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

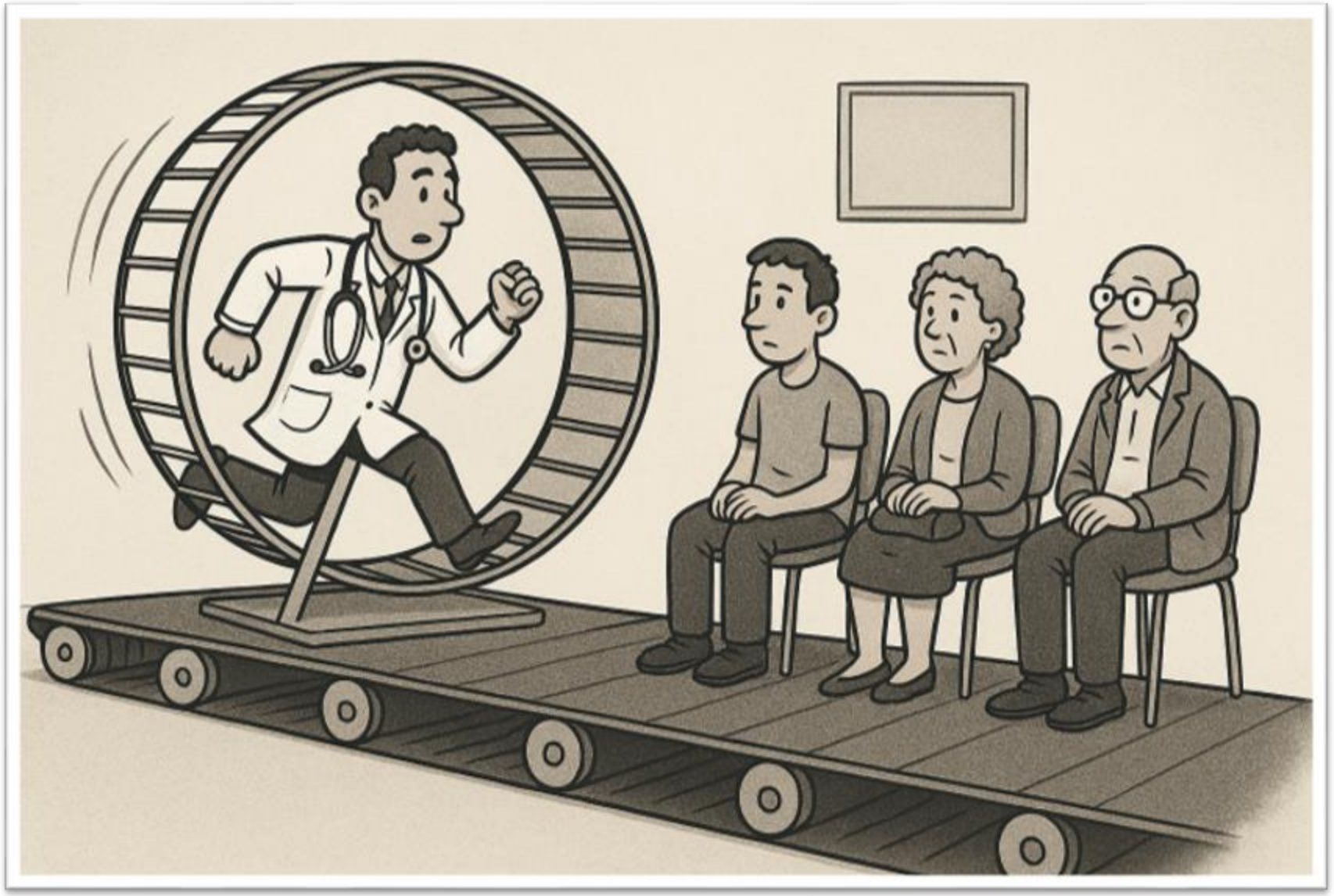
Objective of "FIELD" guide

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

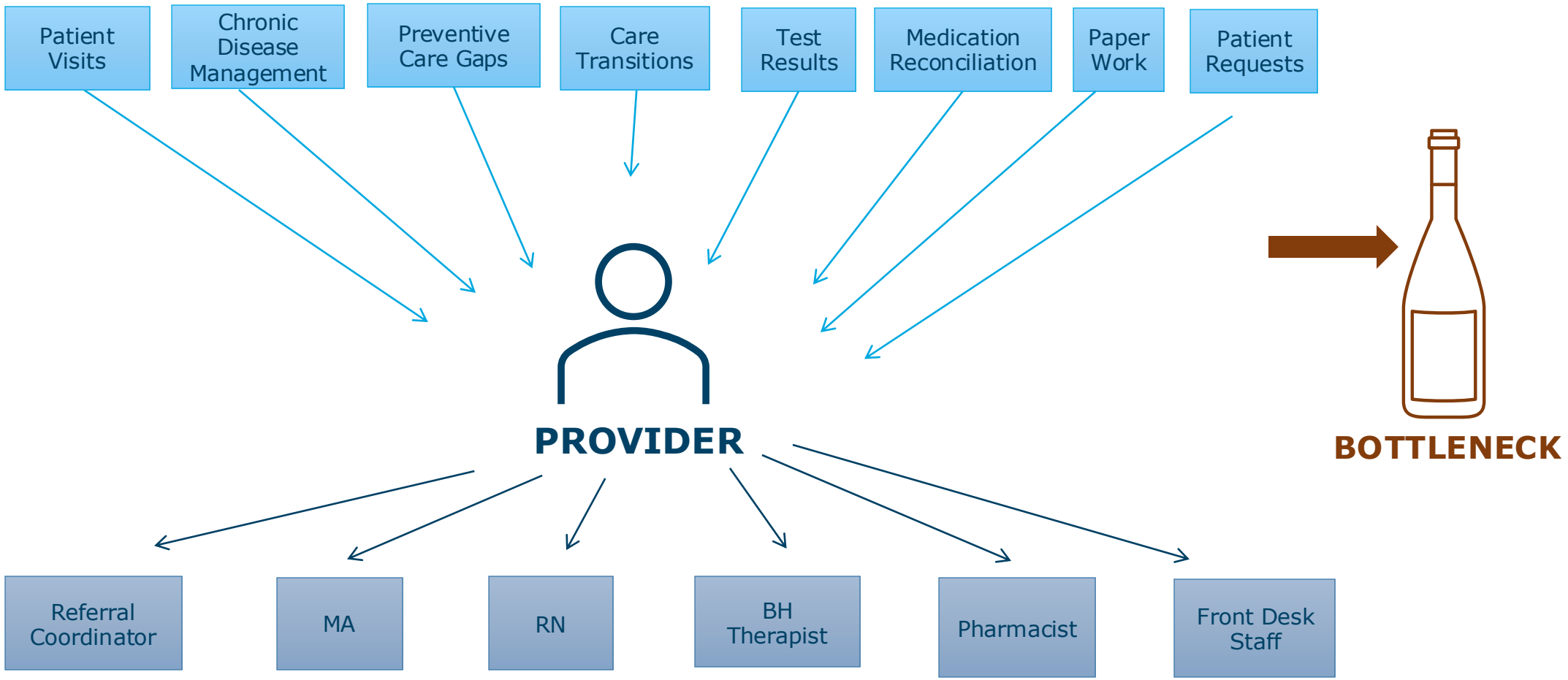
To provide clarity and allow for "**f**rontline **i**mprovement by **e**mpowering **l**ocal **d**ecision-making" (FIELD)

