## Innovative Programs and Initiatives

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

### Member Connected to Care

A homeless member with frequent visits to the emergency department was being treated for congestive heart failure and addiction. Coordinated Care's case management team sent a Member Connections® representative to meet this member and get the Member connected to services and support.

Through contacting a friend, our staff was able to meet the member and get them a free Connections Plus® phone so they could be reached and could call their doctor or health plan. Our staff was able to assist the member to get follow up care scheduled, ensure they had transportation to those appointments, refilled medications and established the member with a regular clinic for ongoing care. The member has begun mental health counseling, is undergoing additional health care and has been assisted to apply for Supplemental Security Income (SSI) through the state. They are continuing in case management with Coordinated Care.

### MemberConnections® Program

Coordinated Care's MemberConnections Program helps members to break down barriers, address needs and connect to services. We assist members in navigating the system by providing them with personalized time and attention by community health worker certified, non-clinical staff. The MemberConnections team focuses on direct calls, coordination of services and benefits through home visits, and community events. In 2013, The 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 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. Coordinated Care also covers 17-Alpha-hydroxyprogesterone (17P) to help prevent premature delivery. 17P is endorsed by the American College of Gynecologists.

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

coordinated care.

# 2014

## At-A-Glance

### The Face of Coordinated Care

Services Offered: TANF, SSI, CHIP, Foster Care, Expanded Medicaid

Number of Local Employees: **150**
First Year of Operations: **2012**

Membership: **169,634**

Percentage of Total Eligibles Served: **14%**


Office Locations

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

www.CoordinatedCareHealth.com



# 2014 Mid-Year Report Card

HEALTH PLAN NCQA ACCREDITATION ACCREDITED

coordinated care™

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

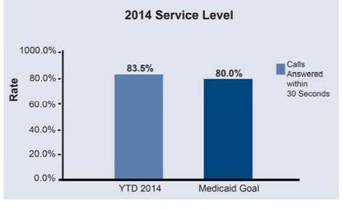
# Health Plan Report Card **Coordinated Care**

The Mid-Year report card provides a snapshot of how Coordinated Care Corporation (Coordinated Care) performed against state, National Committee for Quality Assurance (NCQA), and Coordinated Care standards through June 30, 2014, and what Coordinated Care is doing to improve our member's health outcomes. As of June 30, Coordinated Care was providing managed care services to more than 169,000 Washington Apple Health members and 20,000 Ambetter from Coordinated Care health exchange enrollees.

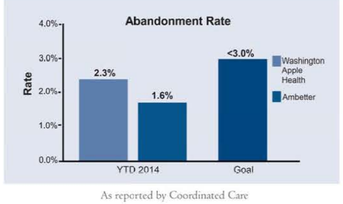
## Member Services

**Washington Apple Health (Medicaid):**
Calls answered: 146,809
Calls answered within 30 seconds: 122,586
Percent of Calls Answered within 30 seconds: 83.5%
Goal: 80% of total monthly calls in 30 seconds or less
Calls Abandoned: 3,413 calls abandoned or 2.3% calls abandoned
Goal: Less than 3%
Average Speed to Answer (seconds): 31 seconds
Goal: 80% of total monthly calls in 30 seconds or less

**Ambetter:**
Calls answered: 30,085
Percent of calls answered with 30 seconds: 75.9%
Abandoned calls: 477
Percent of calls abandoned: 1.6%




As reported by Coordinated Care




As reported by Coordinated Care

## Claims Payment

Plan goal: 95.0% of all claims resolved within 30 days
Plan goal: 99.0% of all claims resolved within 90 days
Claims (Medicaid):
Total resolved in 0-30 days: 99.5%
Total resolved 0- 90 days: 99.65%

Improvements
Over the course of the past 12 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.


As reported by Coordinated Care

## Quality Improvement Initiatives

In 2014, Coordinated Care received full NCQA Accreditation, demonstrating our commitment to quality. Coordinated Care is conducting quality Performance Improvement Projects (PIPs) that, through ongoing measurement and intervention, achieve 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 continued or new 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 project 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. Over 2,700 letters were sent initially.

Following the mailing from Coordinated Care, we also sent another notification on behalf of the member's Primary Care Provider (PCP), further educating the member on the need to schedule her mammogram, and almost 2,300 letters were sent. The current phase of the project includes follow-up telephone calls made to members who are identified as needing a mammogram by administrative data. During the call, our representatives offer assistance with scheduling her mammogram and/or transportation information, and inform members about the CentAccount reward for compliance with this preventive performance measure.

