



Health
Improvement
Program



MONTANA MEDICAID HEALTH IMPROVEMENT PROGRAM

A team-oriented approach to disease
management and prevention

HEALTH IMPROVEMENT PROGRAM

Introduction

- What is the Health Improvement Program
- Who is eligible and how are members identified
- Who provides the services
- What services are provided
- How is primary care integrated into the program

DISEASE MANAGEMENT VS. CARE MANAGEMENT

- Disease Management deals with specific diseases with the idea that if we control the specific disease in a patient, we can control costs, complications, and have better outcomes
- Care Management deals with the specific patient with the idea that patients who incur high costs and complications do so because of multiple medical, social and environmental factors which require attention

Health Improvement Model

- Combines disease management services with a more holistic approach to health and well-being for high risk/high cost patients

And

- Prevention efforts for patients at risk of developing chronic health conditions

Intervention for High Risk/High Cost Members

- Members are identified through predictive modeling software
- Predictive modeling uses claims history and demographic information such as age and gender to calculate a risk score

Prevention for At-Risk Patients

- Patients may be identified and referred by primary care providers
- May include patients who have no claims that generate a high risk score or have not yet been diagnosed with an illness

MEDICAID AND HMK PLUS HEALTH IMPROVEMENT PROGRAM PROVIDER REFERRAL FORM

Montana has a new Health Improvement Program for Medicaid and HMK Plus patients with chronic illnesses or risks of developing serious health conditions. The Health Improvement Program will be operated through a regional network of Community and Tribal Health Centers. Medicaid and HMK Plus patients eligible for the Passport Program are enrolled and assigned to a health center for possible care management. ***Your current Passport patients will stay with you for primary care, but are eligible for case management***

through one of the participating health centers. Nurses and health coaches certified in Professional Chronic Care will conduct health assessments; work with you to develop care plans; educate patients in self management and prevention; provide pre and post hospital discharge planning; help with local resources; and remind patients about scheduling needed screening and medical visits.

Montana uses predictive modeling software to identify chronically ill patients. This software uses medical claims, pharmacy and demographic information to generate a risk score for each patient. Although the software will provide a great deal of information for interventions, it will not identify patients who have not received a diagnosis or generated claims. If you have ***Passport*** patients at high risk for chronic health conditions that would benefit from case management, please complete the following form and ***fax*** it to:

Wendy Sturn, Program Officer
Health Improvement Program
Fax # (406) 444-1861

PCP Name:

Patient Name:

Address:

Address:

Telephone Number:

Telephone Number:

Passport Number:

Patient Medicaid or HMK *Plus* number:

Signature of referring provider:

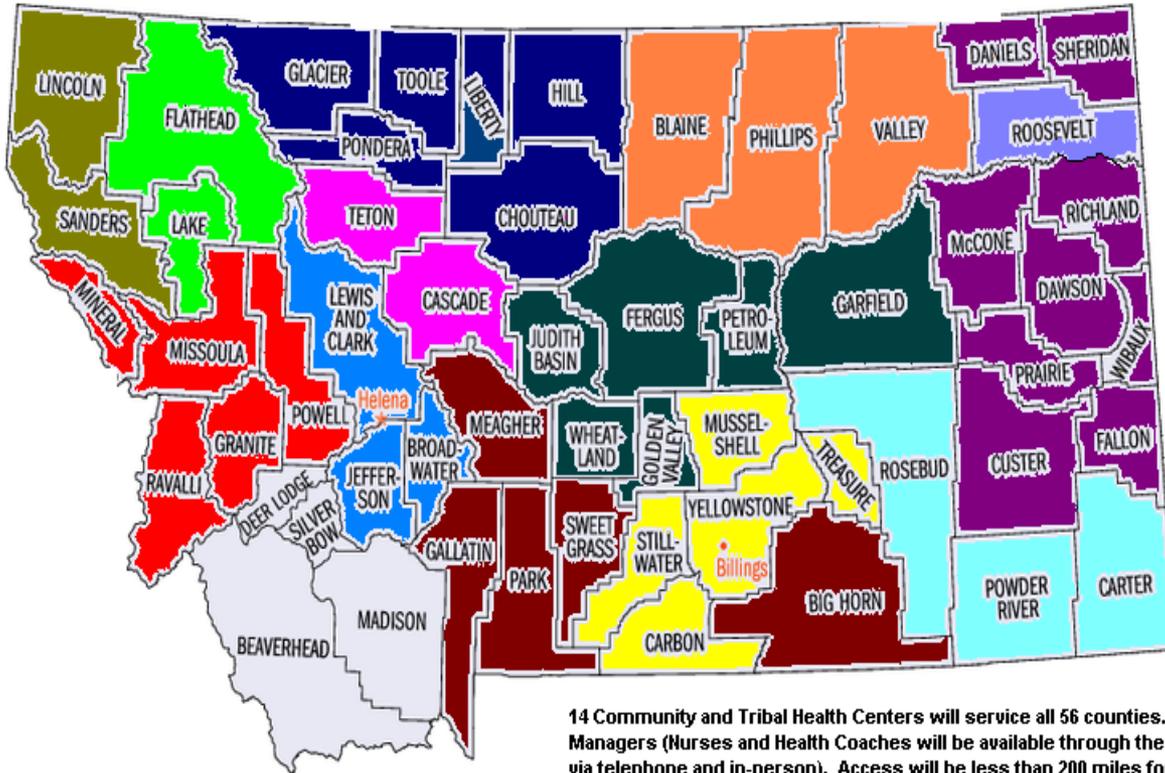
Chronic Disease(s) for which the patient is at risk:

Date:

Service Providers for Program

- Cornerstone of the program is the enhancement of community-based comprehensive primary and preventative health care
- Nurses and health coaches employed by community and tribal health centers
- There are 14 participating centers covering 56 counties

MONTANA HEALTH IMPROVEMENT PROGRAM - SERVICE NETWORK



- Northwest CHC Libby
- Flathead CHC Kalispell
- Partnership CHC Missoula
- Cooperative Health Center Helena
- Cascade CHC Great Falls
- Bullhook CHC Havre
- Butte CHC
- Community Health Partners – Livingston
- Sweet Medical Center Chinook
- Central Montana CHC Lewistown
- RiverStone CHC Billings
- Ashland CHC
- Custer Co. CHC Miles City
- Fort Peck Tribal Health Center Poplar

14 Community and Tribal Health Centers will service all 56 counties. Care Managers (Nurses and Health Coaches will be available through the CHCs via telephone and in-person). Access will be less than 200 miles for every eligible client. Nurses and Health Coaches will also travel to clients as needed and as weather and road conditions permit.

HEALTH IMPROVEMENT PROGRAM SERVICES

- Health Assessment (initial and periodic)
- Ongoing clinical assessment (in person and telephonic)
- Individualized care plan
- Hospital pre-discharge planning and post-discharge visits

Services Continued...

- Self-management education
- Group appointments
- Tracking and documenting progress
- Care Support Pages for patient education
- Assistance with and referral to local resources such as social services, housing and other life issues

SUMMARY

- Focus is on the entire patient rather than just specific diseases
- Patients are identified for intervention using predictive modeling
- Prevention is a component of the program through encouragement of primary care provider referrals
- State partners with community-based health centers to bring services closer to home for patients
- Information is collected from health centers to evaluate program



Managed Care Contacts

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Team Care
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Nurse First
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Health Improvement Program
Wendy Sturn 444-1292
Wsturn@mt.gov

Nurse First Advice Line
1-800-330-7847

Medicaid Help Line
1-800-362-8312

Provider Relations Help Line
1-800-624-3958

**Drug Prior Authorization
Unit**
1-800-395-7961

Visit our website at
www.mtmedicaid.org