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

The Problem with Fee-For-Service Healthcare



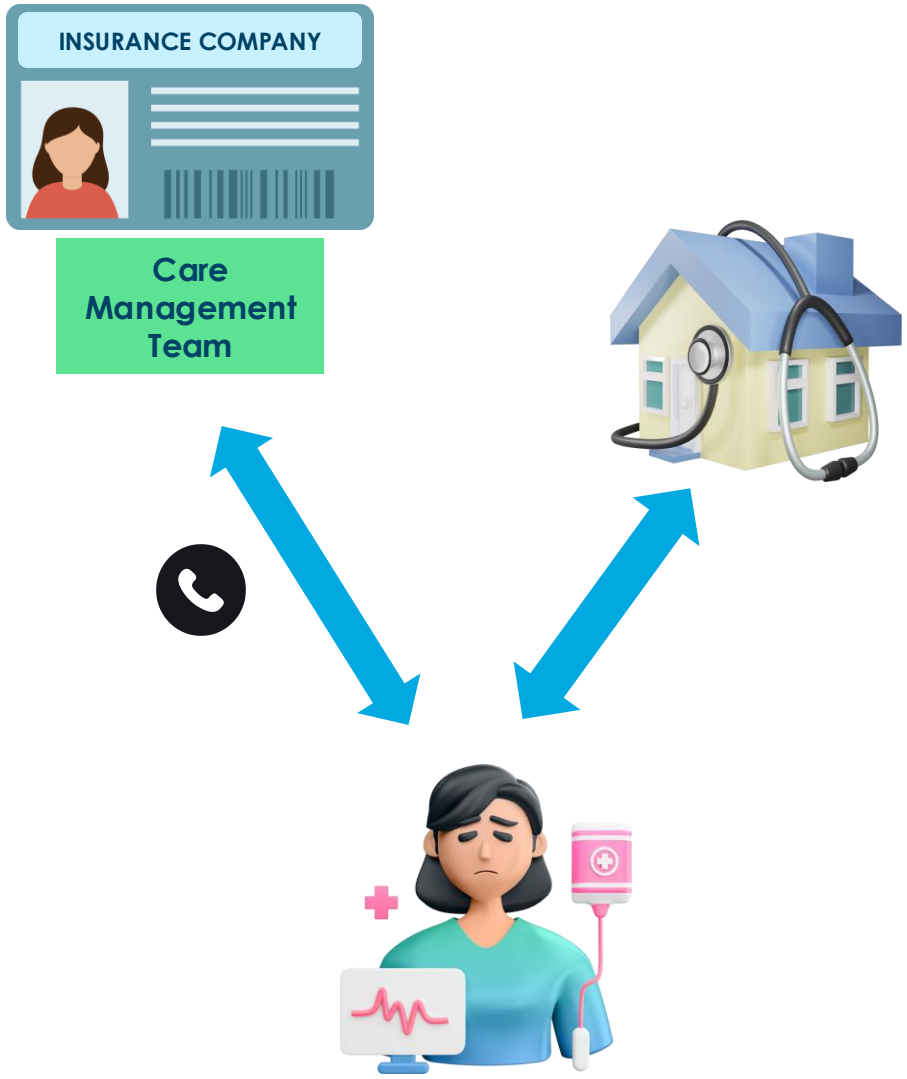
The Other Problem with Fee-For-Service Healthcare



