MEDICAL HOME NETWORK

FIELD Guide

A guide of the MHN ACO care management program for Medical Homes

August 2025

Not for distribution outside of MHN ACO

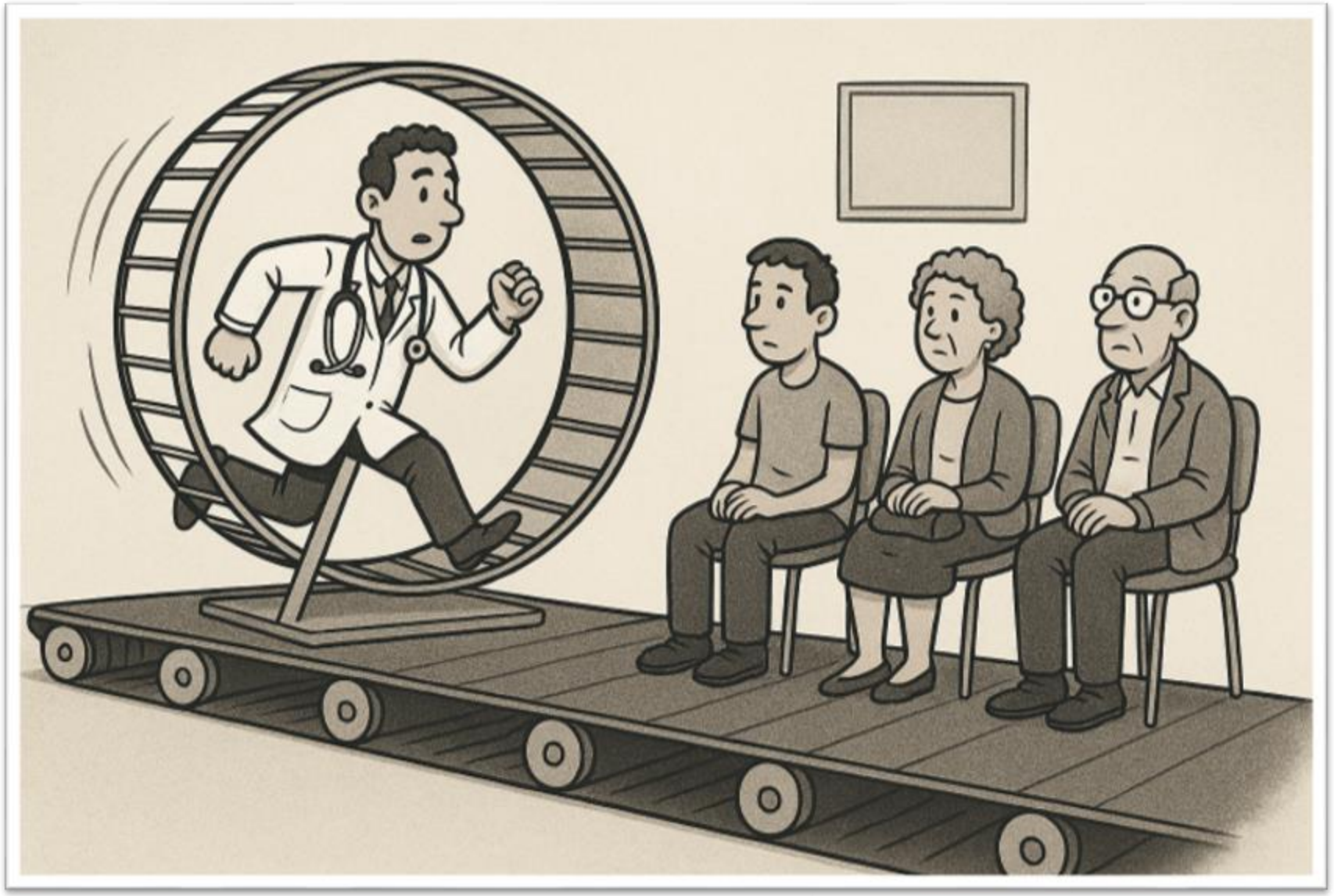
Objective of "FIELD" guide

To concisely explain the value proposition, basic structure, & requirements of the MHN ACO care management program.

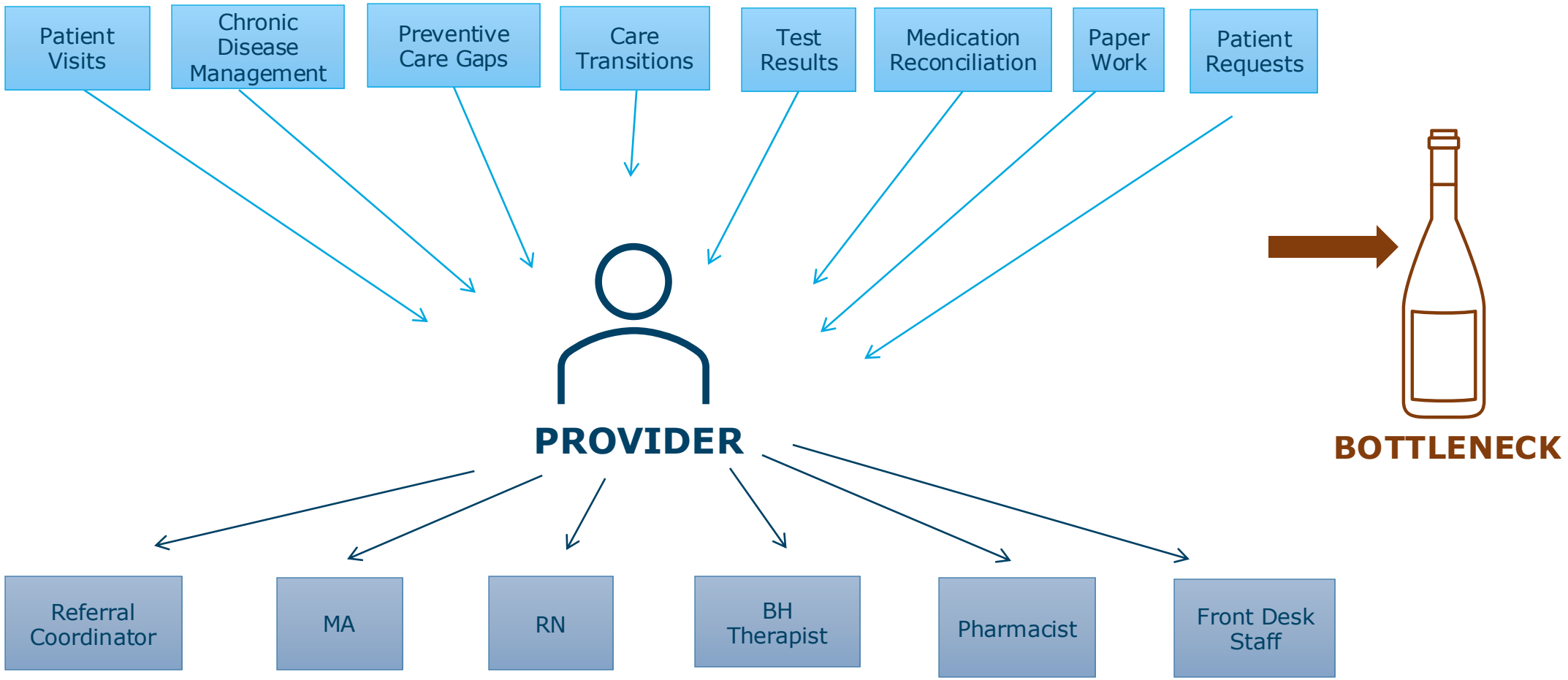
To provide clarity and allow for "**f**rontline **i**mprovement by **e**mpowering **l**ocal **d**ecision-making" (FIELD)

