Washington State Health Care Authority

Health Care Cost Transparency Board

September 21, 2022

Washington State Health Care Authority

Health Care Cost Transparency Board
Board Book

September 21, 2022
2:00 p.m. – 4:00 p.m.

(Zoom Attendance Only)

Meeting materials

Washington State Health Care Authority

Agenda

TAB 1

Washington State Health Care Authority

September 21, 2022
2:00 p.m. – 4:00 p.m.
Zoom Meeting

Health Care Cost Transparency Board
AGENDA

Board Members:					
☐	Susan E. Birch, Chair	☐	Sonja Kellen	☐	Carol Wilmes
☐	Lois C. Cook	☐	Molly Nollette	☐	Edwin Wong
☐	Bianca Frogner	☐	Mark Siegel		
☐	Leah Hole-Marshall	☐	Margaret Stanley		
☐	Jodi Joyce	☐	Kim Wallace		

Time	Agenda Items	Tab	Lead
2:00 – 2:05 (5 min)	Welcome, roll call, and agenda review	1	Susan E. Birch, Chair, Director Health Care Authority
2:05 – 2:10 (5 min)	Approval of August meeting minutes	2	AnnaLisa Gellermann, Board Manager Health Care Authority
2:10– 2:20 (10 min)	Advisory Committee on Primary Care: Staff recommendation and vote	3	Dr. Judy Zerzan-Thul, Medical Director Health Care Authority
2:20 -2:50 (30 min)	The Growing Pressure of Health Prices: Perspective from WA Consumers	4	Emily Brice, NW Health Law Advocates Sam Hatzenbeler, Economic Opportunity Institute Jim Freeburg, Patient Coalition of WA
2:50– 3:00 (10 min)	Public comment	5	Susan E. Birch, Chair, Director Health Care Authority
3:00– 3:30 (30 min)	Pharmacy Pricing, Purchasing, and Access	6	Ryan Pistoresi, Asst. Chief Pharmacy Officer Health Care Authority
3:30 – 3:55 (25 min)	Continued from 8/17: Influence of health workforce trends on health spending growth	7	Bianca K. Frogner, PhD Professor, Dept. of Family Medicine Director, Health Workforce Studies University of Washington
3:55 - 4:00 (5 min)	Adjournment		Susan E. Birch, Chair, Director Health Care Authority

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

Washington State Health Care Authority

August meeting minutes

TAB 2

Health Care Cost Transparency Board meeting minutes

August 17, 2022
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the board is available on the Health Care Cost Transparency Board webpage.

Members present

Sue Birch, chair
Lois Cook
Bianca Frogner
Leah Hole-Marshall
Jodi Joyce
Sonja Kellen
Molly Nollette
Margaret Stanley
Kim Wallace
Carol Wilmes
Edwin Wong

Members absent

Mark Seigel

Call to order

Sue Birch, Board Chair, called the meeting to order at 2:02 p.m.

Agenda items

Welcoming remarks

Approval of minutes

Minutes were approved for both June and July.

Primary Care: Overview and Next Steps

Dr. Judy Zerzan-Thul introduced the Board to the topic primary care and provided an overview of the recommendations to be requested of the new Advisory Committee on Primary Care. There are four recommendations: definition of primary care, claims-based measurement, non-claims-based measurement, and reporting requirements, including barriers and how to overcome them.
Dr. Zerzan-Thul presented information on the Primary Care Transformation Model (PCTM), which began in 2019. Key components of PCTM include provider accountabilities, payer accountabilities, and centralized provider certification. Dr. Zerzan-Thul explained that PCTM defines primary care consistent with CMS guidelines, OFM and

the Bree collaborative. She also explained that primary care practitioners are defined fairly consistently by type, but that it can get "messy" for practitioners who practice in primary and specialty settings, for example behavioral health and pediatrics.