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

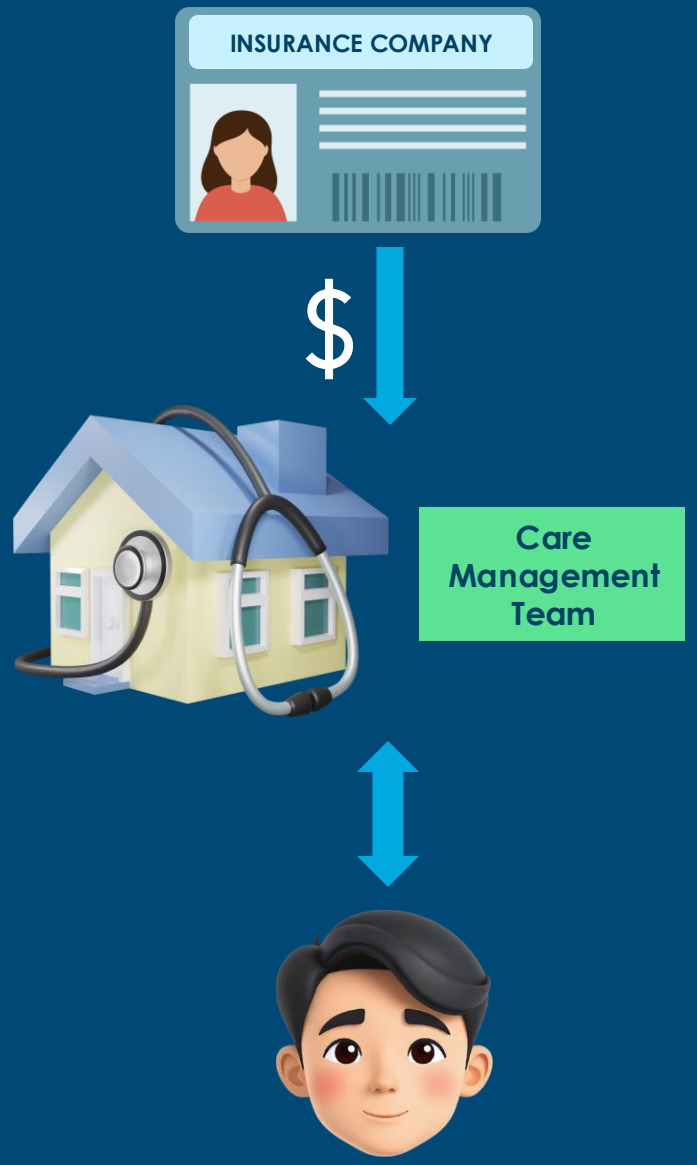
Traditional Care Management

(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

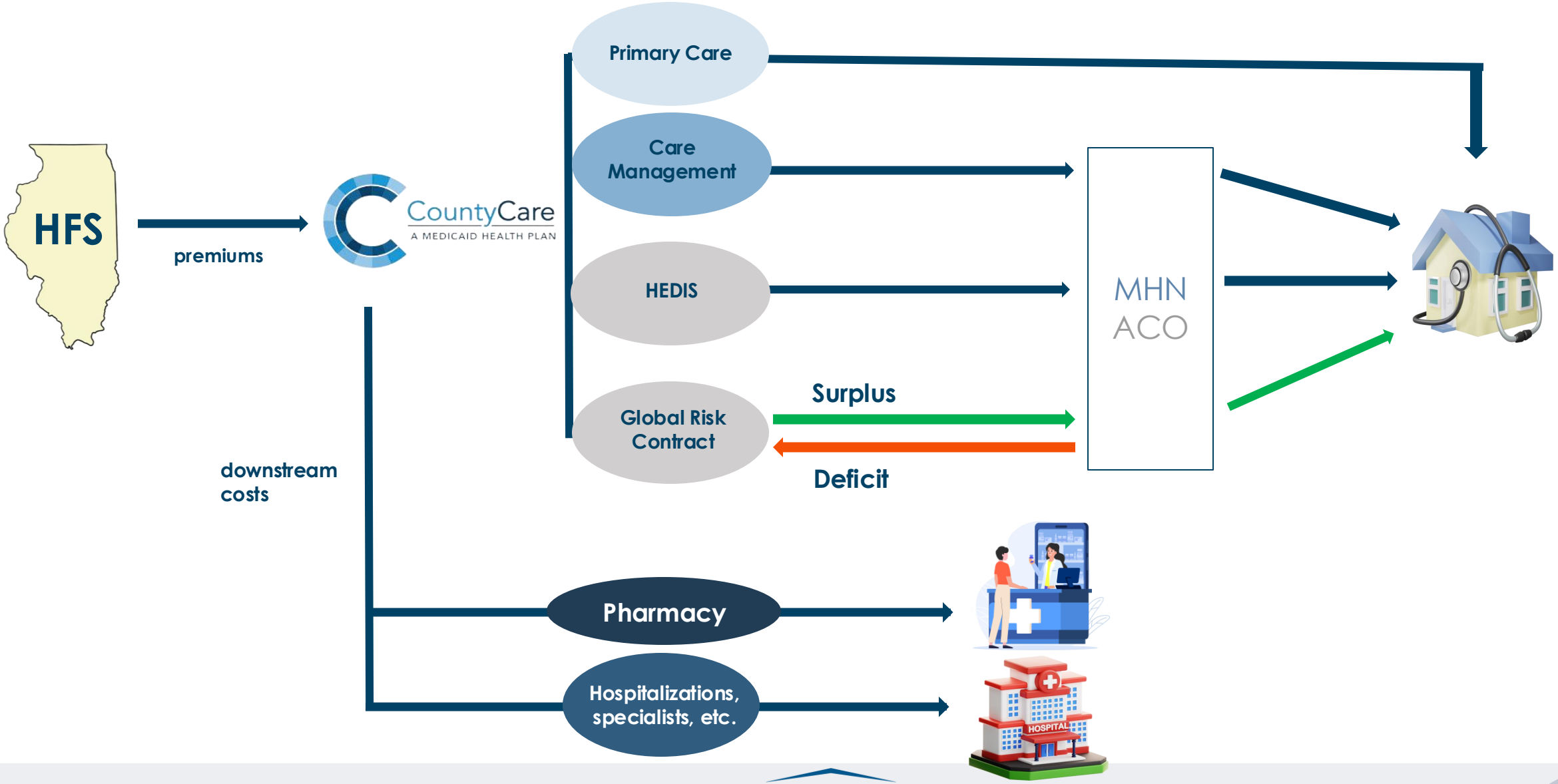
MHN ACO

- **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)