Accountable Care Organization (ACO): why, what, and how

The Problem with Fee-For-Service Healthcare



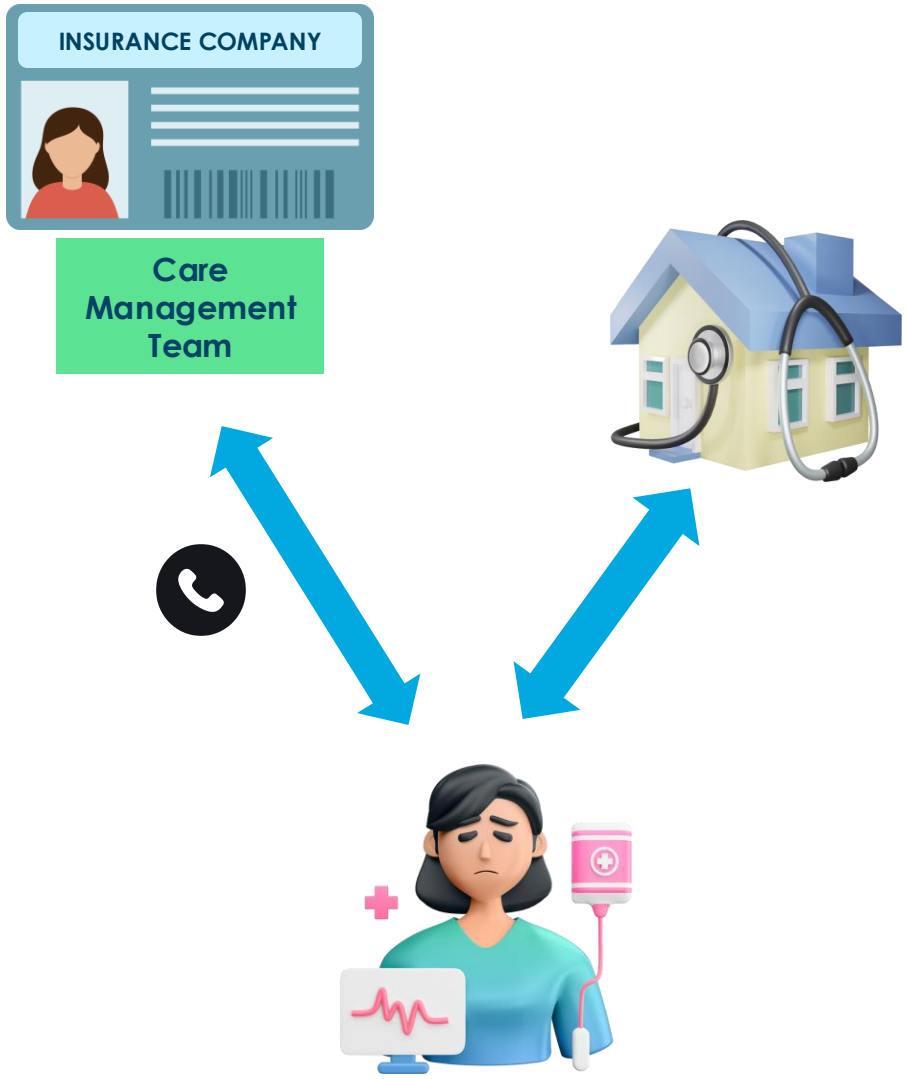
The Other Problem with Fee-For-Service Healthcare



The Promise of Value-Based Care (Patient-First Care)

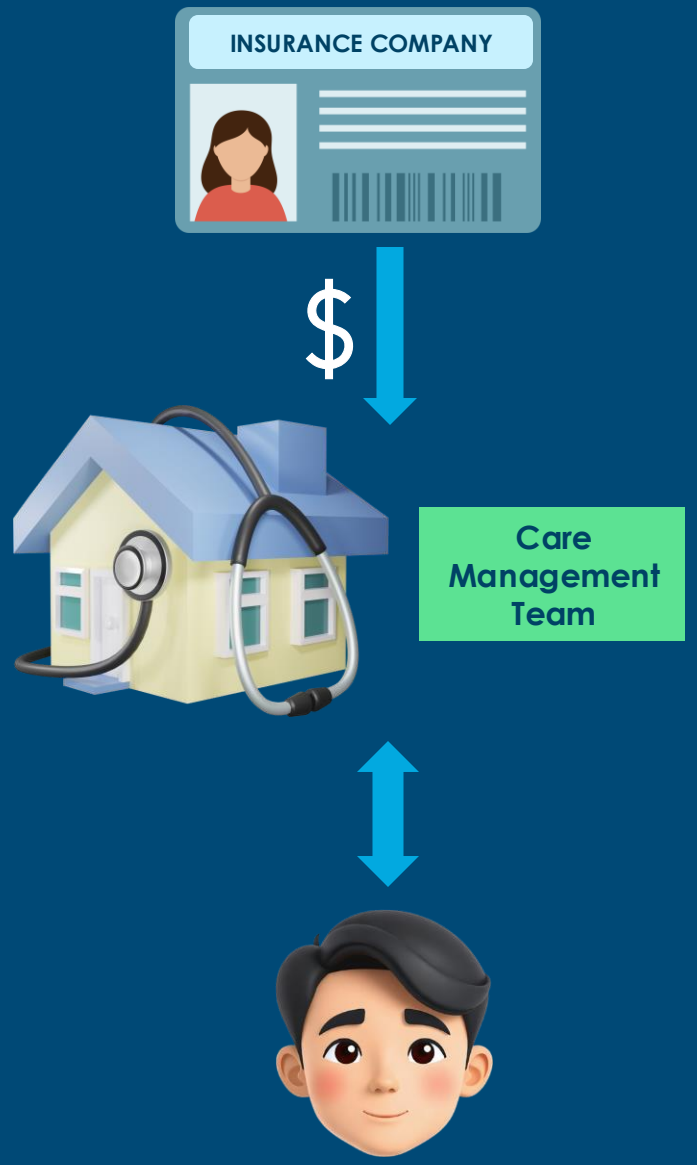
Traditional Care Management

(Siloed)



Delegated Care Management

(Integrated)



MHN ACO partnership framework

Payor

$

HFS

CountyCare
A MEDICAID HEALTH PLAN

Accountable Care Organization

MHN ACO

- Aunt Martha's Health & Wellness
- AHS Family Health Center
- Alivio Medical Center
- CFHC Chicago Family Health Center
- Christian Community Health Center
- Centros de Salud erie Family Health Centers
- Esperanza health centers
- Friend Health
- Greater Family Health — Care to live greater.
- La Rabida Children's Hospital
- Lawndale Christian Health Center — Loving God. Loving People.
- Near North Health
- PrimeCareHealth Community Health Centers
- PCC Community Wellness Center
- RUSH
- Sinai Chicago
- Tapestry 360 Health

