doulas who supported births during the measurement year may be submitted. All documentation must be submitted to Partnership no later than December 31, 2026.

10. Increasing Screening Mammogram Capacity

Specifications

Hospitals with on-site mammography can be incentivized by increasing access/capacity to mammogram screening through increasing breast cancer screening access/capacity for Partnership members by at least 5 to 10%. Hospitals without on-site mammography may meet the measure by hosting a mobile mammography event. Each hospital's baseline rate will be calculated from services provided during the previous measurement year (July 1 through June 30) in which the hospital participated in the HQIP.

Measure Requirements

Hospitals with on-site access to mammography:

Full Points = 5 Points: Increase access/capacity for breast cancer diagnostics and screening by 10% over the previous year's baseline.

Partial Points = 2.5 Points: Increase access/capacity for breast cancer diagnostics and screening by 5-9.9% over the previous year's baseline.

10. Increasing Screening Mammogram Capacity

Very Small Size Hospitals without on-site access to mammography:

Full Points = 10 Points: Host at least one(1) mobile mammography clinic during measurement year with at least 25 exams conducted with priority given to Partnership members. Mammography may be hosted at the hospital or another location such as a Primary Care Provider (PCP) site if collaborating with the clinic with a PCP site.

Reporting

Partnership will utilize claims data to determine the percentage of capacity increase each year.

Exclusions

Breast Magnetic Resonance Images (MRIs) do not count toward the targets.

Note: This measure is not applicable to hospitals with > 25 LGA beds that do not have an owned/affiliated on-site**

mammography center and/or contract with outside vendors for mammography.

11. Vaccines For Children Program Enrollment

Hospitals play a critical role in both fighting viruses like respiratory syncytial virus (RSV) after it is contracted and in preventing it. Vaccinating newborns before discharge from the hospital is an excellent way to help protect against illnesses like RSV; especially for those individuals who may be more likely to not have or miss follow-up well-child visits.

The California Department of Public Health (CDPH) has a Vaccines for Children (VFC) program that can cut costs significantly for hospitals by providing them with a variety of vaccines, like Beyfortus® (Nirsevimab) at ***no cost*** for eligible infants, which includes Medi-Cal members. Vaccines included in program are: DTaP, and DTaP combinations, HepA, HepB, HIB, HPV, IPV, MenACWY, MABCWY, MENB, MMR, PCV, PPSV23, RSV, RV, Td, Tdap, and Freezer vaccines: Covid-19, MMR, MMRV, VARRecent. Since the current list price for newer vaccines like Beyfortus® (Nirsevimab) is significantly high per dose, receiving them for free is a substantial cost savings, and can positively impact the newborn population.

11. Vaccines For Children Program Enrollment

Measure Summary

HQIP birthing hospitals can save costs and positively impact their newborn populations by enrolling in the ‘no cost” Vaccines for Children program through CDPH. Partnership’s HQIP birthing hospitals will be eligible to receive points by successfully enrolling in the CDPH’s VFC program by the end of the measurement year.

Target (5 Points)

Target: Enrollment in VFC program by December 31, 2026

Reporting

Hospitals will send proof of enrollment to Partnership by December 31, 2026.

Resources

Hospitals should visit https://eziz.org/vfc/ to find all pertinent information about the program. The 2025 Program Participation Requirements at a Glance document is a key guide that includes resources and job aid links to understand enrollment and program requirements.

Hospitals can also contact VFCEnrollment@cdph.ca.gov to receive more support for enrolling in this unique cost saving program.

Top 8 Reasons Birthing Hospitals Should Join the Vaccines For Children Program (VFC)

1

Protect infants at the earliest opportunity

Over 60% of children in California do not have a medical home. Providing RSV immunization in the birth hospital helps prevent delays in protection when infants are most vulnerable.

2

Reduce costs

VFC enrollment provides RSV imunizations at no cost. With a list price of over $550 per dose, participation provides substantial financial savings.

3

Improve health outcomes

RSV immunizations (Nirsevimab and Clesrovimab) are highly effective at preventing outpatient visits and hospitalizations related to RSV infection.

4

Support national recommendations

The American Academy of Pediatrics recommends administering RSV during birth hospitalization for early protection.

5

Maintain a minimal formulary

After enrolling, hospitals may choose to order only RSV and Hepatitis B immunizations for infants under their care rather than stocking all pediatric vaccines.

6

Access the exclusive Replacement Model Program

Available only to birthing hospitals, this model allows hospitals to replace doses for any private immunizations administered to VFC-eligible infants, eliminating the need to track separate inventories. (An application is required).

7

Support national performance goals

Participation contributes to Joint Commission National Performance Goal #4: Excellent Health Outcomes for All.

8

Earn public recognition

Join peer institutions listed on the California Department of Public Health's (CDPH) "Immunization-Friendly Birth Hospital Honor Roll" for taking proactive steps to protect infants.