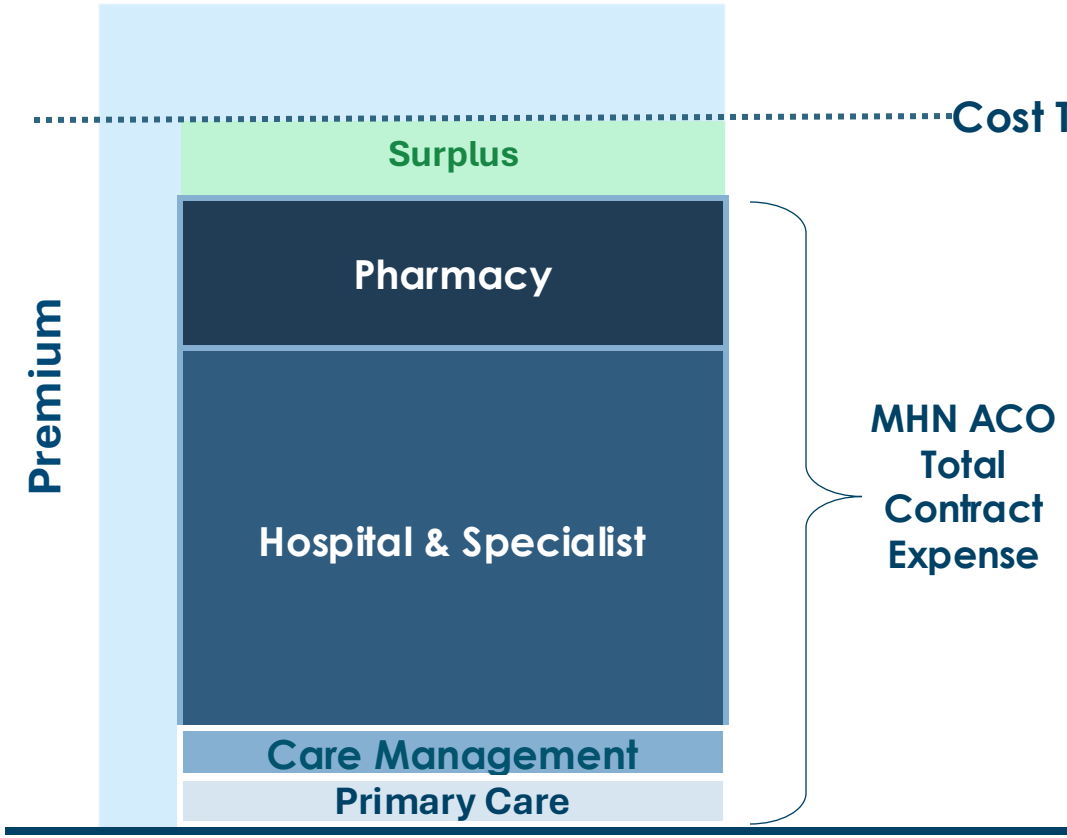
The Flow of Medicaid Funding in MHN ACO



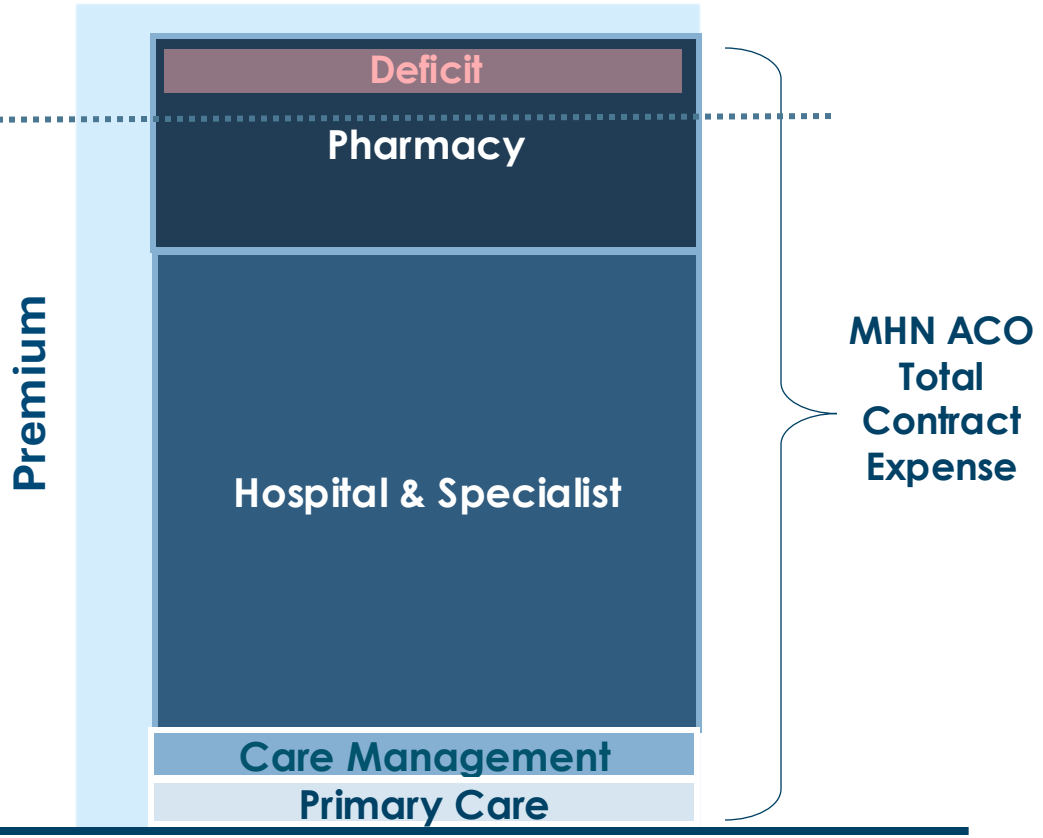
MEDICAL HOME NETWORK

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

Shared Savings occurs when total contract expenses are **below** the **cost target**