Patients

MHN ACO & Medical Home Network Partnership

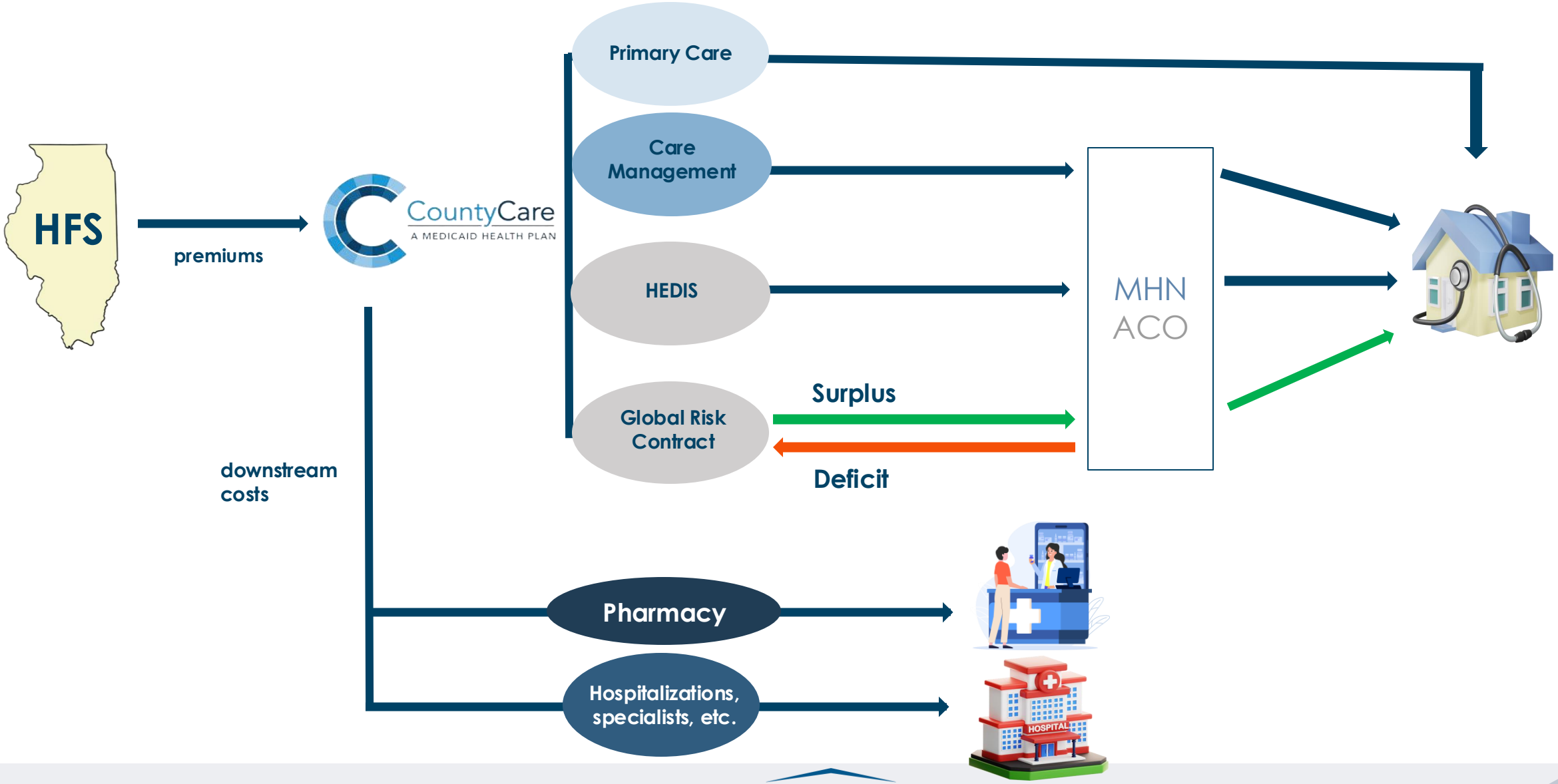
MHN ACO

- **Accountable Care Organization** (14 FQHCs, 3 Hospitals); each organization has a seat on the ACO's Board of Managers.
- Founded in **2014**
- Service area**: Cook County**
- **Contracted with CountyCare** (Delegated Care Management, Value Based Care, & P4P) and **with MHN**

MEDICAL HOME NETWORK

- **Value-based care enablement organization**, specializing in safety net healthcare transformation
- Founded in **2009** by the Comer Family Foundation.
- Service area: **nationwide** (varies by contract)
- **Contracted with MHN ACO** to provide services (care management platform technology, data/analytics, care model design, support, & training, etc)

The Flow of Medicaid Funding in MHN ACO

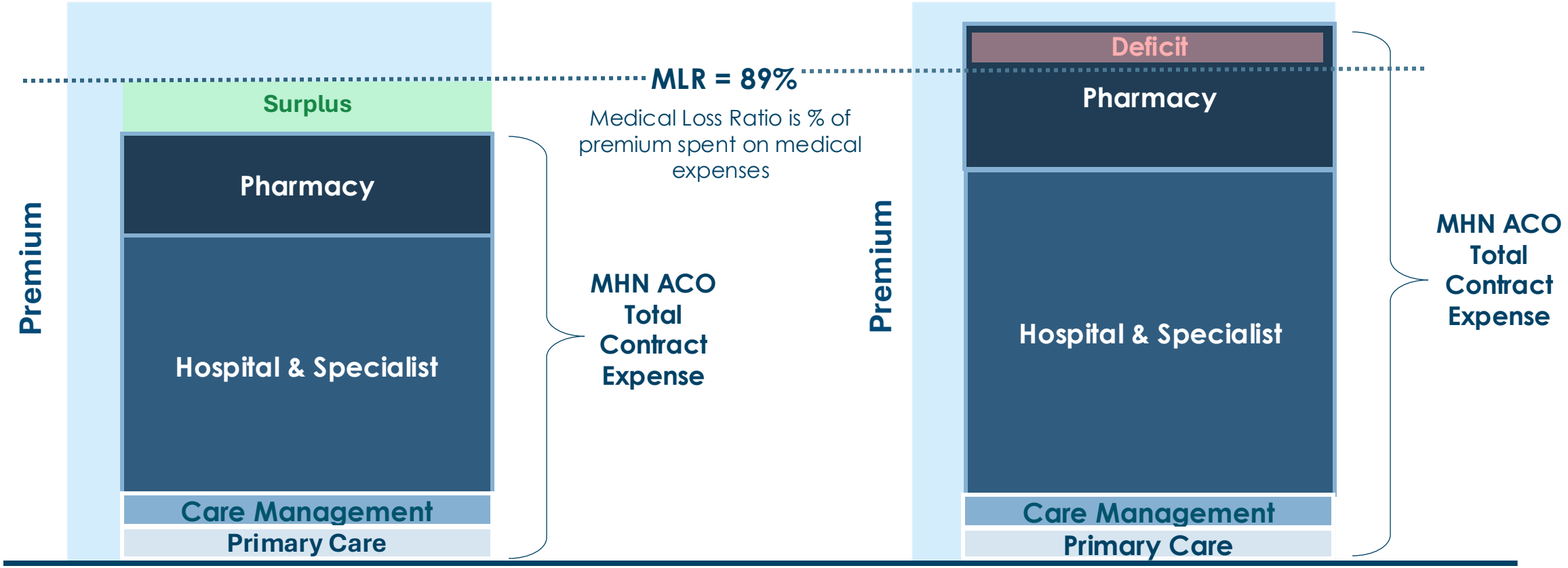


MEDICAL HOME NETWORK

How does MHN ACO achieve shared savings under the CountyCare global risk contract?

