Medicare Quality Innovation Network (QIN) Quality Improvement Initiatives: Goals, Metrics and Planned Activities

**Goal 1**
Improve access to behavioral health and decrease substance abuse

**Metrics**
1.1 Decrease opioid-related adverse drug events (ADEs) and overdose-related deaths
   - 1.1.1 Decrease opioid prescriptions >90 MME
   - 1.1.4 Implement pain and opioid best practices
   - 1.2 Increase access to treatment for mental health conditions

**Goal 2**
Improve patient safety in all care settings*

**Metrics**
2.3.1 Reduce the rate of hospital utilization for ADEs in all community settings
2.5 Reduce the rate of hospital utilization for C. difficile infection

*Focus on infection prevention

**Goal 3**
Chronic Disease: Prevent the progression of cardiovascular, diabetes and chronic kidney disease (CKD)

**Metrics**
3.1 Contribute to preventing cardiovascular events
   - 3.1.1 Achieve 80% performance on the ABCS (Aspirin when appropriate; Blood pressure control; Cholesterol management; Smoking cessation) clinical quality measures
3.3 Prevent beneficiaries from developing diabetes
   - 3.3.1 Achieve 55% referral to Diabetes Prevention Program of eligible community beneficiaries served by QIN-supported practices
3.4.a Prevent progression of CKD or to end-stage renal disease (ESRD) through improved screening, diagnosis and management
   - 3.4.1 Prevent progression of CKD to ESRD by identifying patients high-risk for developing kidney disease
3.4.2 Improve kidney disease outcomes

**Goal 4**
Improve the quality of care transitions

**Metrics**
4.1.a Improve all-cause hospital admissions
4.1.b Improve all-cause hospital 30-day readmissions
4.2 Reduce community-based ADEs for Medicare beneficiaries
4.3 Reduce the rate of emergency department (ED) visits and admissions by super utilizers

**Goal 5**
Improve quality of care in nursing homes

**Metrics**
5.1 Improve the mean total quality score and reduce the percentage of nursing homes with a total quality score of 1258 or less
5.2 Reduce ADEs in nursing homes
5.3 Reduce health care-related infections in nursing homes
5.4 Reduce ED visits and hospital readmissions

**Planned Activities**
- **Baseline Data Collection**
  - Identify type of data currently being collected
  - Provide data support for community projects
- **Environmental Scan**
  - Understand and coordinate with state and local programs doing similar work
  - Assess the needs of communities, patients, families and local care delivery systems
- **Collaboration**
  - Collaborate and align activities to implement community resources and activate patients and families
  - Develop and implement tools
- **Engage and Activate Patients**
  - Assist communities with the implementation of effective patient family advisory councils
  - Integrate the consumer voice into care delivery processes
- **Implement Improvement Interventions**
  - Spread best practices
  - Provide peer-to-peer networking opportunities
  - Access to subject matter experts
  - Ongoing evaluation and monitoring support to ensure identified needs are met