Moving on to claims-based measurement, she shared that it is typically defined by CPT code, to include office visits, preventive/wellness visits, developmental/behavioral health screenings, and may also include vaccine administrations, OB care, and basic laboratory services. Other services, including pharmacy claims, physician administered drugs and medical devices are not automatically included.

Dr. Zerzan-Thul described previous work in Washington on primary care spending, including Washington's Office of Financial Management measurement of claims-based spending beginning in 2018 based on the WA-APCD, and the Bree Collaborative's work on defining primary care. She presented the methodology and reports from OFM's WA-APCD measurement. According to those reports, primary care spending comprised 5.9% of total health care spending in 2019 and ranged between 5.2% and 5.9% between 2018 and 2020. Changes in primary care spending were primarily driven by a narrow definition, while a broader definition remained relatively stable.

Dr. Zerzan-Thul went on to discuss non-claims-based measurement, explaining that this type of measurement was intended to capture spending that may not appear on claims. Examples include services paid as part of an alternative payment mechanism, patient cost-sharing, care coordination, community health workers, and quality incentives.

She then shared her considerations for the composition of the Advisory Committee on Primary Care, explaining that she began with the certification workgroup from PCTM based on their current knowledge and familiarity with the topic of primary care, and the stakeholder representation in the group. She shared the list of PCTM certification workgroup members with the Board and shared the next steps to be taken in developing the final list of committee members for the Board's consideration. She shared that had received initial feedback from the Advisory Committee of Health Care Providers and Carriers, and was working to find members to meet those suggestions, including clinicians with expertise in value- based payment models and representatives of Federally Qualified Health Centers and Rural Health Centers,

Dr. Zerzan-Thul asked the Board for input as to their thoughts and considerations for the committee, and any feedback or guidance on the process for arriving at recommendations.

One Board member suggested that in keeping with the Board's intent to understand the consumer perspective and incorporate it into their decision-making, a consumer representative should be included on the committee. This suggestion was supported by several Board members.

One Board member suggested that the committee should include representation from south-west Washington.

One Board member stressed that the statute called for consideration of work that had previously been done in the state and emphasized the need to balance building on previous work including PCTM with the new charge to the Board to raise spending to a target of 12%. In support of this new goal, she suggested the addition of employers and/or payers to the committee, and that a committee charter would be helpful to clarify the goals of the committee.

One Board member expressed significant concern with the composition, balance, and lens of the proposed membership as being very hospital based, heavy on payers and light on organizations with substantial primary care footprint. She suggested adding a representative from SeaMar and Yakima Valley Farmworkers (large FQHCs in the state). She also suggested looking at the Bree Collaborative membership, which she considered well-balanced.

Presentation: Washington Hospital Costs, Price, and Profit Analysis

John Bartholomew and Tom Nash, Consultants

Mr. Bartholomew presented the results of the study he and Mr. Nash prepared comparing Washington hospital cost, price, and profit. Mr. Bartholomew explained the source (self-reported Medicare Cost Report data) and methodology for arriving at price per patient, cost per patient and profit per patient. His report compared hospitals across different types and peer groups, including health systems, independents, for-profit, not-for-profit, rural, urban, teaching and by bed size.

Mr. Bartholomew shared that based on 2020 data and compared to hospitals nation-wide, Washington ranked 13th highest in price, and 7th and 8th highest in cost. He concluded that overall, Washington hospitals in aggregate have higher prices and costs and are lower using profits as a measure.

Mr. Bartholomew then went on to compare price vs. hospital-only cost between Washington and national hospitals in several categories, including various bed sizes, teaching hospitals and children's hospitals. He also identified Washington hospitals that were cost/price outliers, both above and below median price/cost, in those categories. He concluded his presentation by advising the Board that more work needs to be done to understand hospital cost, and that in order to arrive at a fair and accurate comparison other measures must be considered such as case mix, service intensity measures, operating environment, payer mix and other financial measures.

One Board member asked how Mr. Bartholomew defined a price/cost outlier for purposes of the slides. Mr. Bartholomew responded that he defined an outlier as any entity 10% or more above the national median after cost-of-living adjustment, which was represented by the horizontal line on the chart.