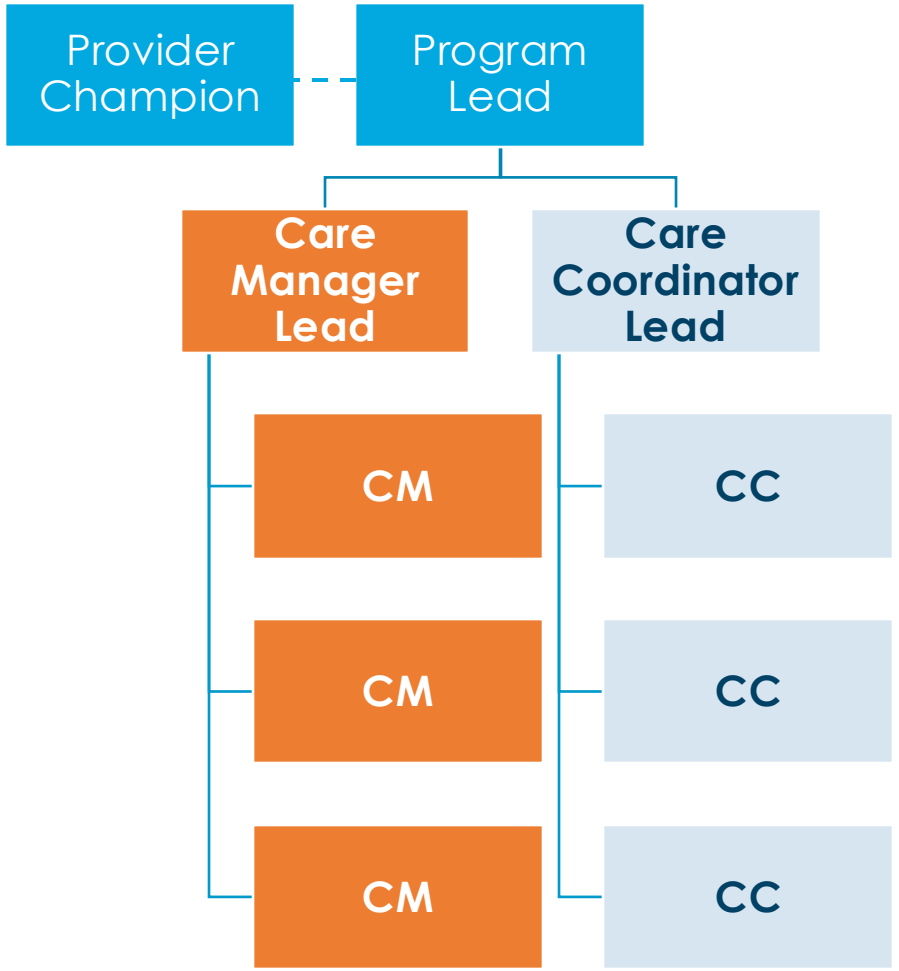
Shared Savings occurs when total contract expenses are **below** the **89% MLR target**

Deficit occurs when total contract expenses **exceeds** the **89% MLR target**



Care Management program overview

Sample Care Management Team Org Chart



	Care Manager [Licensed]	Care Coordinator [Non-licensed]
Role	**Manage high-risk patients** - Comprehensive risk assessment (CRA) - Individualized care planning - Chronic disease management	**Screening** and Risk Assessment
	Manage transitions of care	**Care Coordination** - Appointment scheduling - Addressing barriers to care - Liaison to social services
	Clinical support to care coordinators	**Support Transitions** of Care
Training	Nurse (RN/ LPN) or LCSW/ LSW/ LCPC or APP	Relevant degree, or Relevant health care experience
	MHN Orientation & motivational interviewing training	MHN Orientation & motivational interviewing training
		Certificate in care coordination [recommended]

Care Management of **Population**

Care Management during **Transitions**

Care Managers

Care Coordinators

High Risk Patients

Non-High Risk Patients

Hospitalization

ED Visits

Note: Care Coordinators can help with high risk and hospitalized patients too.

Staffing-to-patient ratios

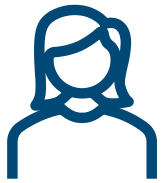
= ~60 patients

1:62

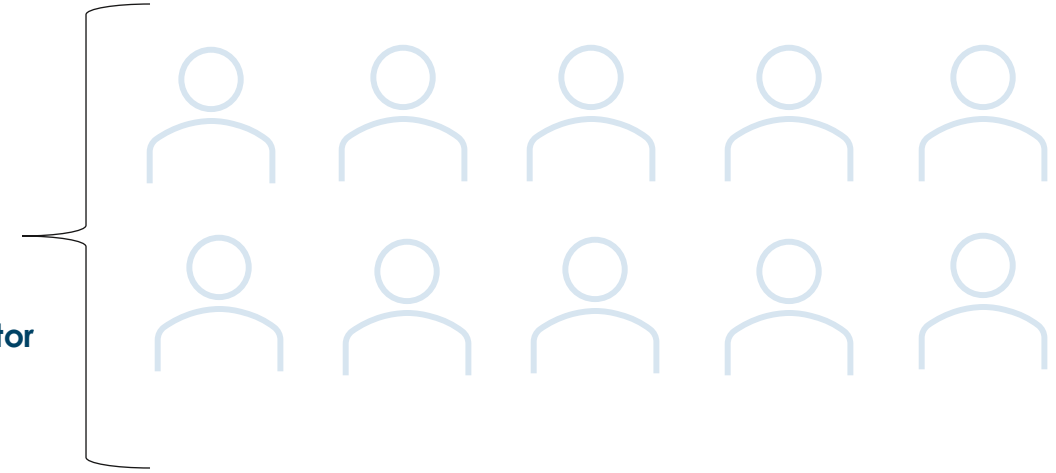
Care Manager

High Risk

1:600



Care Coordinator



Low Risk

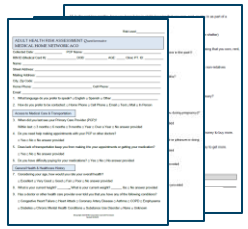

MHNConnect®
Technology platform powering our care management program
HOSPITAL

Risk Screening, Assessment, and Care Planning

Risk Assessment Process Overview

CountyCare
A MEDICAID HEALTH PLAN

Health Risk Assessment



High Risk Patients

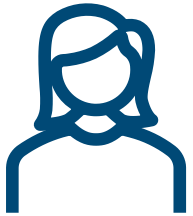
Assigned to Care Manager

Comprehensive Risk Assessment

Care Plan

Non-High-Risk Patients

Care Coordinator Addresses Social/Health Needs



The Health Risk Assessment (HRA)

Access to Medical Care & Transportation

General Health & Healthcare History

Mental Health & Substance Abuse

Social Support & Needs

Health Risk Assessment (HRA)

Risk Level:_____

ADULT HEALTH RISK ASSESSMENT *Questionnaire*
MEDICAL HOME NETWORK ACO

Collected Date: _____ PCP Name: _____

RIN ID (Medical Card #): _____ DOB: _____ AGE: _____ Clinic PT. ID: _____

Name: _____

Street Address: _____

Mailing Address: _____

City, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

1. What language do you prefer to speak? □ English □ Spanish □ Other _____
2. How do you prefer to be contacted: □ Home Phone □ Cell Phone □ Email □ Text □ Mail □ In Person

Access to Medical Care & Transportation

3. When did you last see your Primary Care Provider (PCP)?

   Within last: □ 3 months □ 6 months □ 9 months □ Year □ Over a Year □ No answer provided
4. Do you need help making appointments with your PCP or other doctors?

   □ Yes □ No □ No answer provided
5. Does lack of transportation keep you from making it to your appointments or getting your medication?

