Innovative Programs and Initiatives

MemberConnections® Program

Coordinated Care's MemberConnections Program helps members to break down barriers, address needs and connect to services. Assisting members to navigate the system by providing them with personalized time and attention by community health worker certified, non-clinical staff. MemberConnections team focuses on direct calls, coordination of services and benefits through home visits, and community events. For all of 2013, MemberConnections completed over 5,300 connections with members by phone or in person and participated in 163 community events and activities.

Our SafeLink free cell phone program launched in 2012 and has seen significant growth. SafeLink, a federally funded free cell phone program, provides qualified members with a free cell phone, 250 minutes, unlimited text messaging and unlimited calls to our toll free number. Members identified as high risk and without reliable phone access receive additional assistance in applying for the program by a MemberConnections Representative. The phone numbers are available to their providers via our Provider Portal. We currently have over 5,000 households with a SafeLink phone.

Coordinated Care will continue to monitor this program and plans to launch new features and tools that will assist in improving the health of the member by utilizing SafeLink phones.

Information Technology

Coordinated Care's parent company, Centene Corporation®, provides a standard platform for the management of Medicaid and other state sponsored medical health plans. This platform continues to be enhanced, supporting growth and driving efficiencies. Centene has been recognized as a leader in Information Technology by *InformationWeek* for the last five years. Centene's award winning business intelligence platform, Centelligence®, continues to be extended into new areas, enabling proactive measures to improve medical outcomes and lower costs. Coordinated Care's sophisticated reporting technology allows for sharing of targeted, relevant information to providers with 24 hour a day online access.

Data sharing includes tracking trends over time for each provider, highlighting quality performance measures and outcomes. Real time access to data is also available giving providers the information needed to improve performance, and ensuring members are receiving the appropriate and best care. Lastly, Centene Information Technology continues to invest in better customer service capabilities, utilizing advanced call center technologies and customer relationship management solutions.

Start Smart for Your Baby®

In an effort to help pregnant members deliver healthier babies, Start Smart for Your Baby (Start Smart) incorporates the concepts of case management, care coordination, and disease management. Start Smart has evolved into a complete program that promotes education and communication between pregnant members, their case managers (as appropriate) and physicians to ensure a healthy pregnancy and first year of life for their babies.

Our multi-faceted approach to prenatal and postpartum care includes extensive member outreach and incentives, wellness materials, provider incentives and intensive case management. This reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery and infant disease.

The Start Smart program is comprised of multiple components which allow us to identify more pregnant members, interact with them earlier in pregnancy, reduce the rate of prematurity, shorten neonatal hospital stays, increase birth weights and lessen the chance of repeat premature deliveries. CC also covers 17P to help prevent premature delivery. 17P is endorsed by the American College of Gynecologists.

New to Start Smart in 2013 is a breast feeding program that offers high quality electric breast pumps to members who commit to breast feeding, educational materials and breast feeding support. Coordinated Care also launched a new car seat incentive program to encourage moms to enroll into Start Smart. Moms receive a free convertible car seat prior to the birth of their baby for participating in the Start Smart program when enrolled at least six weeks prior to their due date.

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2013

At-A-Glance

The Face of Coordinated Care

Services Offered: TANF, SSI, CHIP, Basic Health, Foster Care

Number of Local Employees: **117**
First Year of Operations: **2012**

Membership: **82,100**

Percentage of Total Eligibles Served: **10%**

Office Locations

1. **Tacoma**
   1145 Broadway, Suite 300
   Tacoma, WA 98402

www.CoordinatedCareHealth.com

2013 Annual Report Card

coordinated care™

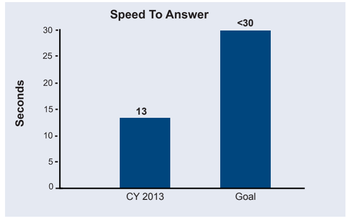
Value to the **State of Washington** and quality healthcare for its Medicaid enrollees.

Health Plan Report Card **Coordinated Care**

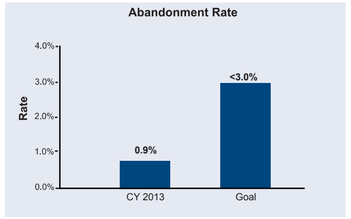
The Year End report card provides a snapshot of how Coordinated Care Corporation (Coordinated Care) performed against state, NCQA, and Coordinated Care standards through December 31, 2013, and what Coordinated Care is doing to improve our member's health outcomes. As of December 31st, Coordinated Care was providing Medicaid managed care services to 82,100 members. Beginning in January 2014, in addition to the Medicaid managed care services historically provided by Coordinated Care, the organization also began serving members who bought health care insurance on the Washington Health Benefit Exchange and who became eligible for Medicaid Expansion under the provisions of the Affordable Care Act (ACA.)

