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

5-Star Best Practices

What It Measures: The percentage of emergency department (ED) visits on or between January 1 and December 24 for adult patients with multiple high-risk chronic conditions who had a follow-up service within 7-days of the ED visit. This measure is based on ED visits, not patients.

Reporting Requirements: Every time a patient who has multiple high-risk chronic conditions visits an ED, a follow-up service needs to occur within 7 days after the ED visit (8 total days). Visits that occur on the date of the ED should also be included in the reporting. The following meets criteria for follow-up:

- Outpatient visit
- Telephone or telehealth visit
- Transitional care management
- Case management
- Complex Care Management
- Outpatient or telehealth behavioral health visit
- Intensive outpatient encounter or partial hospitalization
- Community mental health center visit
- Electroconvulsive therapy
- An observation visit

The measure does not specify credential requirements for care providers.

Who Is Eligible: Any patient who has had an ED visit on or between January 1 and December 24 of the measurement year and had two or more of the below chronic conditions prior to the ED visit, or one year prior to the ED visit.

- COPD and Asthma
- Alzheimer's Disease and related disorders (reference Dementia and Frontotemporal Dementia value set)
- Chronic Kidney Disease
- Depression
- Heart Failure
- Acute Myocardial Infarction
- Atrial Fibrillation
- Stroke and Transient Ischemic Attack

Exclusions: Exclude ED visits followed by admission to an acute or non-acute inpatient care setting on the date of the ED visit or within 8 days after the ED visit, regardless of the principal diagnosis for admission.

Best Practices:

- Get follow-up appointment scheduled within 7 days if patients need to be seen in the office
- Ensure patients receives condition self-management action plan where appropriate

How to Close the Gap in Care:

Once a follow-up service is conducted, record it in one of two ways.

- A dated progress note stating at least one follow-up visit that meet the criteria
- Submit claim encounter data for an ED follow-up
  - For the full list of eligible codes, please contact us at NetworkQuality@scanhealthplan.com

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

Medical Group Guidelines

What It Measures: The percentage of emergency department (ED) visits on or between January 1 and December 24 for members 18 years and older with multiple high-risk chronic conditions who had a follow-up service within 7-days of the ED visit.

What It Is: Primary care teams document and report follow-up visit after a patient with multiple high-risk chronic conditions visits the ED.

How it is Measured:

- *Denominator:* Eligible population with an ED visit on or between January 1 and December 24 of the measurement year where the patient was 18 years or older on the date of the visit.
- *Numerator:* A follow-up service within 7 days after the ED visit (8 total days), including visits that occur on the date of the ED visit. Reference list of services that meet the criteria under "Reporting Requirements" on the back page.

What You (the Medical Group) Can Do:

- Identify where the ED visit occurred.
- Establish a line of communication with primary hospitals to receive notification of ED discharges and the ED visit notes.
- Establish a workflow for receiving ED discharge notifications and ensure gap closure for eligible reporting requirements within 7 days.
- Submit supplemental data in cases where encounter data is not otherwise automatically generated within 7 days.
- *Let your physicians and other providers know about the measure.* Make sure they receive the guidelines and best practices on the other side of this sheet.