Medicaid Health Plan Community Partnership Series

Gateway Health Plan: Prospective Care Management and Home-Based Tools

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As state Medicaid programs are increasingly shifting beneficiaries into managed care organizations (MCOs), some MCOs are expanding their traditional role to better meet the needs of their vulnerable members and communities. This case study is one of a series that describes how select MCOs are addressing myriad barriers and changing the way care is delivered through community engagement and partnerships. The purpose was to identify examples of successful or promising approaches, internal and state policy drivers that motivated the MCOs, challenges they faced, and lessons learned. A Synthesis Report summarizing strategies, lessons for other MCOs serving vulnerable populations, key "ingredients" for successful MCO-community partnerships, and policy implications for state policymakers from the four case studies in this series will be available at www.commonwealthfund.org.

Abstract

Gateway Health Plan, a managed care organization serving Medicaid beneficiaries in Pennsylvania, takes a holistic approach to serving its members, using a Prospective Care Management Model that includes a comprehensive risk assessment and a care plan that links members to a wide range of community resources. Gateway uses technologies such as an up-to-date, on-line community repository to ensure that staff can refer members to an array of health, nutrition, social service, housing, and other local safety net organizations and services. Gateway uses algorithms and multiple data sources to identify and target at-risk members for in-home assessments and treatment, and partners with community based-organizations to offer blood pressure screenings and health education in African-American owned barbershops and beauty salons.

Background and Drivers

Gateway Health Plan is a managed care organization (MCO) with a Medicaid plan serving more than 250,000 children and adults; and an HMO Special Needs Plan serving about 30,000 individuals dually eligible for Medicare and Medicaid. Gateway recently expanded its service area to offer coverage in 45 out of 67 Pennsylvanian counties (January 2013).

Gateway prides itself on taking a holistic approach to managing care. Its trademarked Prospective Care Management (PCM) model (Figure 1) emphasizes being proactive and helping members beyond medical needs. A PCM description notes that "a woman with a housing crisis is not focused on getting a mammogram. If we are engaged in her housing issue, hopefully we can have her engaged in her

healthcare issues."[1] Gateway identifies members at high risk for hospitalization, conducts a comprehensive needs assessment using its BEEMSS tool (which evaluates behavioral, environmental, economic, medical, social and spiritual needs), and develops and implements a care plan that includes finding and linking members to a wide range of community.

Figure 1. Gateway's Prospective Care Management Model

Source: Gateway Health Plan, 2012

Gateway representatives cite internal factors—leadership and history of serving vulnerable populations—as the main drivers of their holistic and public health focus. The CEO, who has a degree in public health, infuses public heath principles into the plan's philosophy and spearheaded the development of the PCM model in 2004 after a three-year planning initiative. About 45% of the staff were involved in "design teams" to create the PCM delivery approach, assessment, computer systems, etc. When launched, all Gateway staff attended an orientation, and all new employees undergo PCM training.

PCM holds that such investments in the short term pay dividends in the long run, and staff attribute the 9% decline in the plan's inpatient admission rate from 2009 to 2012 to the combination of PCM/community initiatives. Gateway plans to develop measures in 2013 to assess the return on investment of PCM components.

Though other health plans serving Medicaid beneficiaries are also involved in community activities, Gateway is viewed by some community organization leaders as the most consistent partner that often "takes their role to the next level." Its community activities promote the plan's image, but many of its actions illustrate a commitment to improving community health without regard to marketing and public relations considerations.

[1] Gateway Health Plan, 2012.

While not the primary drivers, state Medicaid policies support Gateway's community focus. In 2011 Pennsylvania's Medicaid agency began including in its MCO contracts four broad "pillars" to promote community involvement, though there are no numerical requirements or financial incentives tied to them at this time: (1) embed care managers in medical practices, (2) develop transitions of care, (3) help PCPs achieve medical home status, and (4) work with collaborative learning networks. In response, Gateway began placing care mangers in PCP practices this past year. Further, Pennsylvania Medicaid links financial incentives to broader population health, using "efficiency adjustments" that increase or decrease a health plan's payments if the region does much better or worse than expected on selected population health measures.[2]

Below are descriptions of initiatives that demonstrate Gateway's PCM model: a community service repository and "care gap" alert utilizing software technologies, and three programs enabling members to have in-home assessments and treatment—meeting members where they are. We also describe an example of Gateway's partnerships with community-based organizations, offering blood pressure screenings and health education in African-American owned barbershops and beauty salons.

