Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

APPLICABLE LINES OF BUSINESS

- Medicare

MEASURE DESCRIPTION

Percentage of emergency department (ED) visits for patients 18 years and older who have multiple high-risk chronic conditions and who had a follow-up service within 7 days of an ED visit.[i]

Note: If a member has more than one ED visit in an eight-day period, the first eligible ED visit date is counted as the start of the 7-day period. If a patient has more than one ED visit during the year, each ED visit may be counted for this measure.

Eligible Chronic Condition Diagnoses

A person with multiple high-risk chronic conditions is defined as anyone who was diagnosed with two or more of the following conditions during the measurement year or the year prior, but prior to the ED visit:

- Alzheimer's disease and related disorders
- Atrial fibrillation
- Chronic kidney disease
- COPD and asthma
- Depression
- Heart failure
- Myocardial infarction (acute)
- Stroke and transient ischemic attack

EXCLUSIONS

Patients are excluded if they:

- Received hospice or palliative care during the measurement year
- Had an ED visit resulting in acute or non-acute inpatient care on day of visit or within 7 days after the ED visit, regardless of the principal diagnosis for admission
- Are deceased during the measurement year

PATIENT CLAIMS SHOULD INCLUDE

Follow-up care within 7 days after the ED visit (8 days total). This includes visits that occur on the date of the ED visit. The following meet criteria for follow-up:

- Outpatient, telephone visit, or virtual care/telehealth visit
- E-visit or virtual check-in
- Transitional care management services, case management visit, or complex care management services
- Outpatient or telehealth behavioral health visit and electroconvulsive therapy
- Intensive outpatient encounter or partial hospitalization, observation visit, or Community Mental Health Center visit
- Substance use disorder service
- Domiciliary/rest home visits

TIPS FOR SUCCESS

- Keep open appointments so patients with an ED visit can be seen within 7 days of inpatient discharge.
- Schedule post-ED follow-up visits within 2-5 days after discharge.
- Provide follow-up care. In addition to an office visit, follow-up can be provided via a telephone or virtual care/telehealth visit.
- Enroll your practice in an admission, discharge, and transfer alert system (ADT) to ensure timely receipt of information and create provider alerts and tracking for follow-up.
- Flag patients with comorbidities that would require a follow-up after an ED visit.
- Develop centralized team or assigned roles to communicate with patients post-discharge.
- Implement a standard post-ED visit template to reduce patient risk and readmissions that:
    - Assesses patient comprehension of his or her diagnosis and discharge instructions
    - Assesses patient's or caregiver's ability to self-manage medications
    - Asks about barriers or issues that might have contributed to the ED visit and discuss how to prevent them in the future
    - Incorporates knowledge of the "red flags" of a worsening condition and what to do or who to contact
    - Establishes who to contact for questions or concerns about their care going forward
- Encourage patients to have regular office visits with their primary care physician to monitor and manage chronic conditions.

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i National Committee for Quality Assurance. HEDIS® Measurement Year 2022 Volume 2 Technical Specifications for Health Plans