   □ Yes □ No □ No answer provided
6. Do you have difficulty paying for your medications? □ Yes □ No □ No answer provided

General Health & Healthcare History

7. Considering your age, how would you rate your overall health?

   □ Excellent □ Very Good □ Good □ Fair □ Poor □ No answer provided
8. What is your current height? _____ What is your current weight? _____ lbs □ No answer provided
9. Has a doctor or other health care provider ever told you that you have any of the following conditions?

   □ Congestive Heart Failure □ Heart Attack □ Coronary Artery Disease □ Asthma □ COPD □ Emphysema

   □ Diabetes □ Chronic Mental Health Conditions □ Substance Use Disorder □ None □ Unknown

   a. If yes, have you been hospitalized for any of these conditions in the past 12 months?

      □ Yes □ No □ No answer provided

      i. If yes, how many hospitalizations? □ 1 □ 2 □ 2+ □ No answer provided

   b. If yes, have you been to the Emergency Room 3 or more times for any of these conditions in the past 6 months? □ Yes □ No □ No answer provided
10. Have you been hospitalized for other reasons 2 or more times in the past 12 months?

    □ Yes □ No □ No answer provided
11. Have you been to the Emergency Room for any reason 4 or more times in the past 6 months?

    □ Yes □ No □ No answer provided

For Females under the age of 50

12. Are you pregnant? □ Yes □ No □ No Answer Provided

    a. If yes, are you receiving prenatal care? □ Yes □ No □ No answer provided

       b. If yes, what is the name of the OB provider (the medical provider that cares for you during pregnancy)? _____ □ No answer provided

       c. If no, do you need help choosing an OB provider? □ Yes □ No □ No answer provided

Mental Health & Substance Abuse History

13. In the last 2 weeks have you been feeling down, depressed, hopeless or feel little interest or pleasure in doing things? □ Yes □ No □ No answer provided

    a. If yes, are you currently being treated for depression? □ Yes □ No □ No answer provided
14. Do you drink alcohol? □ Yes □ No □ No answer provided

    a. If yes, do you feel you should cut down on your drinking? □ Yes □ No □ No answer provided

    b. If yes, are you being treated for this? □ Yes □ No □ No answer provided
15. Do you smoke cigarettes or cigars: □ Yes □ No □ No answer provided

    a. If yes, are you interested in a Smoking Cessation Program? □ Yes □ No □ No answer provided

Social Support & Needs

16. Do you have access to a Smart Phone with data? □ Yes □ No □ No answer provided
17. Do you have access to internet? □ Yes □ No □ No answer provided

18. In the past two months, have you been living in stable housing that you own, rent, or stay in as part of a household? □ Yes □ No □ No answer provided
19. Where do you currently stay?

    □ House/Apartment □ Transitional Housing (i.e. recovery home, halfway house, long-term shelter)

    □ Nursing Home □ Shelter □ Homeless □ No answer provided
20. Are you worried or concerned that in the next two months you may NOT have stable housing that you own, rent, or stay in as part of a household? □ Yes □ No □ No answer provided
21. What is your living arrangement: (check all that apply)

    □ Live alone □ With spouse/significant other □ With children □ With other relatives □ With non-relatives

    □ With paid caregiver □ No answer provided
22. Do you feel physically and emotionally safe with those who live with you?

    □ Yes □ No □ No answer provided
23. Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?

    □ Yes □ No □ No answer provided

    If yes, provide their name, relationship, and the day-phone of this person:

    Name: _____
    Relationship: _____
    Phone: _____
24. Within the past 12 months, I/we worried whether our food would run out before I/we got money to buy more.

    □ Often True □ Sometimes True □ Never True □ No answer provided
25. Within the past 12 months, the food I/we bought just didn't last and I/we didn't have money to get more.

    □ Often True □ Sometimes True □ Never True □ No answer provided
26. Do you need help with other essential items (clothing, diapers, home goods, etc.)?

    □ Yes □ No □ No answer provided

Staff Member: _____ Date Entered in Portal: _____

Comprehensive Risk Assessment (CRA)

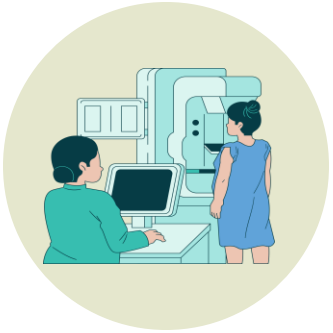
General Health & Healthcare History

Mental Health & Substance Abuse Screening

Functional Needs

ADL's Assessment

Psycho-Social Assessment



Preventive Health Screening

Disease Specific Assessment

Assessment of Benefits

Care Plan

Clinical Needs

Preferences

Goals

Social Needs

Supports

Action Steps

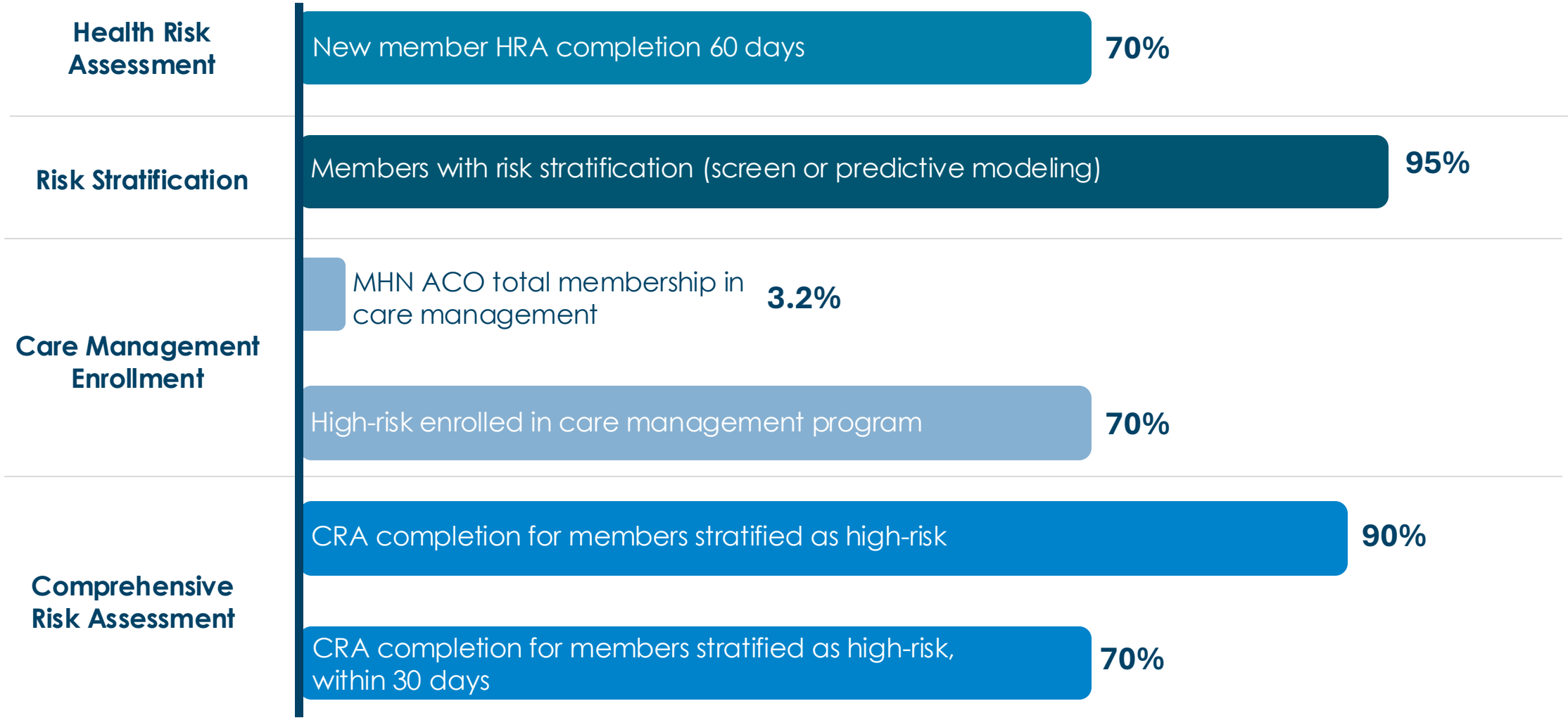
Care Plan Example – 55 yo male with COPD

Goal:
Reduce COPD exacerbations to less than 1 per year.

