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

HEDIS® Measurement Year 2023 Measures

Measure Description: The percentage of emergency department (ED) visits for members 18 years of age and older who have multiple high-risk chronic conditions who had a follow-up service within 7 days of the ED visit (8 total days).

Eligible Population

Medicare members who are 18 years of age or older on the date of the ED visit who:

- had two or more chronic conditions diagnosed prior to the ED visit.
- visited the ED on or before January 1 and December 24 of the measurement year.

  ***Note**: Members may have more than one ED visit in the measurement year. If a member has more than one ED visit in an 8-day period, include only the first eligible ED visit.*

- Members who are in hospice or receiving palliative care are excluded.

Eligible Events

Members who had any of the following events on different dates of service during the measurement year or the year prior to the measurement year but prior to the ED visit:

- At least one acute inpatient encounter with an eligible chronic condition.
- At least one acute inpatient discharge with an eligible chronic condition on the discharge claim.
- At least two outpatient, observation, ED, or telephone visits, e-visits or virtual check-ins, non-acute inpatient encounters, or non-acute inpatient discharges with an eligible chronic condition.

Eligible Chronic Conditions

- Acute myocardial infarction
- Alzheimer's disease and related disorders
- Atrial fibrillation
- Chronic kidney disease
- COPD and Asthma
- Depression
- Heart failure
- Stroke and transient ischemic attack

Exclusions

Any ED visits resulting in acute or non-acute inpatient care on the day of the ED visit or within seven days after the ED visit.

Measure Compliance (numerator)

A follow-up service within seven days after the ED visit, including on the date of the ED visit (eight total days). Any of the following meet criteria for a follow-up service:

- An outpatient, telehealth, observation, or telephone visit.
- An e-visit or virtual check-in.
- A transitional care or complex care management services, or case management visits
- An outpatient or telehealth behavioral health visit.
- An intensive outpatient encounter or partial hospitalization.
- A community mental health center visit
- A substance use disorder service
- A domiciliary or rest home visit

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Best Practices

- Schedule post ED follow-up visit within three to five days after discharge.
- Encourage members to have regular office visits with primary care physician (PCP) to monitor and manage chronic disease conditions.
- Provide a visit summary that includes the discussion during the PCP visit and clear instructions on changes that need immediate attention.
- Encourage patients to call PCP's office/after-hours line when condition changes (weight gain, medication changes, high/low blood sugar readings).
- Develop a daily process to schedule members that have been discharged from the ED or an inpatient stay.
- Establish relationships with area hospitals to develop notification processes for ED visits.
- Submit claims timely and include the appropriate codes for diagnosis, health conditions and services provided.

Numerator Codes

A large list of NCQA approved codes is used to identify numerator services for this measure. The complete NCQA approved code set can be referenced in the coding guide at healthplan.org/providers/patient-care-programs/quality-measures.

For questions, please contact your practice management consultant. To identify your practice management consultant, please refer to healthplan.org/providers/overview/meet-practice-management-consultant.

The Health Plan has a team of member advocates, health coaches, social workers and nurses who can assist you and your patients to remove or overcomeany barriers to care through benefit assistance, community resource referrals or enrollment in a THP clinical program. To refer a patient who is a THP member for assistance, call ***1.877.903.7504*** *and let us know what we can do to help your patient receive and adhere to your recommended plan of care*