



**2024 FMC**

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

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

## Older Adults and Emergency Department Visits



Medicare beneficiaries are at particular risk following ED visits because of their functional limitations, audio and visual impairments and use of multiple medications.



30.1% of Medicare beneficiaries had two or three chronic conditions, 20.9% had four or five and 14.5% had six or more



Older adults discharged from the ED had an average mortality rate of 10%, an average ED readmission rate of 24% and an average post-discharge hospitalization rate of 24% within the first three months after the ED visit.



It is imperative that primary care providers follow up with these patients as soon as possible post ED visit.

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## Measure Description

The percentage of ED visits for patients who are 18 years of age and older with multiple high-risk chronic conditions and who received appropriate follow-up care within seven days of discharge.

ED visits must occur between January 1, 2024-December 24, 2024.

Note: The patient may fall into this measure several times throughout the year. This measure is **based on visits, not on patients.**



Patients 18 years of age and older with multiple chronic conditions who had an ED visit.



Received follow-up care from their PCP within 7 days of discharge.

# X1

Single Weighted Star Measure

Measure Steward: National Committee for Quality Assurance (NCQA)

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Patients are included in the measure who have **two or more** of the following chronic conditions diagnosed during the current performance or prior year and before the ED visit.



**COPD**  
**Asthma/Unspecified Bronchitis**  
**Alzheimer's disease and related disorders**  
**Chronic Kidney Disease**  
**Depression**  
**Heart Failure**  
**Acute myocardial infarction**  
**Atrial fibrillation**  
**Stroke and transient ischemic attack**



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## Required Exclusions

- Patients in hospice or using hospice services anytime during the current performance year
- Patients that pass away any time during the current performance year
- ED visits that result in an inpatient stay
- ED visits that result in admission to an acute or non acute setting on the date of ED discharge or within 7 days of the ED discharge regardless of the principal admission diagnosis



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**Follow-Up Care may include any of the following on the day of discharge through seven days post discharge (8 days total)**

- ❖ An outpatient visit
- ❖ A telephone visit
- ❖ Transitional care management services
- ❖ Case management visits
- ❖ Complex Care Management Services
- ❖ An outpatient or telehealth behavioral health visit
- ❖ An outpatient or telehealth behavioral health visit
- ❖ An intensive outpatient encounter or partial hospitalization
- ❖ An intensive outpatient encounter or partial hospitalization
- ❖ A community mental health center visit
- ❖ Electroconvulsive therapy
- ❖ A telehealth visit
- ❖ An observation visit
- ❖ A substance use disorder service
- ❖ An e-visit or virtual check-in
- ❖ A domiciliary or rest home visit

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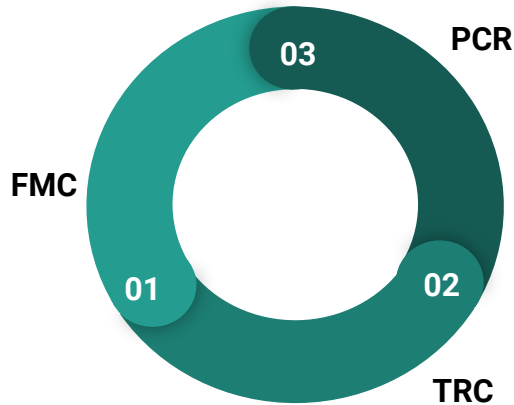
## Best Practices

- ★ Develop a process to schedule follow up visits for patients post ED visit daily.
- ★ Educate patient on the appropriate use of the Emergency Department, Urgent Care and PCP utilization
- ★ Most patients have telehealth services via their health plan. Refer them to their insurance provider for the appropriate telephone number.
- ★ Discuss having ED records sent to your primary care office. Work with your local EDs to create this process.
- ★ Encourage frequent visits to the PCP for chronic conditions. Best practice is 3-4X per year.
- ★ Submit timely claims. Ensure you are using appropriate codes for diagnosis, health conditions and services provided.



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## Importance of following up after an ED discharge



ED visits can lead to several ED visits, causing the patient to fall into the FMC measure denominator several times per year.

Repeat ED visits typically leads to an inpatient admission. This causes the patient to now fall into the Transitions of Care measure (TRC) (X1) , as well as the Plan All-Cause Readmission (PCR) (X3) measure.

Older adults typically have chronic conditions and a higher rate of readmission. This may have a negative effect on the PCR measure dropping your star rating. In addition, the patient has now fallen back into the the TRC and PCR measure for the second time.



**Thank you!**