Member Services

Calls Answered from January 1 – December 31, 2013: 115,486
Percent of Calls Answered within 30 seconds: 88.9%
Goal: 80% of total monthly calls in 30 seconds or less
Calls Abandoned: 1,099 calls abandoned or 0.9% calls abandoned
Goal: less than 3%
Average Speed to Answer (seconds): 13 seconds
Goal: 80% of total monthly calls in 30 seconds or less



As reported by Coordinated Care

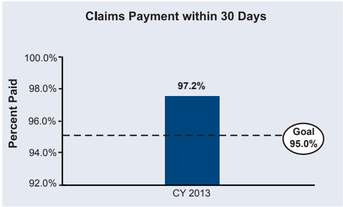


As reported by Coordinated Care

Claims Payment

Plan goal: 95.00% of all claims resolved within 30 days
Total resolved in 0 to 30 days: 97.2%
Plan goal: 99.00% of all claims resolved within 90 days
Total resolved in 0 to 90 days: 99.9%

Improvements
Over the course of the past twelve months Coordinated Care worked diligently to improve claim payment targets with a cross functional team, focused on quality, first time claims payment accuracy, and continued aggressive timely payment. We look forward to the opportunities with ICD-10 implementation to increase performance and quality.



As reported by Coordinated Care

Quality Improvement Initiatives

Coordinated Care is conducting quality Performance Improvement Projects (PIPs) that achieve through ongoing measurement and intervention, demonstrable improvement in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. The following have been identified by Coordinated Care in 2014 as areas for intervention:

Improving Women's Health

Studies indicate that insured, low-income populations find accessing health care more difficult which often leads to barriers in receiving appropriate preventive care at the same rate as the general population.

Coordinated Care launched a three-year project in 2012 to improve annual mammogram screenings for women over the age of 40 in an attempt to remove these barriers and educate members on the importance of preventive health care.
In the second year of the project (Re-measurement year 1) Coordinated Care identified women over the age of 50*, who did not show claim-based evidence of a mammogram screening and enrolled them into our program. The program includes a detailed letter mailed to the member educating them on the prevalence of breast cancer and how a mammogram can provide early detection, earlier treatment, and save her life. Coordinated Care began mailing these to identified women in October 2013. Nearly 2,300 letters were sent. Following the mailing from Coordinated Care, we also sent another notification on behalf of the member's PCP, further educating the member on the need to schedule her mammogram. Over 1,800 letters were sent. (* The minimum age for the project was changed to age 50 years to be in alignment with the revised HEDIS technical specifications which changed in fall 2013).

Finally, Coordinated Care will place a follow-up phone call to the member offering assistance with scheduling her mammogram and/or transportation information and informing members about the CentAccount reward for compliance with this preventive performance measure.

Improving outcomes for Members with Diabetes

Increasing compliance of Coordinated Care members with Type II Diabetes mellitus with their treatment plans. Regular monitoring and managing blood glucose levels is important to slow down the development of the disease however, nearly one in four Medicaid members with diabetes does not get regular testing. The indicators for this project are a) HbA1C annually, b) LDL test annually, and c) Eye screening exam for retinal disease annually, as appropriate. Interventions include a letter and educational brochures.

Also, members receive a dollar reward in their CentAccount® annually for compliancy with the screening requirements. Letters and brochures were sent out in July 2013. In addition, HEDIS diabetic performance measure information was faxed and mailed to PCPs.

Opticare, our sister company and vision provider is phone calling/mailing diabetic members to remind them to get a dilated eye exam which may motivate members to be more compliant with their diabetic management.

Improving the Transition of Care

We are involved in peer managed care workgroups sponsored by the Health Care Authority/Department of Health regarding the transition of care and the development of a pediatric behavioral health screening tool. The expected outcome of the Transition of Care workgroup is to assure timely follow up with primary care providers, and care management for high risk patients while assuring safe, effective and coordinated care as patients move between settings. This group is currently piloting a project with a local hospital, St. Joseph's, to notify the Plan/providers in real-time of inpatient/discharge status. Monthly meetings and teleconferences have taken place. A baseline rate of 63% compliance of members with PCP/Specialist visit within seven days of discharge is noted.

