The **PRIME Eligible Population** includes: (1) individuals of all ages with at least 2 encounters with the PRIME Entity Primary Care team during the measurement period **OR** (2) individuals of all ages who are in Medi-Cal Managed Care with 12 months of continuous assignment to the PRIME Entity during the Measurement Period.

PRIME Project 2.2 Care Transitions: Integration of Post-Acute Care

Project 2.2 Objectives[1][1]
• Improve communication and coordination between inpatient and outpatient care teams • Increase patients' capacity for self-management • Improve patient experience • Reduce avoidable acute care utilization • Reduce disparities in health and health care
Project 2.2 Target Population[2]
1) PRIME Eligible Population AND 2) Experience at least one inpatient discharge from any of the PRIME Entity's acute care facilities during the measurement year
Project 2.2 Metrics[2] (applied to the Project 2.2 Target Population; metric 2.2.2-*HCAHPS* is an exception)
2.2.1 - **DHCS All-Cause Readmissions – Statewide Collaborative QIP metric** • For individuals 21 years of age and older, the number of acute inpatient stays at the PRIME Entity facility during the measurement year that were followed by an unplanned acute readmission at the PRIME Entity facility for any diagnosis within 30 days. 2.2.2 - **NQF 0166: H-CAHPS – Care Transition Composite: Understanding Your Care When You Left The Hospital** *[The PRIME Eligible Population and Project Target Population do not apply to the denominator for this metric]* • Question #23: During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left. • Question #24: When I left the hospital, I had a good understanding of the things I was responsible for in managing my health. • Question #25: When I left the hospital, I clearly understood the purpose for taking each of my medications. 2.2.3 - **NQF 0097: Medication Reconciliation within 30 days** • The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse. 2.2.4 - **NQF 0646: Reconciled Medication List Received by Discharged Patients** • Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. 2.2.5 - **NQF 0648: Timely Transmission of Transition Record** • Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.

[1] Source: PRIME Attachment Q

[2] Source: DY12 Mid-Year Reporting Manual

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PRIME Project 2.3 Complex Care Management for High-Risk Medical Populations

Project 2.3 Objectives[1]
• Improve patients' functional status • Increase patients' capacity to self-manage their condition • Improve medication management and reconciliation • Improve health indicators for chronically ill patients including those with mental health and substance abuse disorders • Reduce avoidable acute care utilization (readmissions, admissions & ED visits) • Improve patient experience
Project 2.3 Target Population[2]
1. PRIME Eligible Population AND 2. Age 18 and over as of the last day of the measurement period AND 3. 4 or more chronic medical conditions during the year preceding the measurement period as defined by the Chronic Condition Indicator (ICD-9: http://www.hcup-us.ahrq.gov/toolssoftware/chronic/chronic.jsp#files , ICD-10:https://www.hcup-us.ahrq.gov/toolssoftware/chronic_icd10/chronic_icd10.jsp#technical) AND 4. Participating systems may decide to apply additional criteria to better define a subpopulation of patients who would be most likely to benefit from services provided by a coordinated complex care management program. (e.g. selecting one or more index conditions that must be one of the 4 chronic conditions; narrowing chronic conditions to specified multi-morbidity patterns (http://www.chcs.org/media/clarifying_multimorbidity_patterns.pdf); including criteria on number of chronic daily medications; etc.)
Project 2.3 Metrics[2] (applied to the Project 2.3 Target Population)
2.3.1 - **Care coordinator assignment: High Risk Medical Populations** • Percentage of clients in the target population with an assigned care coordinator. 2.2.3 - **NQF 0097: Medication Reconciliation within 30 days** • The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse. 2.3.3 - **AHRQ Prevention Quality Indicators (PQI) #90** • Overall composite: ages 18 years and older. Includes admissions for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, angina without a cardiac procedure, dehydration, bacterial pneumonia, or urinary tract infection. 2.3.4 - **NQF 0648: Timely Transmission of Transition Record** • Percentage of patients, regardless of age, discharged from an inpatient facility (e.g., hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.