Quality Spotlight 2026

Follow-up After ED for Multiple Chronic Conditions

For Medicare Advantage & Traditional Medicare Population:

BCBSM, BCN, Priority, HAP, Humana

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

Percentage of ED visits for members with multiple high-risk chronic conditions who had a follow-up service within seven days of the ED visit in the measurement year.

- Ages: 18+ (Medicare Advantage)
- Had **two or more different chronic conditions prior to** the ED visit

Patients with 2 or more of the following conditions need a visit within 7 days (8 including the date of the ED visit)

- Acute myocardial infarction
- Alzheimer's disease and related disorders
- Atrial fibrillation
- Chronic Kidney disease
- Chronic obstructive pulmonary disease, or COPD, and asthma
- Depression
- Heart failure
- Stroke and transient ischemic attack

Services that close the measure:

- Outpatient visit
- Virtual care visit
- Behavioral health visit
- Case management visit
- Electroconvulsive therapy
- Substance use disorder service
- Community mental health center visit
- Complex Care Management Services
- Intensive outpatient or partial hospitalization
- Transitional care management (TCM) services

Exclusions

- Hospice or palliative care during the measurement year
- Member who died during the measurement year
- Admission to an acute or non acute inpatient facility on or within 7 days of ED visit, regardless of the principal diagnosis for the admission

FMC Measure for Various Payers

BCBSM, HAP and Humana

- If a member has more than 1 ED visit in an 8-day period include first eligible ED visit

Priority Health

- After EVERY ED discharge for people with multiple high risk chronic conditions

FMC Best Practices

- Determine best person at practice to perform ED follow up phone calls
  - Prioritize these **high-risk patients** (Any of 8+ Diagnosis)
  - Educate staff on Health Focus high risk tags on TCM tracker
  - Ensure staff calling this patient population views and utilizes resources:
    - ED Follow Up Phone Call Presentation (On GLPO.org)
    - ED Follow Up Phone Call Best Practice Tool (On GLPO.org)
- Schedule MD, DO, PA, NP visit within 7 days
  - Follow up can be for any diagnosis (Not related to ED visit)
  - Educate patient on ability to call office 24/7
- Determine which patients need ongoing weekly “check-ins”
  - Determine if patient needs medication reconciliation
  - Determine if MA, Practice Care Manager performs next phone follow up
  - Determine and refer if eligible for ECM

Scheduling & Cancellations

- Discuss the importance of **timely, keeping recommended follow-up visits**
  - Especially if one or more of these high-risk diagnosis
  - Stress the importance of follow-up and adherence to treatment recommendations
- Allow **scheduling flexibility** to accommodate a follow-up visit within seven days of the ED visit, including telehealth visits.
- **Educate members on ED avoidance** and other care options like telehealth, telephone, or urgent care. Clinician always on call.
- Outreach to patients who cancel appointments and assist them with **rescheduling as soon as possible**
- Determine how are these specific patients being **tagged in scheduling system in case they call to cancel the appt.**
  - Develop outreach internal team and/or assign care/case managers to members to ensure members keep follow-up appointments or reschedule missed appointments
  - Consider other options: telehealth, telephone visit or care manager visit.

What You Say During the Follow Up Call Matters!

Basic Follow up Call: Discuss the discharge summary; verify understanding of instructions and verify if all new prescriptions were filled.

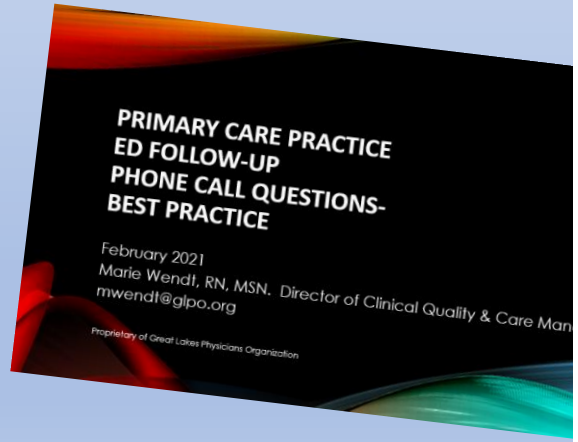
A good follow up call elicits patient seeking ED red flags:

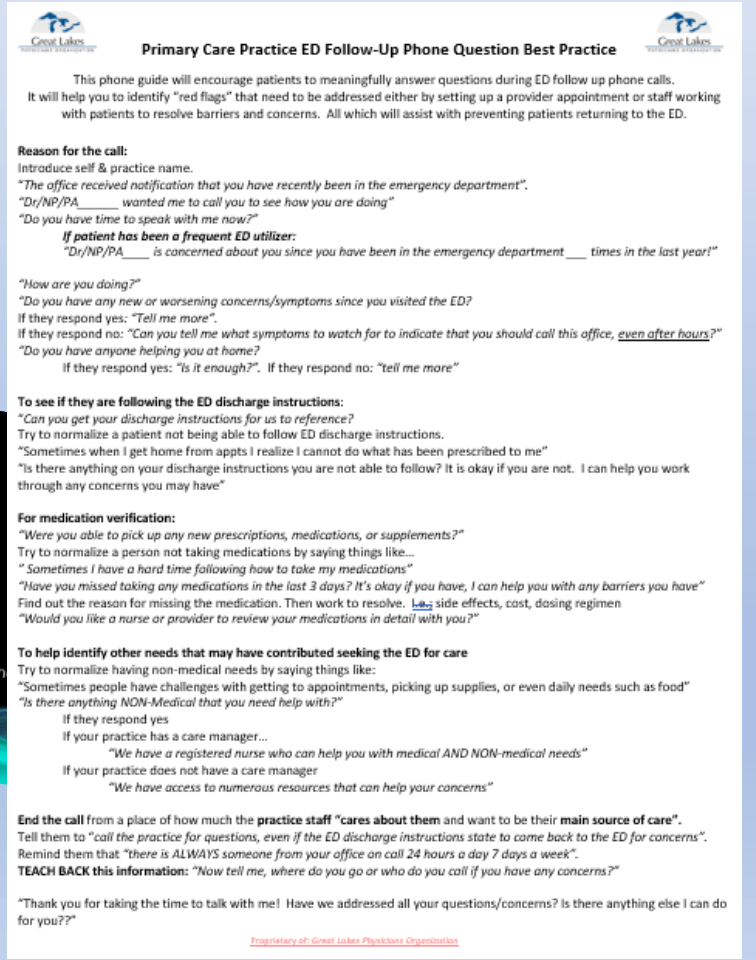
Tools on GLPO for staff to utilize

- Primary Care Practice ED Follow up Phone Questions Guide
- 10-minute video presentation

Open ended questions regarding

- Clinical Conditions Symptoms
- Medications
- Discharge Instructions
- NDOH
- Other red flags that led them to the ED





Primary Care Practice ED Follow-Up Phone Question Best Practice

This phone guide will encourage patients to meaningfully answer questions during ED follow up phone calls. It will help you to identify "red flags" that need to be addressed either by setting up a provider appointment or staff working with patients to resolve barriers and concerns. All which will assist with preventing patients returning to the ED.

Reason for the call:
Introduce self & practice name.
"The office received notification that you have recently been in the emergency department".
"Dr/NP/PA_____ wanted me to call you to see how you are doing"
"Do you have time to speak with me now?"
If patient has been a frequent ED utilizer:
"Dr/NP/PA____ is concerned about you since you have been in the emergency department ___ times in the last year!"

"How are you doing?"
"Do you have any new or worsening concerns/symptoms since you visited the ED?
If they respond yes: *"Tell me more".*
If they respond no: *"Can you tell me what symptoms to watch for to indicate that you should call this office, even after hours?"*
"Do you have anyone helping you at home?
If they respond yes: *"Is it enough?".* If they respond no: *"tell me more"*

To see if they are following the ED discharge instructions:
"Can you get your discharge instructions for us to reference?
Try to normalize a patient not being able to follow ED discharge instructions.
"Sometimes when I get home from appts I realize I cannot do what has been prescribed to me"
"Is there anything on your discharge instructions you are not able to follow? It is okay if you are not. I can help you work through any concerns you may have"

For medication verification:
"Were you able to pick up any new prescriptions, medications, or supplements?"
Try to normalize a person not taking medications by saying things like...
" Sometimes I have a hard time following how to take my medications"
"Have you missed taking any medications in the last 3 days? It's okay if you have, I can help you with any barriers you have"
Find out the reason for missing the medication. Then work to resolve. I.e., side effects, cost, dosing regimen
"Would you like a nurse or provider to review your medications in detail with you?"