Performance Measures Interventions include:
- Letters and educational brochures to all diabetic members
- Member reminder letters regarding breast cancer screenings
- Letters to parents of newborns regarding well baby checks (including a personalized immunization chart from the CDC)
- Pertussis vaccination reminders
- Start Smart mailings sent to pregnant members
- Member phone calls regarding: Coordinated Care sponsored flu shot clinics, mammogram reminders and child vaccination reminders and well child reminder birthday cards sent
- EPSDT non-compliance list was sent to the larger provider groups.
- Phone calling patents of 8-9 month olds showing as non-compliant (4 visits) with their PCP for a well child check.
- Phone calling the parents of 12 month old members to remind the parents to take their child in for well baby visits (5-6 before the age of 15 months); Centaccount information was given. There were 370 households called.
- Phone calling of the parents of children aged 3,4,5,6 years of age to remind them to get their child(ren) in for their well child visits which may include immunizations and a flu shot; CentAccount information was given.
- Flu PSA announcement during on-hold time with phone calls to member services.

Coordinated Care has chosen to take part in the CAHPS survey for 2013 which took place in spring 2013. CAHPS data indicates that regarding the composite, "Getting Care Quickly," about half of our members scored us at the most favorable response. In the composite "Getting Needed Care" we scored at almost the 75th percentile with Q14 "Ease of getting care, tests, or treatment needed" at the 2 points less than the mean.

HEDIS 2014:

Coordinated Care will be reporting performance measures following NCQA guidelines in 2014 using 2013 data. In addition to submitting claims data to NCQA, we will be doing medical record reviews for the following performance measures: childhood immunizations, well child visits in the first 15 months of life; well child visits in the third, fourth, fifth and sixth years of life; adolescent well care visits. Coordinated Care has implemented a process for reminding members and providers that Members may need a service, screening, or test related to their medical condition. These reminders are called "Care Gaps." These Care Gaps Alerts are implemented based on Coordinated Care's Administrative claims data.

The state of Washington required reporting on these clinical measures in June 2013:

- Inpatient utilization – general hospital acute care
- Ambulatory care (outpatient and emergency room)

Ambulatory Care:
AMB ER Visits/1000- 60.1
AMB OP visits/1000- 283.2

Inpatient Utilization:

Maternity Tot ALOS	2.4
Maternity Tot Days/1000	117.0
Medical/SurgicalTot ALOS	4.4
Medicine Tot Days/1000	245.8
Tot IP ALOS Total	4.5
Tot IP Days/1000	503.3

Community Involvement

Coordinated Care is actively engaged in community health care initiatives such as Pierce County Coalition for Immunizations, Children with Special Health Care Needs (CWSHCN), Immunization Action Coalition of Washington, Health Coalition for Children and Youth, Washington Coalition on Medicaid Outreach, Eastern Washington Outreach Coalition, Consortium for Health Information and Access serving Pierce and Kitsap counties, Child Profile meetings and alignment with the WAIIS (WA immunization database) for data sharing for the purpose of gap analysis for immunizations.

We are also involved in peer managed care workgroups sponsored by the Health Care Authority/Department of Health regarding the transition of care and the development of a pediatric behavioral health screening tool. We have many ongoing collaborations including:
- Working with Pierce County Clean Air for Kids program to do home visits and education for high risk children with asthma.
- A partnership with Tacoma Fire Department and FD Cares program assess Coordinated Care members during a 911 call and refer to case management or warm-transfer calls directly to NurseWise for those who do not need to be transported to the ER.

Coordinated Care partners with many important regional non-profit health improvement organizations like: WithinReach of Washington, Comprehensive Health Education Foundation, American Diabetes Association, Mercy Housing and March of Dimes.

Working Together to Address Member Needs

Coordinated Care received a referral from a member's Primary Care Provider. The member was homeless with an extensive mental health history, cultural and language barriers, and no access to a reliable phone. MemberConnections was able to meet the member at his next physician's appointment to help him apply for a SafeLink cell phone and to get him connected to a behavioral health case manager for mental health support services. The member has stayed in touch with his PCP-making all appointments regularly, He has continued to go to access centers for mental health counseling, and was given access to cultural support services and other community resources.