Using Technologies: Community Repository and Care Gap Alert

Community Repository

Gateway has developed and maintains an on-line repository of approximately 3,000 community agencies located throughout the regions it serves. A proprietary software program, the repository can be accessed by all Gateway employees through its intranet, but it is used primarily by its by care management, member services, and utilization management staff. A team of staff persons verifies and updates information on database agencies annually and validates and enters new agencies identified by members and professionals. Gateway staff also participates in a wide variety of community meetings to network with social service providers and volunteer at community events for outreach purposes. Staff seeks feedback from members about the agencies and incorporates that information as needed into the database.

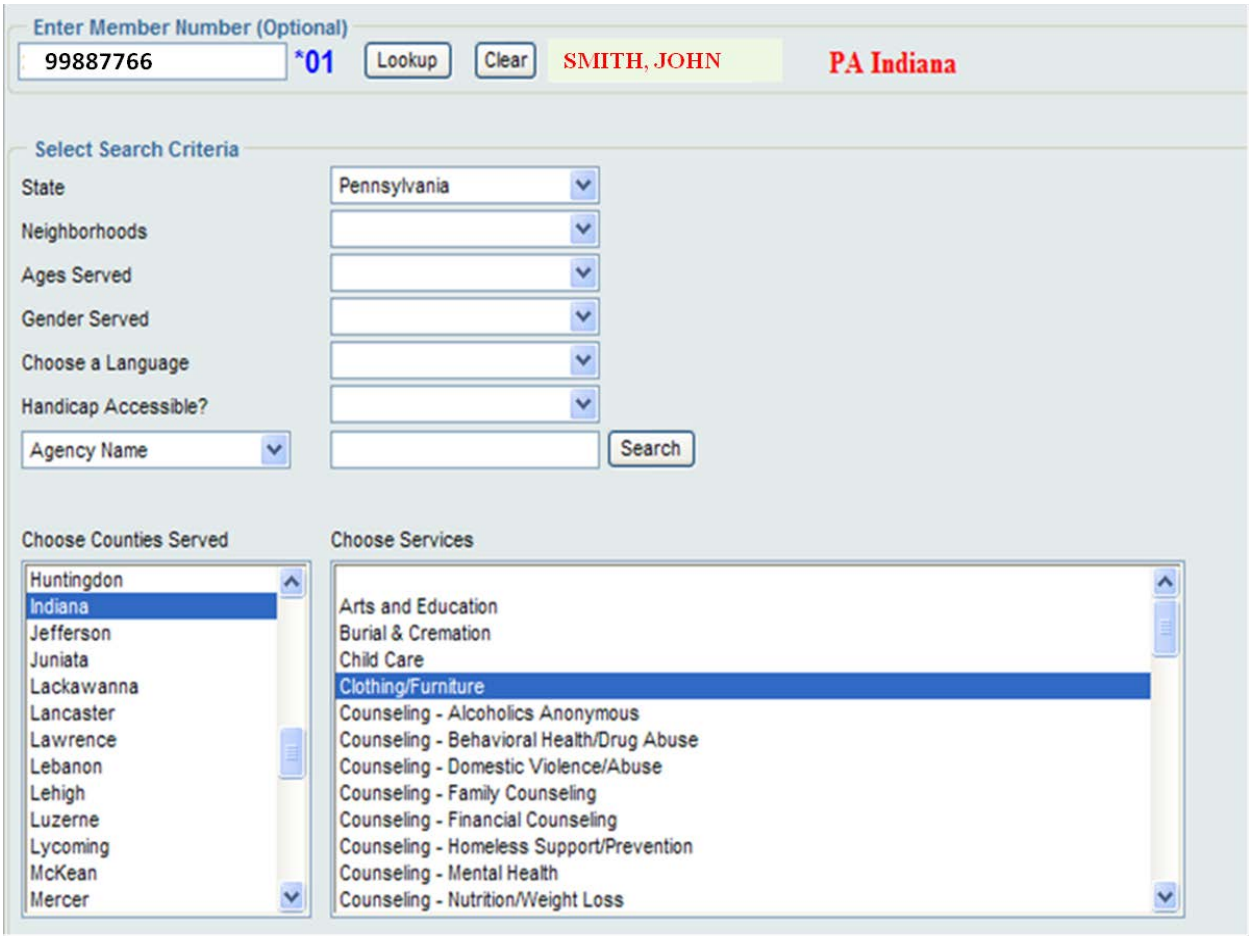
The repository facilitates and streamlines referrals to a wide range of community services. Care Managers use the detailed information they learn about members during the BEEMSS℠ needs assessments, to match their search of the repository to each member's specific needs (transportation, food, behavioral health, etc.), county, age, gender, and languages spoken (see screenshot, Figure 2). The care manager reviews the repository results with a member on the phone and can print out and mail a detailed resource list to the member. The care managers also record the referrals that are made either in the member's care management file or in the repository itself. This allows a care manager to follow-up later with the member and see if the resource was helpful. The repository was used in approximately