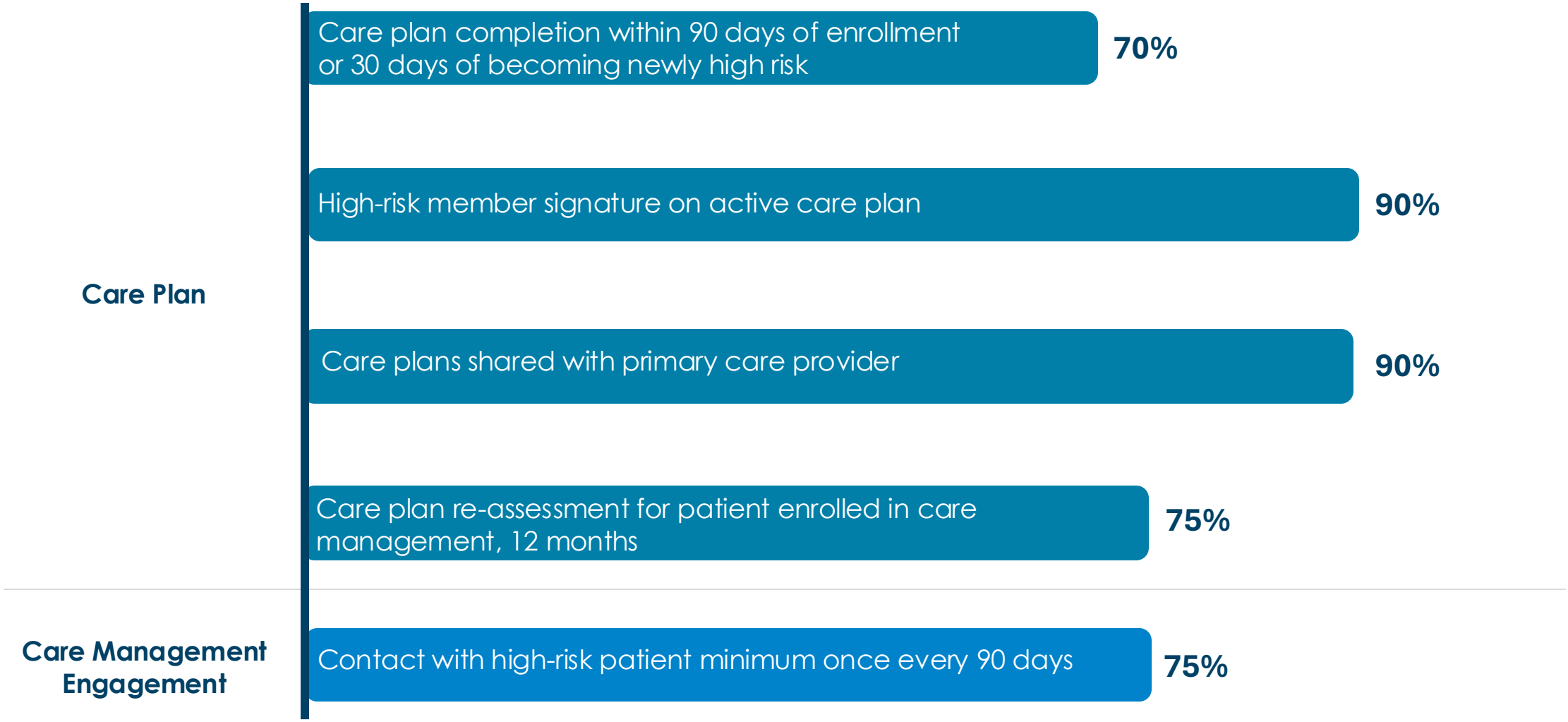
Action Steps:
- Quit smoking
- Use inhalers as prescribed
- Attend COPD education sessions

