



# Overview

- Individuals with chronic diseases are the leading cause of illness, disability, and death in the United States
- Individuals with multiple chronic conditions require ongoing medical attentions and impact quality of life
- There are 1 out of 3 adult Americans that have multiple chronic conditions
- Individuals with multiple chronic conditions are the leading drivers of our nation's \$4.1 trillion in annual health care costs

The American Journal of Managed Care. (11, June 2021). *Management of Individuals With Multiple Chronic Conditions: A Continuing Challenge*. Retrieved April 12, 2023, from

 $\frac{https://www.ajmc.com/view/management-of-individuals-with-multiple-chronic-conditions-a-continuing-challenge}{challenge}$ 

Centers for Disease Control and Prevention. (21, July 2022). *About Chronic Diseases*. Retrieved April 12, 2023, from https://www.cdc.gov/chronicdisease/about/index.htm

#### WHY IS IT IMPORTANT

- ➤ It's critical that members with multiple chronic conditions who had an ER visit have a f/u visit with their primary care provider within 7 days to review the reason for visit, review medication list and initiate additional treatment to prevent repeated ER visit or end up getting hospitalized
- > Educate patients on how to contact primary care provider when experiencing new symptoms before symptoms get worse
- > To review with patients how conditions are coordinated between healthcare team and how conditions are being managed at home

https://www.ncqa.org/hedis/measures/follow-up-after-emergency-department-visit-for-people-with-high-risk-multiple-chronic-conditions/

https://www.multiplechronicconditions.org/



# Understanding the Measure

Follow-up after ED for People with Multiple High-Risk Chronic Condition (FMC)

- How is someone identified for the measure:
  - Members 18 years of age and older with multiple high-risk chronic conditions diagnoses before the current year and during the current year, but before ED visit
  - Conditions that are being tracked:
    - ✓ COPD and asthma
    - ✓ Alzheimer's disease and related disorders
    - ✓ Chronic kidney disease (CKD)
    - ✓ Depression
    - ✓ Heart failure
    - ✓ Acute myocardial infarction (MI) or old MI
    - ✓ Atrial fibrillation
    - ✓ Stroke and transient ischemic attack (TIA)
- How is it measured:
  - Member has a follow up visit with PCP within 7 days of each ED visit



#### TALKING POINTS WITH PROVIDER GROUPS

- Remind provider groups that FMC is based on ED visits. Members may be in the measure more than once, if they had multiple ED visits
- Discuss with provider groups the importance of the follow-up visit within 7 days
- Remind provider groups that FMC measure does not require in person visit. Follow-up can be provided via telehealth, telephone, e-visit or virtual visit
- Discuss and share the quality care gaps report showing noncompliant eligible members for this measure
  - Instruct provider groups to review these members(s) medical record to verify if the visit was completed
    - Identify the reason why FMC measure was not closed may be a coding issue
- Remind provider groups to tell their patient after each provider visit, to contact PCP the day after leaving the ED, to make a follow-up appointment within 7 days
- Verify that they have a process in place to identify these members and that they have available time slot to complete the follow-up visit within 7 days after ED visit
- Discuss the option of submitting supplemental flat file to capture all FMC visits



#### PROVIDER GROUP'S KEYS TO SUCCESS

- Ensure that provider groups have a work process to complete f/u ED visit within 7 days
- Because it must be done within 7 days of ED visit, remind patients that have multiple chronic conditions, to call clinic the next day after any ED visit, to schedule appointment
- Encourage providers to have available appointments for patients that need follow up within 7 days of their discharge.
- Remind provider groups to offer telehealth, telephone, e-visits or virtual visits
- Verify if provider groups have a work process to be notified when their patients are seen in ED and encourage provider groups to call patients to complete telehealth visit
- Submit supplemental flat file to capture completed services and close the care gap in our system



## Resources

- HEDIS Quick Reference Guide (page 18)
- FMC