[2] Measures include: preventable admissions, readmissions, C-sections, low acuity Emergency Department (ED) visits, and overuse of high-tech radiology. See: Silow-Carroll, Edwards and Rodin. "State Levers for Improving Managed Care for Vulnerable Populations," Health Management Associates, February 2013.

40% of care management cases for referrals to community agencies. Appendix A lists the most frequent types of referrals that are made.

To prepare for Gateway's expansion into new regions in 2012-2013, Gateway's preventive health specialist has been meeting with community agencies throughout the new territory to learn about and add them to the repository. She has been attending community meetings and brings information back to care managers about neighborhood characteristics, transportation routes and barriers, parks, trash collection, food availability, and other issues that impact health and well-being.

Figure 2. Screen Shot Community Repository



Care Gap Button

In 2008 Gateway built into its computer member profile system a "care gap" button that alerts Gateway staff to preventative screenings that are due or overdue. Based on claims data, this tool was intended to improve the plan's performance on HEDIS scores and Medicaid's pay-for-performance program. It is used by any Gateway department in direct contact with members and their providers. For example, if a

member calls in to member services,[3] or if a care manager is contacting a member for any reason, the member's profile is accessed, and a care gap button flashes if *any covered member of the household* is due for certain screenings, such as well child visits, breast cancer screens, or annual PCP visits.

Gateway has just completed a reorganization of the screenings that are included in the care gap. It is allowing the roll out of the new measures to happen for 6 to 12 months and then will evaluate the effect the care gap alert may have on improving screening rates.

The care gap alert supplements quarterly outreach reports that identify households due for screenings and members who are frequent "no shows" for doctor visits. These reports prompt care managers to call the member, help schedule appointments and transportation (when necessary), remind the member of appointments, and follow up to confirm that the appointments and screenings were completed. The health plan's medical director reports that Gateway is at the 98th percentile compared to other Medicaid plans in prenatal visits.

Home-Based Screenings and Treatment

Neighborhood Diabetes Screening

In July 2011 Gateway partnered with a durable medical equipment (DME) vendor to conduct in-home assessments and education on self-care to provide value-added services when a member signs up for home delivery of testing supplies. Non-clinical technicians conduct in-home HbA1c testing for members whom Gateway identifies as having diabetes with a gap in monitoring. These members are provided with in-home test strips and educated on how and when to use them. If, during home testing, the HbA1c is determined to be at a level of more than 10, Gateway care management staff and the member's PCP are notified. Quarterly calls from the DME vendor reassesses if the appropriate test frequency is occurring, before additional strips are sent to the member.

Gateway has found that the convenience of in-home testing and personal self-care education have improved testing completion. Among the 3950 members who have been visited, approximately 1200 have completed an A1c, and about 14% of those tests identified and referred to follow up members with high A1c (>10). With a full year of experience, Gateway will now be able to evaluate more thoroughly the cost-effectiveness of this initiative.