Barriers:
- Transportation
- No/limited social supports
- Financial

Care Management Program Targets set by HFS

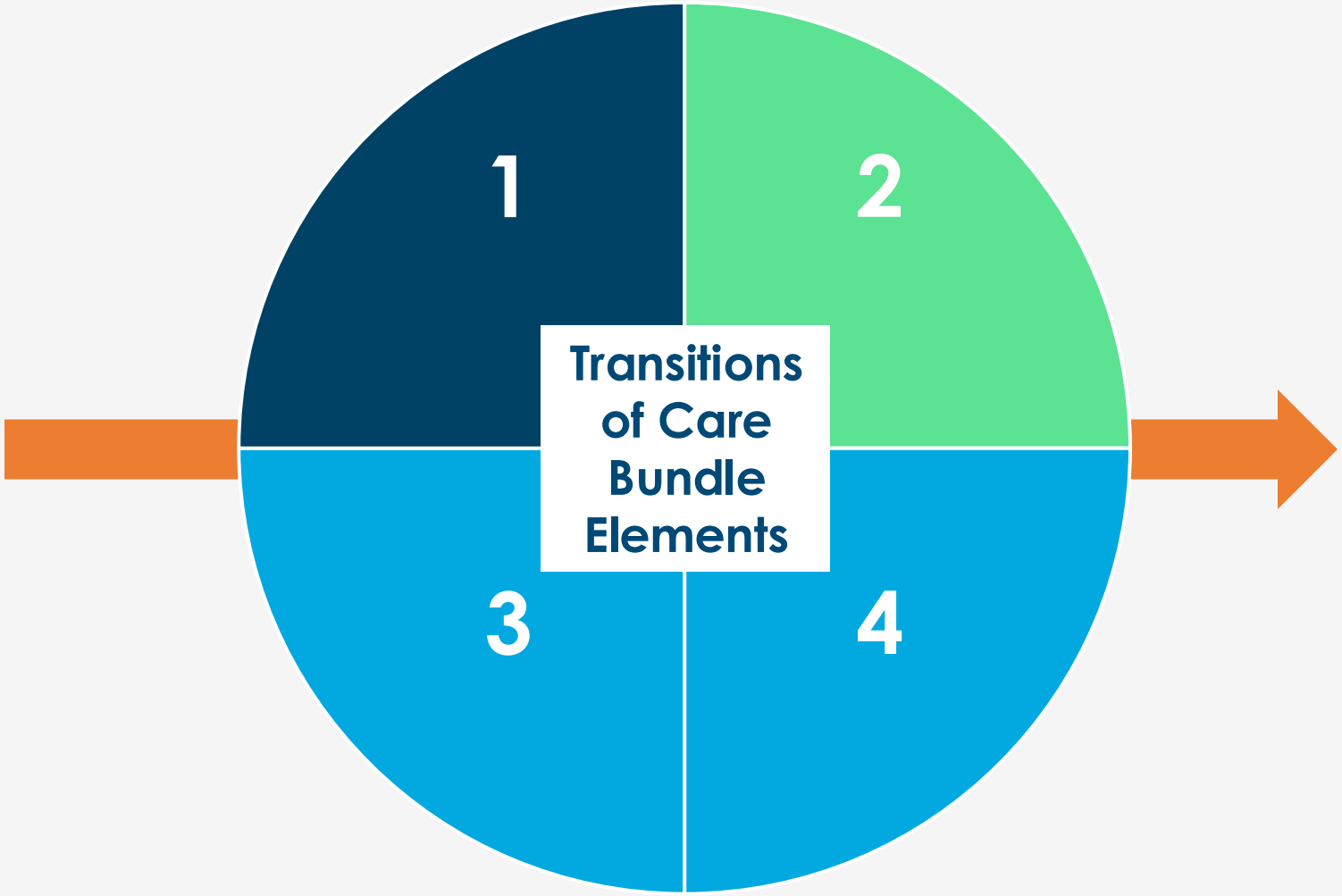


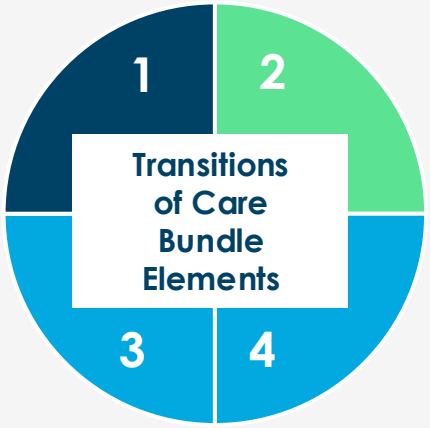
Care Management Program Targets set by HFS

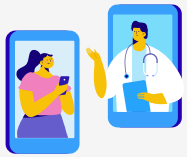


Transitions of Care (TOC) Model

TOC - from Hospitalization to Med Home







Admission Alert via MHNConnect

1

While in Hospital

Initial Contact With Patient

2

<=2 Days Post-Discharge

Phone call with Patient

3&4

<=7 Days Post-Discharge

Med Reconciliation

& Follow-Up Appointment

1

TOC Bundle Element #1

CM can complete telephonically or face to face.

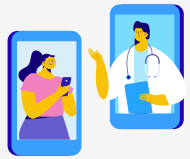
1

While in Hospital

Initial Contact With Patient

2

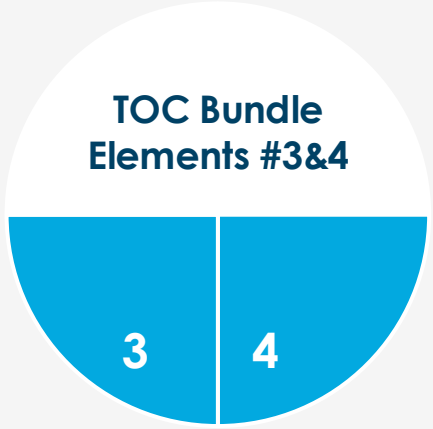
TOC Bundle Element #2



2

<=2 Days Post-Discharge

Phone call with Patient



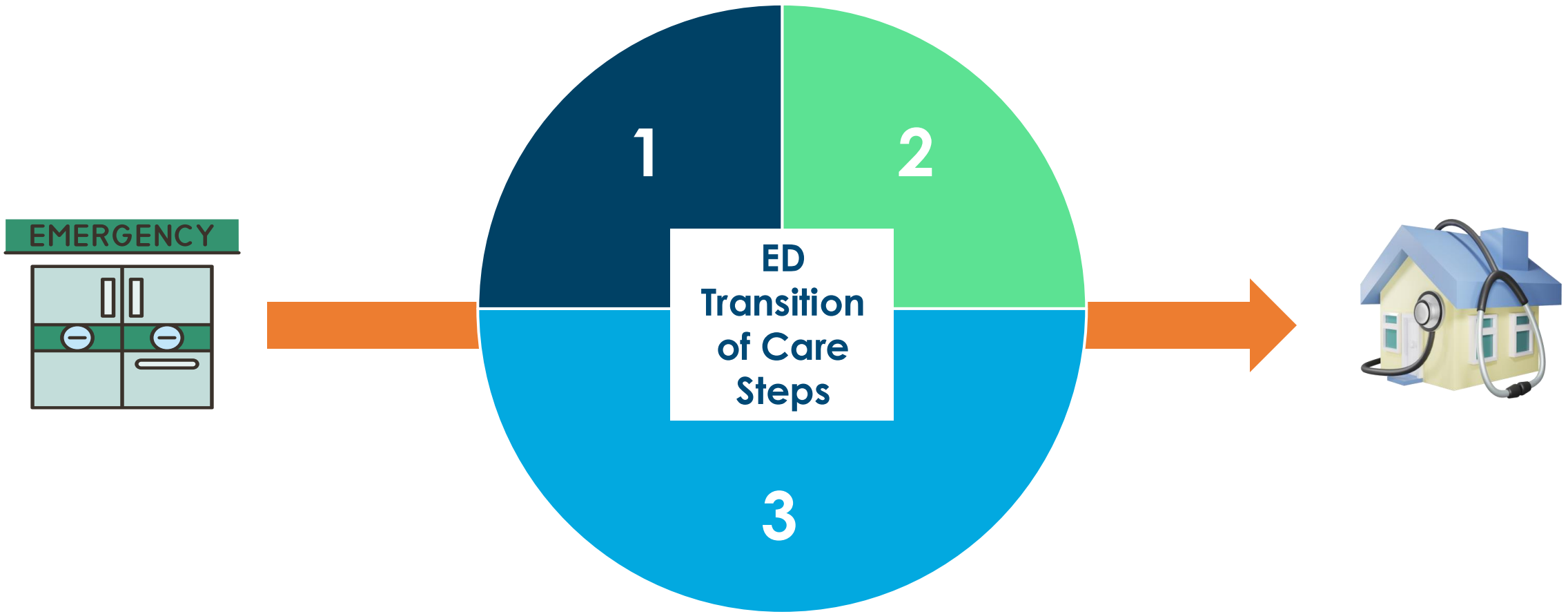
3&4

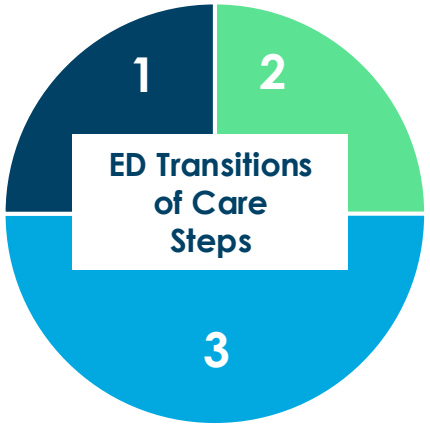
<=7 Days Post-Discharge

Med Reconciliation

& Follow-Up Appointment

TOC - from Emergency Dept (ED) to Med Home





1

2

3

ED Alert via MHNConnect

While in ED

Contact ED Staff & Patient/family

<=2 Days Post-Discharge

ED visit summary & PCP notification

Phone call with Patient

<=7 days (or 30 days) Post-Discharge

Follow-Up Appointment

Quality Measures

HEDIS is the quality measure program the ACO uses

- **H**ealthcare
- **E**ffectiveness
- **D**ata
- **I**nformation
- **S**et

The HEDIS incentive structure in MHN ACO

Preferred member empanelment if good performance on HEDIS measures

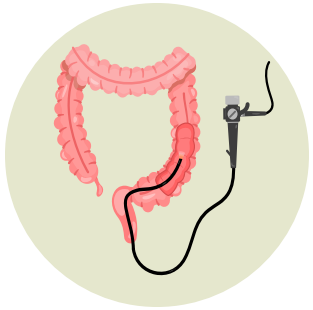
CountyCare
A MEDICAID HEALTH PLAN

$ incentive to meet targets on specified HEDIS measures

MHN ACO

$ incentive to meet targets on specified HEDIS measures

Quality Measures - 2025



- **Cervical Cancer Screening** (Age 21- 64)
- **Colorectal Cancer Screening** (Age 45-75)