Contact us today for white-glove enrollment support at VFCEnrollment@cdph.ca.gov.

PARTNERSHIP HEALTHPLAN of CALIFORNIA

12. Patient Safety Organization Participation

Measure Summary

Participation in an approved PSO during the measurement year to maintain an environment of safety.

Large Hospitals:
Participation in at least two collaborative forums with other providers, either in-person or virtually, during the Measurement Year
Submission of 50 patient safety events to a PSO, for events occurring within the measurement year or the year prior

Small Hospitals:
Participation in at least one collaborative forum with other providers, either in-person or virtually, during the Measurement Year
Submission of 5-10 patient safety events to a PSO, for events occurring within the measurement year or the year prior

12. Patient Safety Organization Participation

Targets

All Small Hospitals: Full Points = 5 points. No partial points are available for this measure.

Reporting

By December 31, 2026, hospitals will submit evidence of participation with a new PSO that includes evidence of patient safety data submission (the number of events submitted). If possible, PSOs can email a report to hqip@partnershiphp.org with the number of patient safety events submitted by a hospital.

13. Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT)

Specifications

Option 1:

Hospitals of all sizes can earn full credit for the measure by providing proof of a dedicated full-time substance use navigator for SUD referrals (i.e., Bridge Program Model). Hospitals' proof of dedicated full-time Substance Use Navigator consists of job description, and sample of weekly work schedule.*

Option 2:

Denominator: Emergency Department or inpatient admissions of Partnership members with ICD10: F11.1x diagnosis code of opioid use disorder billed in any position on the claim.

13. Substance Use Disorder (SUD) and Medication Assisted Treatment (MAT)

Numerator: Any subsequent prescription of buprenorphine ***or*** any subsequent office visit with a diagnosis of F11.x

Buprenorphine Rx may include Buprenorphine, Buprenorphine HCl, Buprenorphine-naloxone, Suboxone, Zubsolv, Vivitrol, and/or Butrans.

"Subsequent" is defined as the period between 1 and 60-days post discharge after an ED or inpatient stay, during the Measurement Year.

Data Collection: Partnership will use medical and Buprenorphine pharmacy claims data for the period 1-60 days post-discharge during the Measurement Year, as well as outpatient provider data to determine performance.

SUD/MAT Targets (10 Points)

Below are the two ways in which hospitals can meet this measure by option 1 or option 2:

Option 1:	Option 2:	Option 2:	Option 2:
All Hospital Sizes:	**Large and X-Large Hospitals** **with ≥ 50 LGA beds:**	**Small Hospitals** **with 25 - 50 LGA beds:**	***Very Small Hospitals*** ***with < 25 beds:***
Proof of Full-time, dedicated navigator position **and*** 40% of members received prescription or office visit	Full points ≥ 10 Partnership Members **and** 40% of Partnership Members received prescription or office visit	Full Points ≥ 5 Partnership Members	Full Points ≥ 3 Partnership Members

***Note:** Hospitals that have a dedicated Substance Use Navigator are still required to meet the numerator and/or rate targets to earn points for this measure.*

Reporting

Partnership will access claims data to determine performance.

14. Hospital Quality Institute Platform

Measure Summary

Participation in the Hospital Quality Improvement Platform and timely, complete data submissions. The HQI Platform is available to all California Hospital Association members at no additional charge. This measure is broken into three (3) parts;

1. Participation in HQI Platform (verified by September 30, 2026), including NHSN rights conferral (Partnership will assess hospital usage December 31, 2026) and,

2. One (1) submission of data into the HQI platform by September 30, 2026, and,

3. Timely, complete and consistent submission of discharge data into HQI Platform

Target

Full Points = 5 points: Hospitals maintain a data sharing agreement with HQI for prior measurement year or successfully sign up with HQII, confer NHSN rights, submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by September 30, 2026, and continue to submit all discharge data into the platform for the remainder of the measurement year. Partnership assesses timely data submission at the end of the measurement year.

14. Hospital Quality Institute Platform

Partial Points = 2.5 points: Hospitals maintain data share agreement with HQI from prior measurement year or successfully sign up with HQI, confer NHSN rights, and submit all discharge data due to HCAI into the Hospital Quality Improvement Platform by December 31, 2026.

Measurement Period

July 1, 2026 – December 31, 2026

All reporting happens through the HQI platform.

To begin participation in the HQI platform: visit https://hqinstitute.org/the-hospital-quality-improvement-platform/, complete the Business Associate and Participation Agreements in the "Join the Program" section, and retrieve upload instructions.

Thank you for attending the HQIP Kickoff Webinar!

Resources and Contact Information

Your HQIP Team:

Troy Foster, Program Manager II
Hospital and Perinatal QIPs

James Devan,
Director of Quality Management
Health Services - Quality and Performance Improvement

Please visit the HQIP webpage for everything HQIP including specifications, newsletters and webinars

You can send questions or comments to hqip@partnershiphp.org