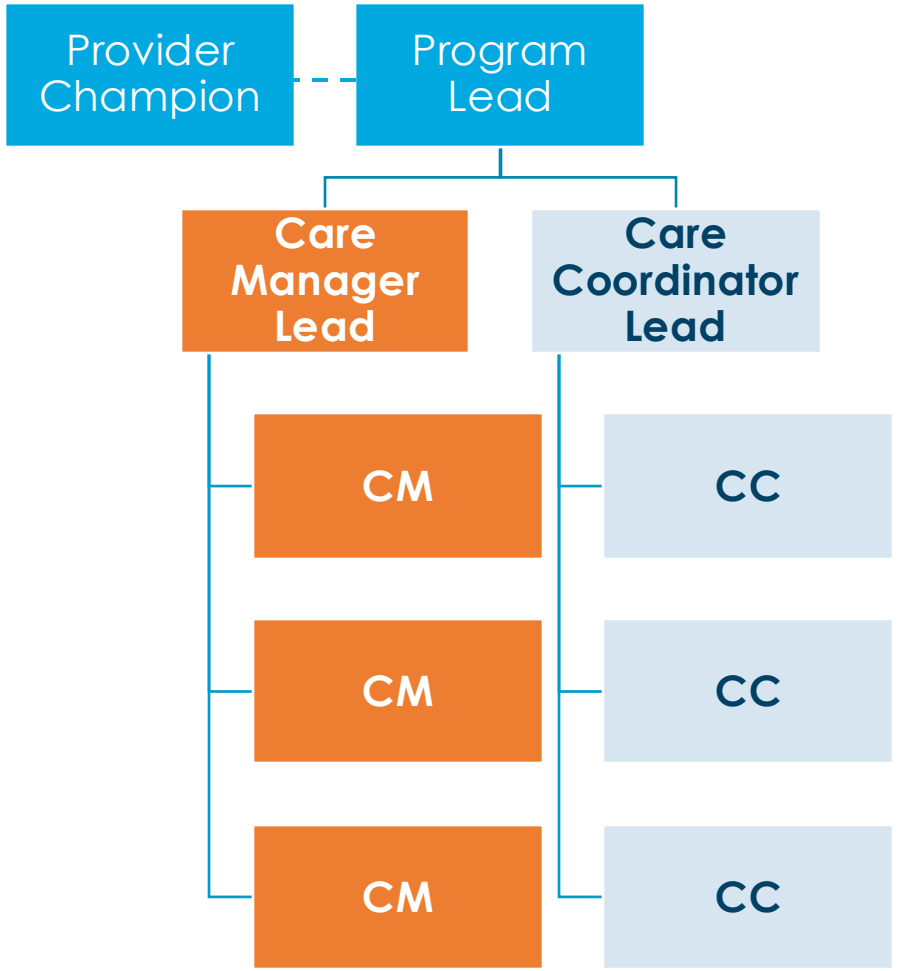


Deficit occurs when total contract expenses **exceeds** the **cost target**



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

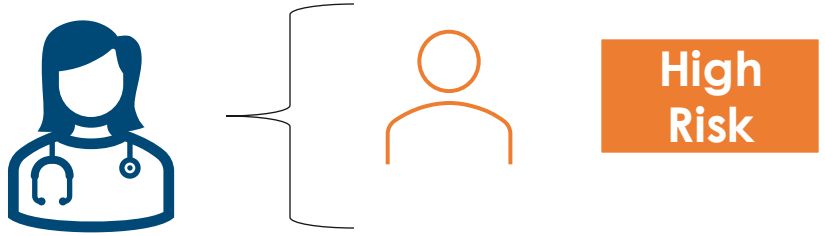
Hospitalization

ED Visits

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

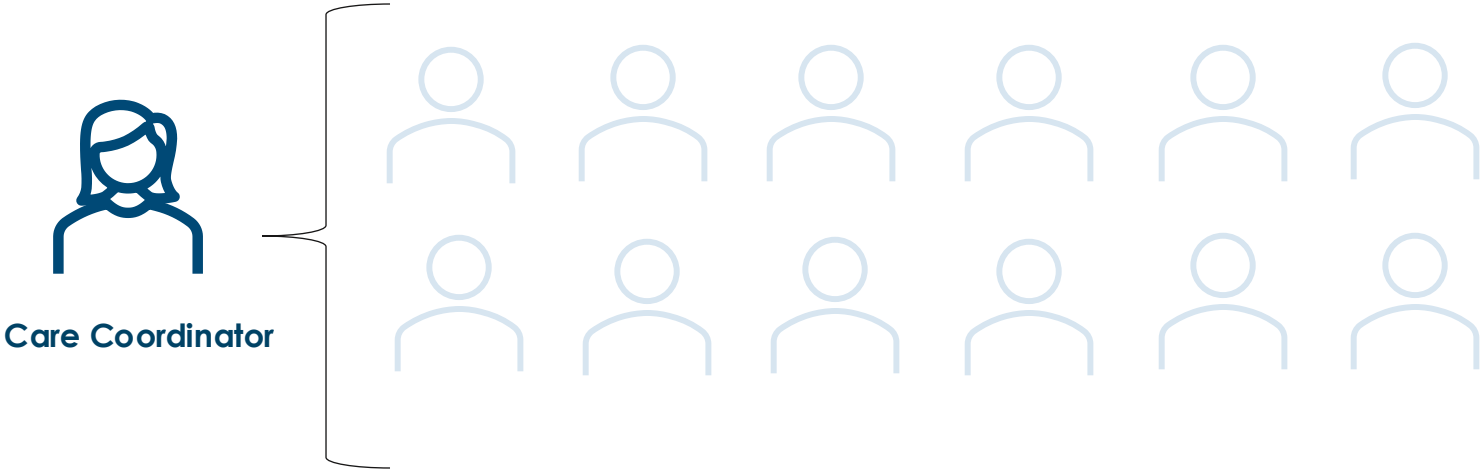
Staffing-to-patient illustration

High touch



Care Manager

Broad reach



Care Coordinator

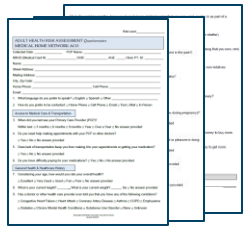

MHNConnect®
Technology platform powering our care management program
HOSPITAL

Risk Screening, Assessment, and Care Planning

Risk Assessment Process Overview

CountyCare
A MEDICAID HEALTH PLAN

Health Risk Assessment



High Risk Patients

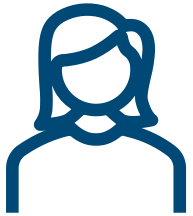
Assigned to Care Manager

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

Comprehensive Risk Assessment (CRA)

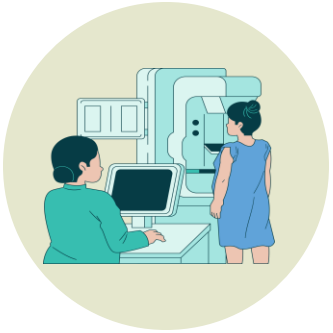
General Health & Healthcare History

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

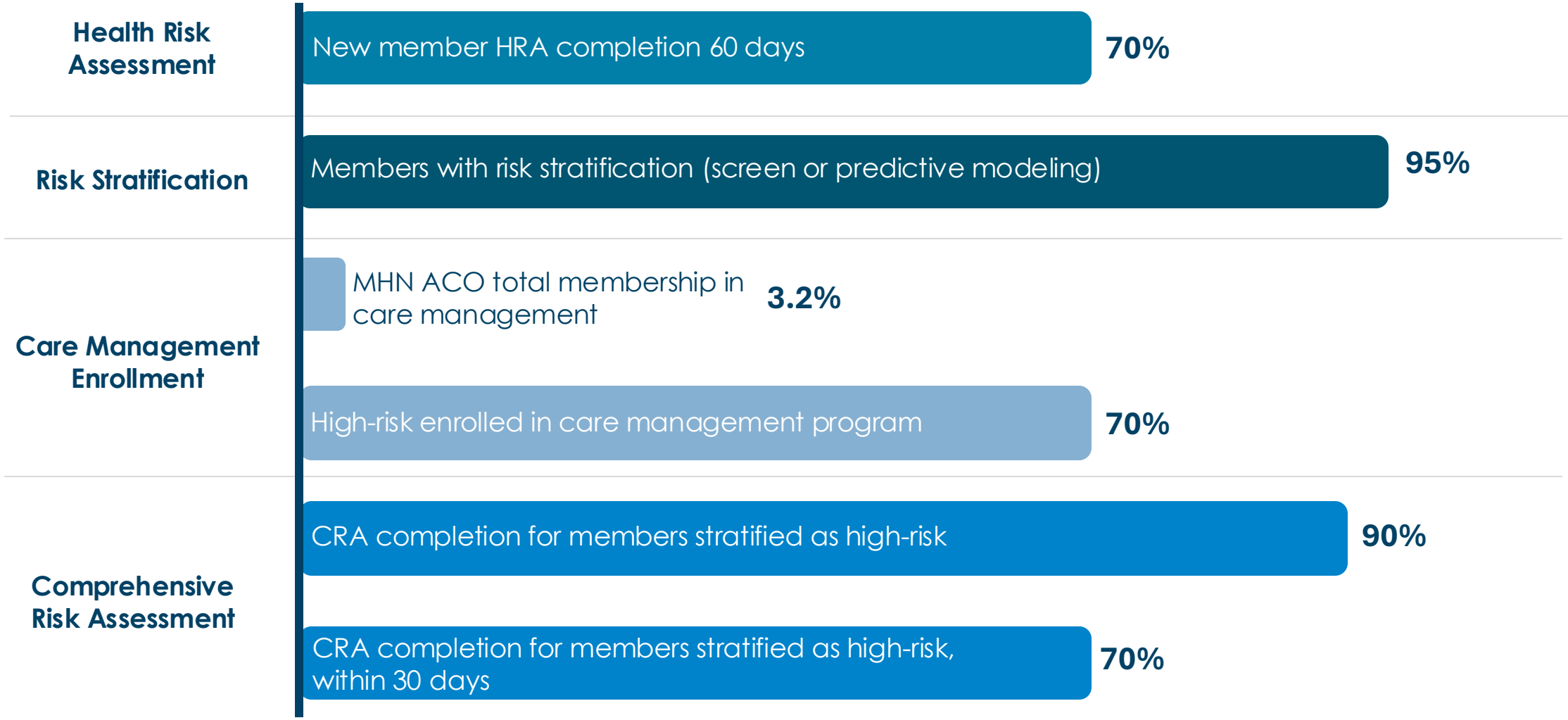
Care Plan Example – 55 yo male with COPD