To help identify other needs that may have contributed seeking the ED for care
Try to normalize having non-medical needs by saying things like:
"Sometimes people have challenges with getting to appointments, picking up supplies, or even daily needs such as food"
"Is there anything NON-Medical that you need help with?"
If they respond yes
If your practice has a care manager...
"We have a registered nurse who can help you with medical AND NON-medical needs"
If your practice does not have a care manager
"We have access to numerous resources that can help your concerns"

End the call from a place of how much the **practice staff "cares about them** and want to be their **main source of care".**
Tell them to *"call the practice for questions, even if the ED discharge instructions state to come back to the ED for concerns".*
Remind them that *"there is ALWAYS someone from your office on call 24 hours a day 7 days a week".*
TEACH BACK this information: *"Now tell me, where do you go or who do you call if you have any concerns?"*

"Thank you for taking the time to talk with me! Have we addressed all your questions/concerns? Is there anything else I can do for you??"

Proprietary of: Great Lakes Physicians Organization

(On GLPO.org)

These Specifically Diagnosed Patients NEED Ongoing Care Management or Clinician Support to prevent returning to ED!

- Develop standard of care to call patient on weekly, every two weeks or monthly cadence to prevent returning to ED for escalating symptoms
- Encourage patients to call their PCP's office, including the after-hours number, when condition changes (weight gain, medication changes, high/low blood sugar readings, breathing, activity level changes).
  - Does the patient have a red, yellow, green action plan in place that has been reviewed with them?
- Encourage these high-risk diagnosis patients to have regular office visits with their primary care practitioner (PCP) or care manager to monitor and manage chronic disease conditions.
  - Determine what cadence they are currently being followed regularly.

Virtual Care Options

- Virtual care visit(s) can be used to document exclusions and the 7-day follow-up service.

- Document and code all identified chronic conditions/diagnoses.

- Compliance with appropriate documentation can be met through coding or approved EMR supplemental data exchange.

Health Focus "At Risk" Column & Tags for FMC

Dashboard / TCM Tracker

TCM Tracker

TCM Tracker | Edit Filters

Risk Type(s): Multiple High Risk Conditions (BCBS/BCN); Multiple High Risk Conditions **Encounter Type(s):** ED **Status:** Active; Inactive; Remove

Payer	At Risk	Risk Rank	Admit Date	Event Type	Discharge Date	Follow-up
Blue Cross Blue Shield	!	High	05/06/2024, 6:51 am	ED	05/07/2024, 9:57 am	MM/DD/YYYY
	!	High	05/06/2024, 9:13 pm	ED	05/07/2024, 12:21 am	MM/DD/YYYY
	!	High	05/06/2024, 4:59 pm	ED	05/06/2024, 10:10 pm	MM/DD/YYYY
ield	!	High	05/06/2024, 10:31 am	ED	05/06/2024, 4:46 pm	MM/DD/YYYY
~~Blue ue Shield~~	!	~~High~~	~~05/06/2024, 8:38 am~~	~~ED~~	~~05/06/2024, 3:38 pm~~	~~MM/DD/YYYY~~
	!	High	05/06/2024, 11:50 am	ED	05/06/2024, 3:06 pm	MM/DD/YYYY
Blue Cross Blue Shield	!	High	05/05/2024, 4:57 pm	ED	05/06/2024, 1:03 pm	05/06/2024
Humana	!	High	05/06/2024, 10:26 am	ED	05/06/2024, 11:25 am	MM/DD/YYYY
Blue Cross Blue Shield	!	H			05/06/2024, 9:50 am	MM/DD/YYYY
Medicare ACO	!				05/06/2024, 2:15 am	MM/DD/YYYY
~~Blue Care Network~~	!	~~H~~			~~05/06/2024, 2:07 am~~	~~MM/DD/YYYY~~
	!	High	05/05/2024, 8:22 pm	ED	05/05/2024, 10:22 pm	MM/DD/YYYY
	!	High	05/05/2024, 3:14 pm	ED	05/05/2024, 6:05 pm	MM/DD/YYYY

Blue ! Signals a BCBS Patient that is in the measure

Gray ! Indicates a patient not on the BCBSM list for the measure, but has the CC that would put them into the measure

Questions