Home Colorectal Cancer Screening Kits

Gateway noticed that colorectal cancer screening rates were lower than average among its Medicare/Medicaid dual eligible membership. After examining barriers to members' undergoing colonoscopies, in 2011 Gateway partnered with a lab to begin sending iFOBT (immunochemical fecal occult blood test) kits to member homes. To increase the likelihood that members would be able to understand how to complete these tests in their homes, Gateway rewrote the instructions at a third

[3] Given that the plan does not have correct phone numbers for one-third of members, checking screening status when a member contacts the MCO is particularly valuable.

grade reading level and included a picture for each step of the process. In addition, instructions are included in each kit in either English or Spanish, depending on the member's preferred language. Initially, Gateway targeted these kits to members who had exhibited a "preventive health tendency" in the last 12 months—illustrated by claims data that showed the member obtained either a flu shot or mammogram in the prior year. Gateway experienced a 22% return rate—858 samples mailed in among 3,985 members receiving the kits in 2011. This contributed to a 22% increase in Gateway's rate for this HEDIS measure for the Medicare members in the project. Of the kits returned, 8% had abnormal results, and the patients obtained further follow up. Gateway is expanding this campaign in 2012.

Targeted In-Home Care Management and Treatment

In May 2012 Gateway partnered with a national vendor to provide extra care and care management to some of its more clinically challenging and highest utilizers. Proprietary algorithms are used to identify the most clinically at-risk members—those who have eight chronic conditions or those who have experienced at least two inpatient admissions within the prior 12 months. A physician or certified registered nurse practitioner (CRNP) visits the member at home and conducts comprehensive health assessments and care management services. Lab draws and IV infusion therapy are performed when necessary. The physician or CRNP coordinates with and directs members to their PCPs and stays engaged with the members through scheduled and unscheduled visits and 24/7 telephonic support until the member is able to effectively self-manage or care management services are no longer desired. The goal is to teach members self-management techniques, improve understanding of clinical condition/diagnoses, and address barriers to care that could result in avoidable emergency room visits and hospitalizations. Gateway hoped to reach 500 high-risk members by the end of 2012 and will evaluate the program's impact in 2013.

Community Events: Neighborhood Screenings and Education

Gateway partners with many community-based organizations to participate in and help underwrite community events focused on disease prevention, health education, and outreach. One of these long standing partnerships is with the University of Pittsburgh's Center for Health Equity (CHE) on their annual event "Take a Health Professional to the People Day (TADay)," which brings health professionals into African American-owned and operated barber shops and beauty salons in Pittsburgh to promote health and wellness and to help connect people to medical homes. Gateway places clinical and non-clinical staff at these locations to provide blood pressure screenings and to educate customers and staff about healthy lifestyle, nutrition, body mass index, and other health topics. High blood pressure is a condition that disproportionately affects African Americans and can lead to major health problems. If individuals are found to have very high blood pressure on TADay, the health professional counsels and encourages them to contact their primary care physician (PCP); if they do not have a PCP, a CHE staff person will transport them to a federally qualified health center (FQHC) or local emergency room (ER) and, with their permission, call them back to inquire about their plan of follow-up care. If their blood pressure is high but not an emergency, the health professional provides counseling, literature regarding

blood pressure control, and instructions to see their PCP or a list of FQHCs that could serve as their medical home.[1]

In 2010, Gateway asked the center if it could place staff into certain shops on a monthly basis—extending Gateway's presence beyond TADay and helping to create year-round health education in the shops. Gateway staff began monthly screenings in four barber shops where prior screening identified a large number of customers with high blood pressure and a need for additional health resources to address the health concerns of shop staff and customers. Gateway surveyed shop/salon owners and staff, who indicated the services are highly valued (see Figure 3 below).