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

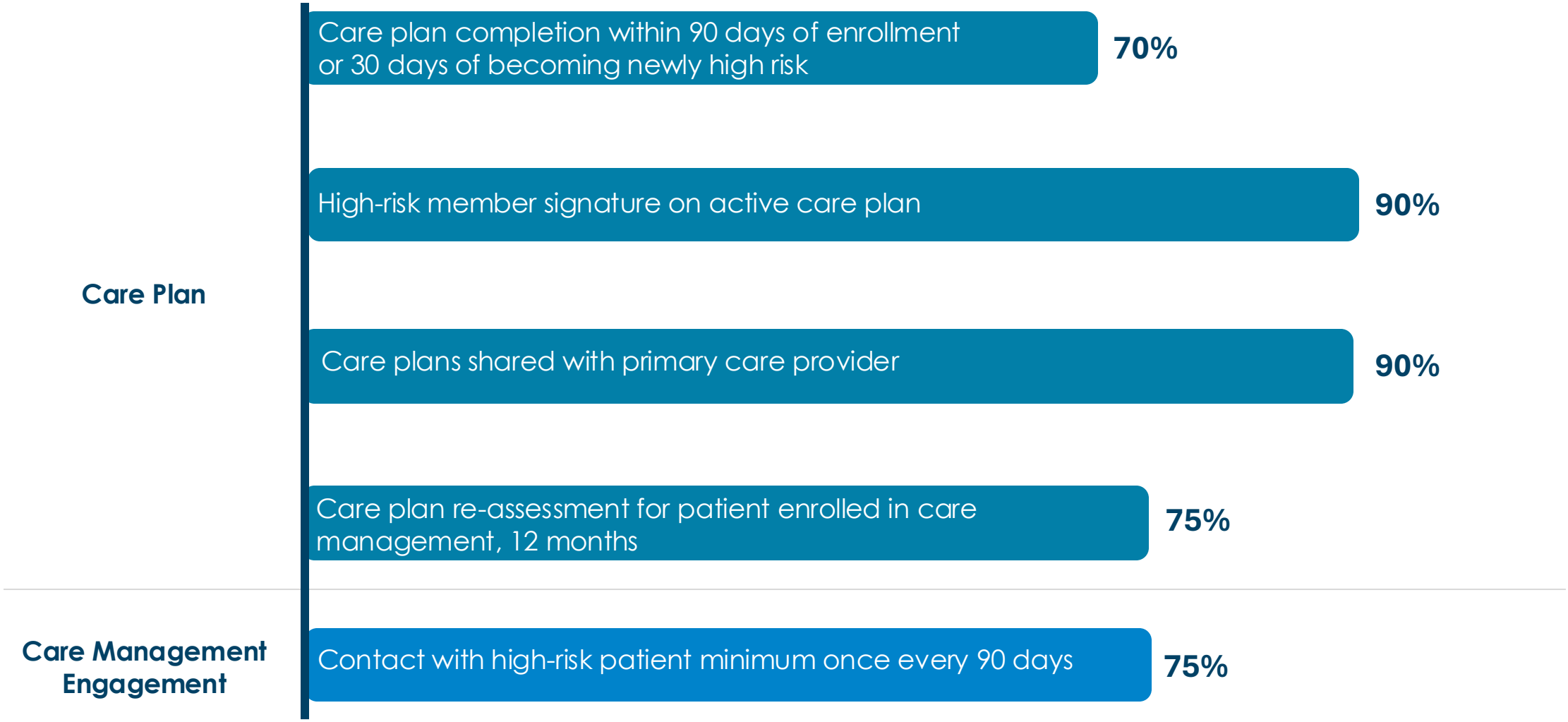
Action Steps:
- Quit smoking
- Use inhalers as prescribed
- Attend COPD education sessions