- **Prenatal Care** in the first trimester
- **Postpartum Care** 7-84 days after delivery

- **Childhood Immunization** Status (Combo 3: DTaP, IPV, MMR, HiB, HepB, VZV and PCV by age 2)

- **Access** to Ambulatory Services – **Ages 20+**
- **Access** to Ambulatory Services – **Ages 20-44**

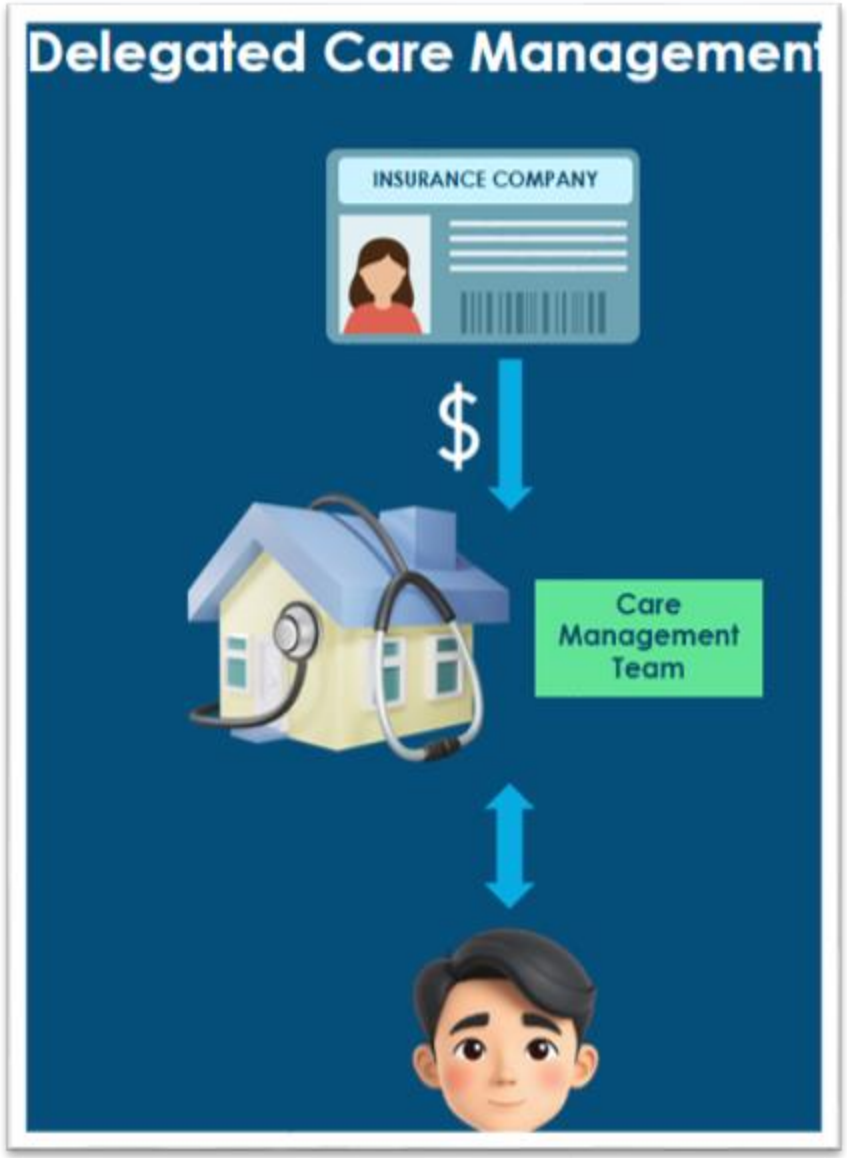
- **Controlling High Blood Pressure** (<140/90) ages 18–85 with hypertension Diabetes –
- **Glycemic Status** <8.0% for Type 1 & 2 Diabetics All Ages *(UDS: Inverse reported as HbA1c >9)*

- **Follow-Up After ED Visit for Mental Illness** – 7 & 30 Days (ages 6+)
- **Follow-Up After Hospitalization for Mental Illness** – 7 & 30 Days (Ages 6+)

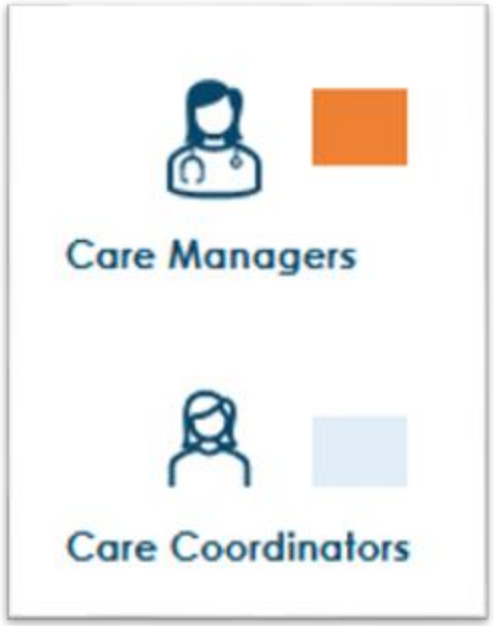
Also a UDS Measure

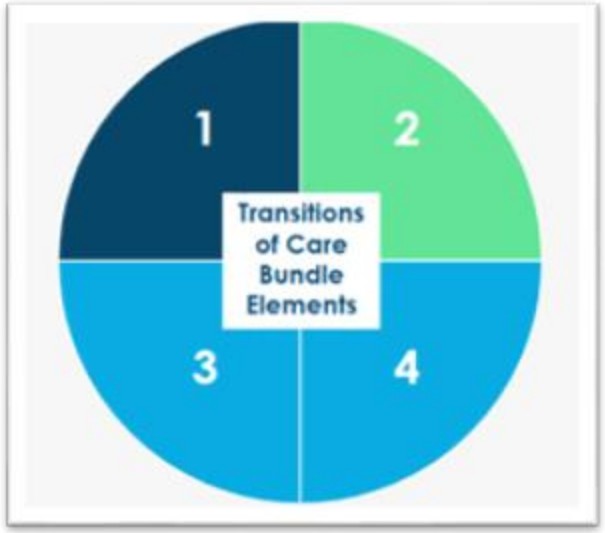
FIELD Guide Recap

Bringing the Big Picture Into Focus



Putting the FIELD Guide into Action





☑ HEDIS

Glossary

ACO – Accountable Care Organization

ADT – Admission, Discharge, & Transfer

BH – Behavioral Health

CC – Care Coordinator

CM – Care Manager, or Care Management

CP – Care Plan

CRA – Comprehensive Risk Assessment

ED – Emergency Department

FFS – Fee-For-Service

FIELD – Frontline Improvement by Empowering Local Decision-Making

HEDIS – Healthcare Effectiveness Data Information Set

HFS – Illinois Health and Family Services

HRA – Health Risk Assessment

MA – Medical Assistant

MLR – Medical Loss Ratio

NCQA - National Committee for Quality Assurance

PBC – Public Benefit Corporation

PCP – Primary Care Provider

RN – Registered Nurse

TOC – Transitions of Care

VBC – Value Based Care