One Board member said it would be helpful to come up with a list of risk adjustment factors with the goal of distinguishing between what costs are "explainable" based on those factors and those costs that could not be explained.

One Board member indicated interest in understanding how educational and children's hospitals in Washington compare to similar entities in Oregon.

One Board member stated that looking at wage differences would be important in assessing comparative cost but questioned the usefulness of looking at CPI for differences in hospital wages.

Public Comment

Ms. Birch called for comments from the public.

Jeb Shepherd, Washington State Medical Association. Mr. Shepherd suggested that in its consideration of primary care, the Board should reach out to some specialty societies in primary care work, as they would be involved and have important perspective. He also requested that materials and agenda for the Board be posted at least one week in advance of the meeting, to allow interested stakeholders time to consider and prepare comments on the materials. He stated this was both a requirement of the Open Public Meetings Act, and an important element of public dialog.

Albert Froling, Washington State Hospital Association. Mr. Froling thanked the Board for inviting WSHA to present at the July meeting but acknowledged that the presentation was not competed due to running out of time. On behalf of WSHA, he requested an additional opportunity to finish its presentation. He recommended an interesting recent Health Affairs article on hospital cost prepared by the University of Washington, that found that Washington hospital spending is one of ten lowest states in overall spend (*this article will be included in September materials at the direction of the Board chair*). He encouraged the Board to factor in intensity of services input pricing when comparing costs, and to consider a wage index as well in order to get an accurate understanding of

hospital cost. He reminded the Board that they were required by their statute to consider several adjustment factors when reporting on cost and spend.

Renee Rassilye-Bomers, Chief Nursing Officer for the Providence Swedish Central Service Area, and CNO for the Cherry Hill campus. Ms. Rassilye-Bomers testified that working in a large complex hospital network allows better service to a community of patients, and specialization of services which resulted in improved quality outcomes, operational efficiencies and maximized training opportunities for staff. She shared that Cherry Hill and First Hill patients are intentionally very different, and that the difference is very apparent in the CMI case mix index for the two facilities, with Cherry Hill's index being twice that of First Hill's. She shared that CMI also recognizes Seattle as one of the most expensive places in the country for hiring nurses and other employees. She supported Mr. Froling's request to consider these variables and others to achieve an accurate and fair understanding hospital cost.

Consuelo Echavarria, Washington Health Care for All. Ms. Echavarria requested that the Board pursue an analysis of how insurance and billing-related costs impact the total cost of care in Washington state. She stated that these costs result in making health care less affordable and less accessible to the people of the state.

Presentation: The influence of health workforce trends on health spending growth

Bianca K. Frogner, PhD, University of Washington

Dr. Frogner's objectives for the presentation were to define the health workforce, understand its connection to health spending, identify COVID effect on heath workforce, and educate the Board on workforce shortage and support strategies. She presented information on various sectors within the health care industry and how much employment they represent, occupations within the health care industry, average education in each sector, and racial and ethnic distribution. She went on to describe the relationship between labor and health care spending, emphasizing that health care labor and wage rates have generally grown fairly smoothly, but that the contribution of labor to health care spending is not well understood, especially at the state level.

Dr. Frogner then turned to the impact of COVID on employment, wages, and competition. She shared that overall, 1.4 million health care jobs were lost at the first peak of the pandemic in April 2020. She shared the methods used for tracking turnover among health care workers during the pandemic, and various analyses of turnover rates per COVID phase by sector, occupation, race/ethnicity, and gender/parenthood.

Dr. Frogner then shared information contrasting median hourly wages across health care occupations, for both permanent and temporary positions. Dr. Frogner presented her key takeaways from this information; that COVID has had the largest effect on long-term care employment, that wage rates have increased since the start of COVID and are increasing faster in WA, and that how may work as travelers and what they are paid is hard to identify.