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

Care Management Program Targets set by HFS

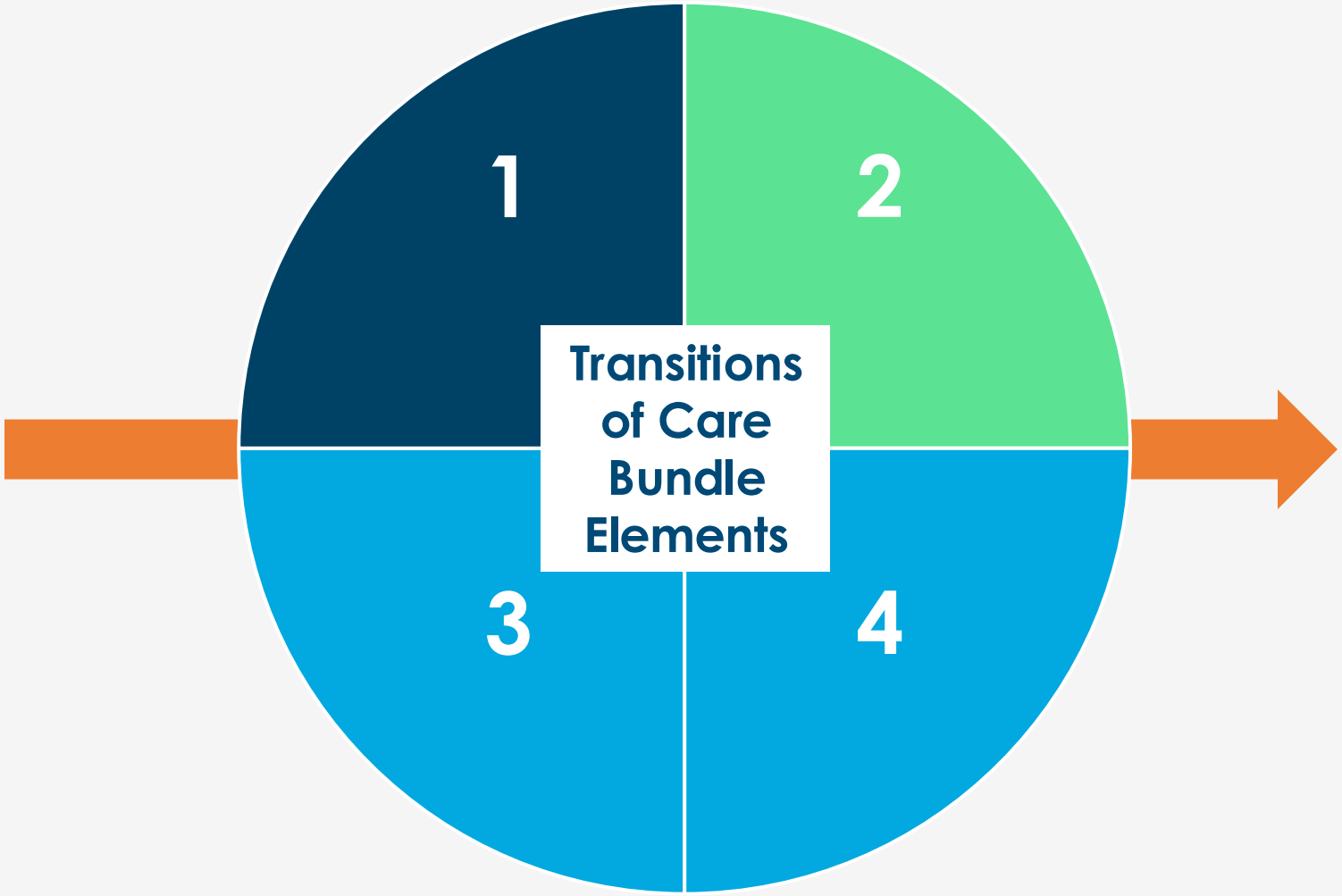


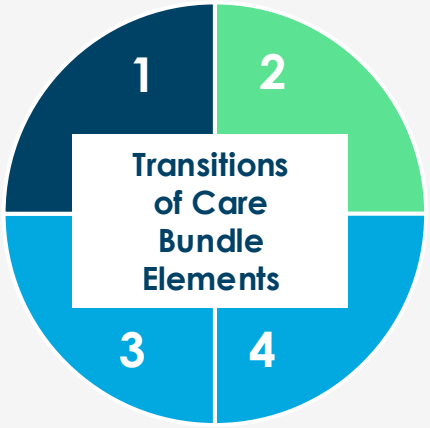
Care Management Program Targets set by HFS

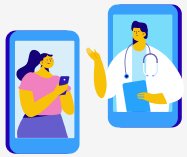


Transitions of Care (TOC) Model

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.

