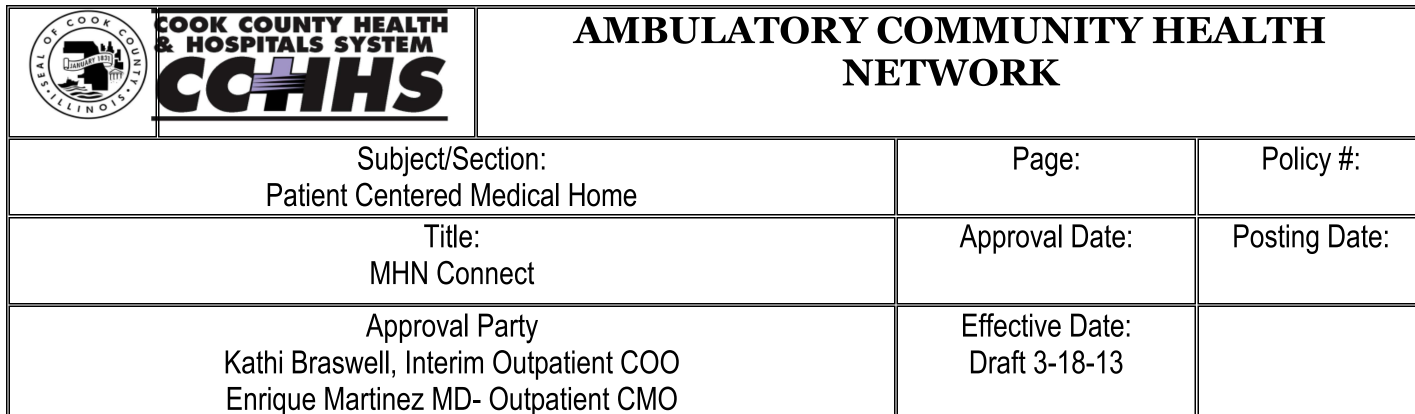

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS	AMBULATORY COMMUNITY HEALTH NETWORK	
Subject/Section: Patient Centered Medical Home	Page:	Policy #:
Title: MHN Connect	Approval Date:	Posting Date:
Approval Party Kathi Braswell, Interim Outpatient COO Enrique Martinez MD- Outpatient CMO	Effective Date: Draft 3-18-13	

PURPOSE: This policy will direct the use of MHN Connect – a web-based regional data-exchange platform that supports the management of care transitions.

AREAS AFFECTED: Medical, nursing, unlicensed clinical staff, clerical.

CROSS REFERENCE: Transition Care Policy.

POLICY GUIDELINES:
MHNConnect will be used on a daily basis to determine ED and inpatient discharges for ACHN's Illinois Health Connect and CountyCare enrollees. All discharged patients will be contacted within 72 hours of discharge and scheduled for a follow-up appointment within 7 days after discharge. Contact and scheduled appointments will be documented in MHN Connect as well as the electronic health record. Once the f/u visit has occurred, the completion of the visit is documented in the MHNConnect portal.

DEFINITION:
MHNConnect is a secure web-based platform that enables virtual integration between participating providers. MHNConnect improves care coordination, tracks patient activity throughout the delivery system, provides patient clinical history, and facilitates near real-time information exchange between emergency departments, hospitals, and the Patient-Centered Medical Home. As of the effective date of this policy, the following hospitals are participants: CCHHS, Rush, Sinai, St. Anthony, Holy Cross, La Rabida and three Advocate hospitals, Christ, Hope Children's, Trinity and South Suburban,

PROCEDURE:

1. Designated staff to log into MHN Connect on a daily basis with personal user name and password. MHNConnect website: www.mhnconnect.com.

2. Identify ED and inpatient discharge notifications.

3. Contact enrollee within 72 hours after discharge and perform activities as specified in transition of care policy and procedure.
4. Review ER notes, discharge summaries and prescription data.
5. Schedule an appointment within 7 days of discharge for patients determined to need an appointment.
6. Assess patients for teaching opportunities; schedule this with the nurse or other disciplines as indicated.
7. Document care coordination activity as correspondence in CERNER. Notify other team members via Message Center.
8. Document care coordination activity in the Clinic Connect Dashboard of MHNConnect. Log all outreach dispositions: "deceased," "unreachable" (3 call attempts), "appointment declined," and "completed appointment scheduling."
9. At each point of contact, reinforce to patient how to contact the PCMH staff.
10. After the post-Hospital/ED follow-up visit, CLOSE the LOOP! Document the visit occurrence in the MHNConnect portal .