Of the original 2,708 members identified for this project, roughly 1,053 remain to be contacted by phone (third phase of Step-Wise interventions) before completion of this year's interventions at the end of September.

As of June 30, 2014, 385 members were called, 139 members were reached and offered assistance with scheduling, and 30 members were assisted with scheduling a mammogram.

(* 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).

## Improving Outcomes for Members with Diabetes

Our intention is to increase compliance of Coordinated Care members with Type II Diabetes mellitus with their treatment plans through regular monitoring and managing blood glucose level, 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 test annually, b) LDL test annually, and c) Eye screening exam for retinal disease annually, as appropriate.

Interventions include a letter and educational brochures. Additionally, 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 overall diabetic management.

Also, members receive a dollar reward in their CentAccount® annually for compliance with all of the screening requirements. Letters and brochures were sent out in July 2013 and again in August and September 2014. In addition, HEDIS diabetic performance measure information was faxed and mailed to PCPs, and will be reviewed with each Provider Relations on-site visit with our providers.

## 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. The project will be looking to align itself with WSHA (Washington State Hospital Association) to work together on narrowing the focus of the PIP and, by enlarging the data pool, extracting meaningful information that can be mined for useful intervention implementation at the Plan level. As a reflection of the Plan's participation in this pilot project and the initial findings of insufficient coordination of care, the Plan instituted its own Transitional Care Unit in April 2014 to better interface with all hospitals and increase primary care engagement, with the intent of decreasing overall re-admission rates.

Coordinated Care reported on three critical measures to the State last year: W15 (Well-Child 15 months), W34 (Well-Child ages 3-6), and Adolescent Well-Child. Of these three measures, the Plan exceeded the NCQA goal of 75th percentile only with Well-Child 15 months of age, at 28.24 percent. The Plan will initiate a new Performance Improvement Project in Fall 2014 designed to help impact the overall Well-Child/Adolescent compliance rate.

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 Centers for Disease Control and Prevention (CDC)
- OptiCare phone calls and postcard outreach to members to encourage annual dilated eye exam
- Pertussis vaccination reminders
- Start Smart mailings sent to pregnant members
- Member phone calls regarding: Coordinated Care sponsored flu shot clinics, mammogram reminders, child vaccination reminders and well-child reminder birthday cards sent
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) non-compliance list was sent to the larger provider groups
- Phone calling parents of 8-9 month olds showing as non-compliant (4 visits) with reminders to visit 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.
- Phone calling to parents of children aged 3-6 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
- Pilot project with Yakima Valley Farm Workers Clinic to improve well-child examination compliance through pre-scheduled extended hour evening visits
- Flu Public Service Announcement (PSA) announcement during on-hold time with phone calls to member services

CAHPS® data indicate 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 NCQA 75th percentile with "Ease of getting care, tests, or treatment needed" at the 2 points less than the mean. The Plan participated in another CAHPS Survey in Spring 2014, the results of which are pending at the time of this publication. This information will be compared with the previous year and evaluated for intervention opportunities.

## HEDIS 2014:

Coordinated Care will be reporting performance measures following NCQA guidelines in 2014 using 2013 data. In addition to submitting metrics to NCQA, we will be performing 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; and 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. Physicians can identify a member's active Care Gaps by logging on through the Provider Portal and reviewing their patient's profile.

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

- Inpatient utilization – general hospital acute care
- Ambulatory (AMB) care (outpatient (OP) and emergency department (ED)

| AMBULATORY CARE: | June 2013 | June 2014 |
|---|---|---|
| AMB ED Visits/1,000 | 60.1 | 64.4 |
| AMB OP visits/1,000 | 283.2 | 345.94 |
| **INPATIENT UTILIZATION:** | **June 2013** | **June 2014** |
| Maternity Tot ALOS | 2.4 | 2.31 |
| Maternity Tot Days/1000 | 11.71 | 13.85 |
| Medical/SurgicalTot LOS | 3.17 | 3.38 |
| Medicine Tot Days/1000 | 7.95 | 9.02 |
| Tot IP ALOS Total | 3.24 | 3.52 |
| Tot IP Days/1000 | 22.12 | 26.85 |

## Community Involvement

Coordinated Care is actively engaged in community health care initiatives such as Pierce County Immunization Coalition, 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, Washington Coalition of Medicaid Outreach, Pierce County Community Health Worker Collaborative, King County Promotores/CHW NetworkConsortium 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 perform 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 Emergency Department.