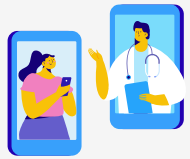
1

While in Hospital

Initial Contact With Patient

2

TOC Bundle Element #2

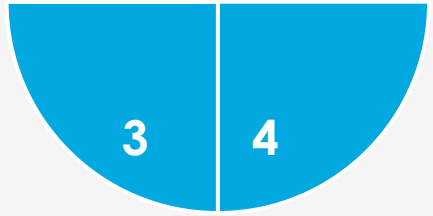


2

<=2 Days Post-Discharge

Phone call with Patient

TOC Bundle Elements #3&4



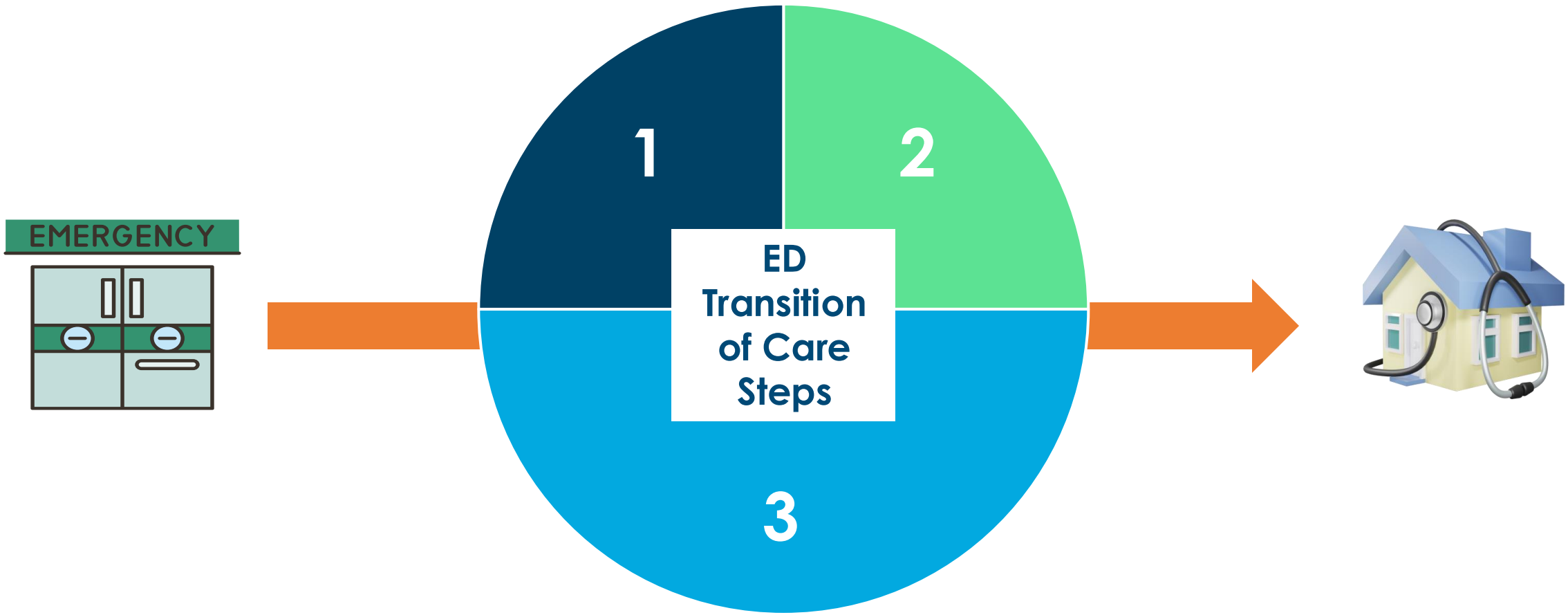
3&4

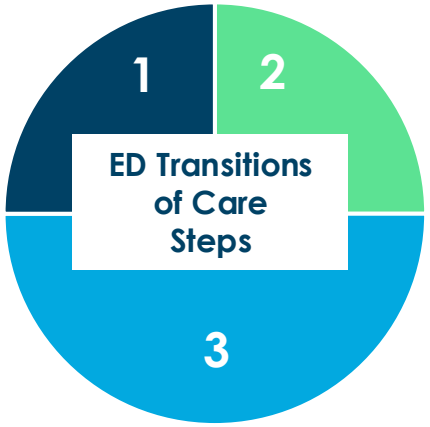
<=7 Days Post-Discharge

Med Reconciliation

& Follow-Up Appointment

TOC - from Emergency Dept (ED) to Med Home





ED Alert via MHNConnect

1

While in ED

Contact ED Staff & Patient/family

2

<=2 Days Post-Discharge

ED visit summary & PCP notification

Phone call with Patient

3

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

Follow-Up Appointment

Quality Measures

HEDIS is the quality measure program that HFS, CountyCare, and the MHN ACO uses

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

The HEDIS incentive structure in MHN ACO

Measures health plan quality using HEDIS

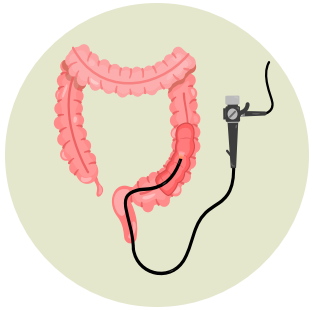
CountyCare
A MEDICAID HEALTH PLAN

Creates incentive program to improve quality measures

MHN ACO

Incentivizes medical homes to meet targets

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**

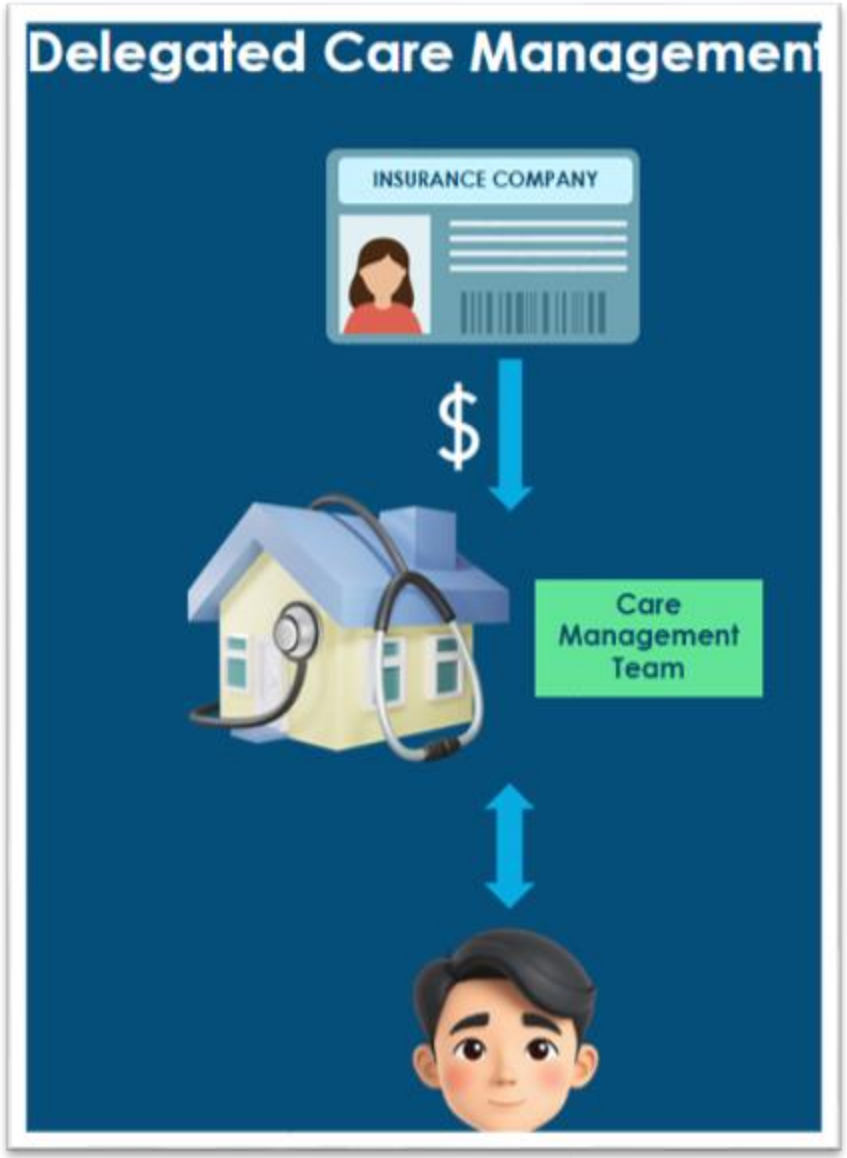
- **Controlling High Blood Pressure** (<140/90) ages 18–85 with hypertension Diabetes –
- **Glycemic Status** <8.0% for Type 1 & 2 Diabetics All Ages *(UDS: Inverse reported as HbA1c >9)*

- **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+)

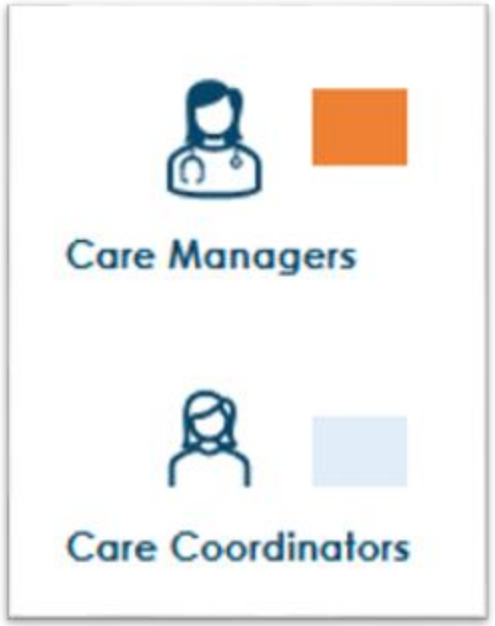
Also a UDS Measure

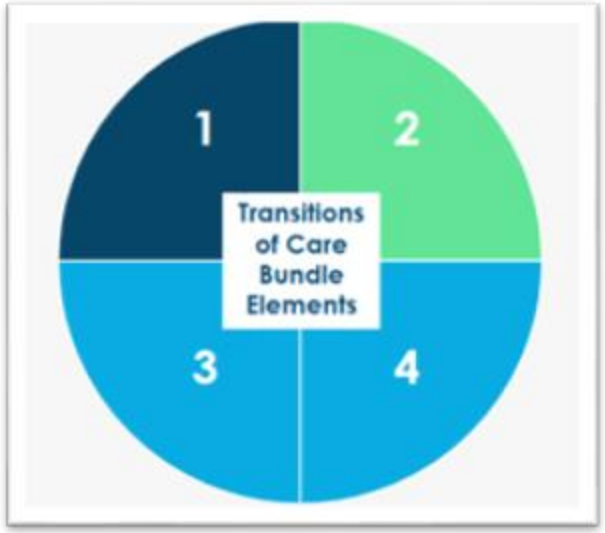
FIELD Guide Recap

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

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