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 the best care for the newborn.

The Start Smart program is comprised of multiple components that, when applied, should help improve pregnancy outcomes. Key elements include:

1. Preconception counseling and support
2. Early prenatal care
3. Increased use of medical resources
4. Education and support for pregnant women and their families
5. Support for families after birth

The Start Smart program includes the following initiatives:

- A breast feeding program that offers high-quality electric breast pumps to members who commit to breast feeding, educational materials, and breast feeding support.
- A car seat program to encourage enrollment in 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.

Coordinated Care’s sophisticated reporting technology allows for sharing of targeted, relevant information to providers with 24-hour access online. Data sharing includes tracking trends over time for each provider, highlighting quality performance measures, and outcomes. Real-time access to data is also available providing the ability to identify areas for improvement, adjust strategies, and track performance trends.
Improving the Transition of Care

We are involved in a joint primary care workgroup sponsored by the Health Care Authority, Department of Health, and the Washington State Department of Social and Health Services (DSHS) to identify best practices during the transition of care and the development of a pediatric behavioral health workgroup. We are committed to improving the transition of care to Coordinated Care members to more easily follow up with primary care providers, and care management for high risk youth with special health care needing. This group is actively planning a project implementing the Patient-Centered Medical Home (PCMH) in revision of our inpatient-exchange plan. Monthly meetings and a tool kit that was taken place to improve the quality and compliance of members with PCMH/PCMH/CPM/CPM with this visit to continue.

Coordinated Care has chosen to take part in the CPSI survey for 2013 which took place in spring 2013. CPSI data indicates regarding the composite “Getting Care” is around 87% of our members scored the most favorable experience, “Getting Needed Care” is scored almost the 75th percentile with Q14 “Ease of getting care, tests, and treatment information” and Q27 “The member had access to cultural support services and other community resources”.

Coordinated Care partners with many important regional non-profit health improvement organizations like:

• A partnership with Tacoma Fire Department and FD Cares program across Coordinated Care member during a 911 call to request care and management of widened/risk directly to WarmCare 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:

Combining Vision

Coordinated Care received a referral from a members’ 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 her local pharmacy’s pharmacy in this effort to apply for a cell phone and get her connected to enhanced health care management for mental health support. The member has stayed in touch with the IPT program regularly, he has continued to go access centers for mental health counseling, and was given access to cultural support services and other community resources.

Coordinated Care is actively engaged in community health care initiatives such as Pierce County Council for Immunizations, Children with Special Health Care Needs (CSHCN), Immunization Action Coalition of Washington, Western Washington Outreach Coalition, Consortium for Health Equity Education, Western Washington Outreach Coalition, Washington Coalition on Medicaid Outreach, Medical/Surgical Tot ALOS 4.4, Community Involvement

AMB ER Visits/1000 60.1

Ambulatory Care:

• Inpatient Utilization – general hospital acute care

• Inpatient utilization – general hospital acute care

Member Services

Coordinated Care

Callers abandoned: 1,996 calls abandoned. 4% of calls abandoned or <40% calls abandoned. Average tone: Low (25th percentile). Average Speed of Answer: (35 seconds), 13 seconds. Goal:保密 within 30 seconds or less. Confidential total monthly calls at 159,946. 92.0% or 103% calls abandoned. 4% calls abandoned.

Quality Improvement Initiatives

Coordinated Care is conducting quality performance Improvement Projects (CPAs) that achieve ongoing measurement and improvement, demonstrate improvement in areas of clinical care and non-clinical care that are expected to have a beneficial effect on health outcomes and patient satisfaction. The following have been identified by Coordinated Care in 2014 as areas for intervention:

• A partnership with Tacoma Fire Department and FD Cares program across Coordinated Care member during a 911 call to request care and management of widened/risk directly to WarmCare 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:

Coordinated Care Core members are provided with a set of health care Coordination Core partner workgroups sponsored by the Health Care Authority, Department of Health regarding the transition of care and the development of a pediatric behavioral health workgroup. Coordinated Care workgroups in the following care needs: infant health, child and family, childhood immunizations, well child visits in the first 15 months of life, well child visits in the third, fourth, fifth and sixth years of age to remind them to get their child(ren) in for their well child check. There were 370 households called.

100.0%

95.0%

97.2%

94.0%

97.2%

95.0%

92.0%

94.0%

97.2%

97.2%

95.0%

95.0%