Figure 3. Survey Results from Monthly In-Shop Initiative

	Strongly agree		No opinion		Strongly disagree
	5	4	3	2	1
1. I know more about health topics because of what Gateway staff has taught me.	55%	39%	5%		
2. Customers know more about health topics because of what Gateway staff has taught them.	71%	21%	5%		3%
3. Gateway staff talks about health topics in a way that is easy to understand.	84%	8%	8%		
4. Gateway staff answers questions about health topics.	89%	11%			
5. Gateway staff talks about the health care help that exists in our community.	71%	21%	5%		
6. Gateway staff gets along well with shop staff and customers.	87%	8%			
7. It helps me and the customers learn about health having Gateway staff here.	84%	8%	3%		
8. The educational handouts are helpful.	71%	18%	5%		3%
9. I think Gateway staff should keep coming to the shop.	82%	13%			

Source: Gateway Health Plan, based on approximately 50 respondents in four shops during April through December 2011.

CHE is planning to expand the monthly screening model to place health professionals in additional shops and salons, utilizing lessons learned from Gateway's experience in the four barber shops. Further, Gateway exemplified its commitment to improving community health over marketing and public

[1] At the September 2011 TADay® event, over 200 people received health information from 70 health professionals representing 20 health and human service provider organizations; 15 men received the PSA screening test for prostate cancer; of 132 blood pressures taken, 47 people were identified with an elevated blood pressure and referred to their PCP or a FQHC for follow-up care.].

relations considerations by offering to not recruit individuals served at the salons and shops for health plan membership and by preferring to not advertise their name on CHE program materials.

Challenges and Lessons

Gateway has faced some challenges pursuing the above initiatives, particularly when targeting highest-risk members. Challenges include finding patients (about one-third of the phone numbers the plan receives from State records are disconnected or otherwise non-functioning), obtaining agreement for a health practitioner to make a home visit, ensuring all educational materials respond to a low health literacy level, ensuring patients understand their medication regimens, , and supporting high-risk members to adhere to care plans and get to doctor appointments.

Data is a key element of Gateway's approach. Staff analyze Gateway's claims, administrative, and HEDIS data to determine gaps in care, drilling down to county or zip code, race, ethnicity, age and gender. They then look for community partners that can have relationships with and can help reach the target population. In some cases, community-based organizations identify local needs and invite Gateway to participate in interventions.

Gateway has learned the importance of keeping the primary care physicians informed of the MCO's community-based initiatives through general provider relations venues and special communications. This ensures that the physicians are aware of ongoing interventions and understand both the benefits to the patients and the potential implications for them. For example, Gateway sent a letter to its physician network describing the iFOBT colorectal cancer screening intervention and asked PCPs whether they wanted to opt out the Gateway patients in their practice. No physician refused.

Most importantly, the PCM holistic approach is ingrained throughout the organization. All Gateway staff undergoes training about PCM, and Gateway representatives link the combination of holistic and community-based strategies to clinical and utilization improvements, such as the plan's 9% decline in inpatient admission rate from 2009 to 2012. Gateway is establishing specific metrics for determining the return on investment for PCM components and will conduct the first measurements of it in 2013.

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About Health Management Associates

HMA is an independent, national research and consulting firm with 15 offices nationwide. HMA specializes in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. www.healthmanagement.com .

Appendix A

Following are the most frequently needed services for which referrals were made in the Repository in a 6 month period, listed alphabetically:

Child Care
Clothing/Furniture
Counseling - Alcoholics Anonymous
Counseling - Family Counseling
Counseling - Financial Counseling
Counseling - Homeless Support/Prevention
Counseling - Mental Health
Counseling - Nutrition/Weight Loss
Counseling - Smoking Cessation
Disease Education Organization
Emergency Shelter - Individuals or Families
Employment/Vocational Training
Exercise and Nutrition
Food
Housing
Housing - Home Modifications
Information & Referral
Law Enforcement/Legal Assistance
RX Programs
Senior Services - Adult Day Care
Senior Services - Area Agency on Aging
Senior Services - Respite Care
Senior Services - Senior Centers
Senior Services - Social Support/Services
Social Support
Special Needs
Spiritual Support
Transportation
Transportation - MATP
Utility Assistance - Electric
Utility Assistance - Gas
Utility Assistance - Weatherization Assistance
Vision and Hearing