Due to time, Dr. Frogner was requested to delay the remainder of her presentation until the September Board meeting, and she graciously agreed.

Adjournment

Meeting adjourned at 4:00p.m.

Next meeting

Wednesday September 21, 2022

Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.

Washington State Health Care Authority

Advisory Committee on Primary Care: staff recommendation and vote

TAB 3

Proposed Advisory Committee on Primary Care

Health Care Authority

September 21, 2022

Washington State Health Care Authority

Activities to Form the Proposed Committee

- Goal: First meeting September 28

- Starting place: Primary Care Certification Workgroup
  - Advisors for multi-payer PC Transformation Model
  - Stakeholder representation, current knowledge

- Advisory Committee of Health Care Providers and Carriers meeting
  - Provided to Board on August 17 (excel spreadsheet in materials index)

- Revised List shared electronically
  - Provided to Advisory Committees and other stakeholders for additional comment.
  - Feedback and additional nominations were accepted until September 13.
  - Simultaneous confirmation of interest, and collection of CV's and resumes.

Suggestions for additional expertise

- Nurse practitioner who owns a practice
- Physician assistants
- Community-oriented clinicians
- Consumer representatives
- Professional expertise in data and coding
- Practitioners familiar with value-based purchasing
- Practical experience billing, coding and payment
- Providers who have successfully integrated physical and behavioral health
- Federally qualified health centers

Representation added to the Proposed Committee

- Federally Qualified Health Center (FQHC)
- Primary care practitioners - including physician assistant (PA) and advanced registered nurse practitioner (ARNP)
- Additional expertise in state-based efforts: OFM, Bree
- Practitioners with experience in value-based purchasing and data
- Purchaser expertise: billing and coding
- Consumer representation

Committee Nominees

Name	Title	Place of Business
Chandra Hicks	Assistant Director – Delivery System Analytics	Regence
David DiGiuseppe	Vice President of Healthcare Economics	Community Health Plan of Washington
DC Dugdale	Medical Director, Value-Based Care	University of Washington Medicine
Eileen Ravella	Urgent Care Physician Assistant	Kaiser Urgent Care
Ginny Weir	Chief Executive Officer	Foundation for Health Care Quality, Bree Collaborative
Jonathan Staloff	Family Medicine Doctor, Fellow	University of Washington Medicine
Katina Rue	Family Medicine Doctor, President-Elect	Washington State Medical Association
Kevin Phelan	Vice President, Network Management	Molina Healthcare
Kristal Albrecht	Senior Vice President of Finance	Community Health Association of Spokane
Lan H. Nguyen	Medical Director	Premera
Linda Van Hoff	Primary Care Nurse Practitioner, President ARNP United	Advanced Registered Nurse Practitioner United, Overlake Clinic
Maddy Wiley	Family Nurse Practitioner	Family Care of Kent
Mandy Stahre	Managing Director, Forecasting and Research	Office of Financial Management
Meg Jones	Director of Government Relations	PacificSource Health Plans
Michele Causley	Vice President of Health Plan Operations	United Healthcare
Nancy Connolly	Internal Medicine Doctor	University of Washington Medicine
Sarah Stokes	Associate Director of Network Operations	Kaiser Permanente
Sharon Brown	Executive Director	Greater Columbia Accountable Community of Health
Sharon Eloranta	Medical Director	Washington Health Alliance
Shawn West	Chief Medical Officer	Embright
Sheryl Morelli	Chief Medical Officer	Seattle Children's Care Network
Staici West	Vice President	Coordinated Care
Tony Butruille	Family Medicine Doctor	Cascade Medical Center
Tracy Corgiat	Vice President Primary Care	Confluence Health

Advisory Committee on Primary Care

- Motion and Discussion

Washington State Health Care Authority

The growing pressure of health prices: perspective from WA consumers

TAB 4

The Growing Pressure of Health Prices: Perspective from WA Consumers

Health Care Cost Transparency Board
September 21, 2022

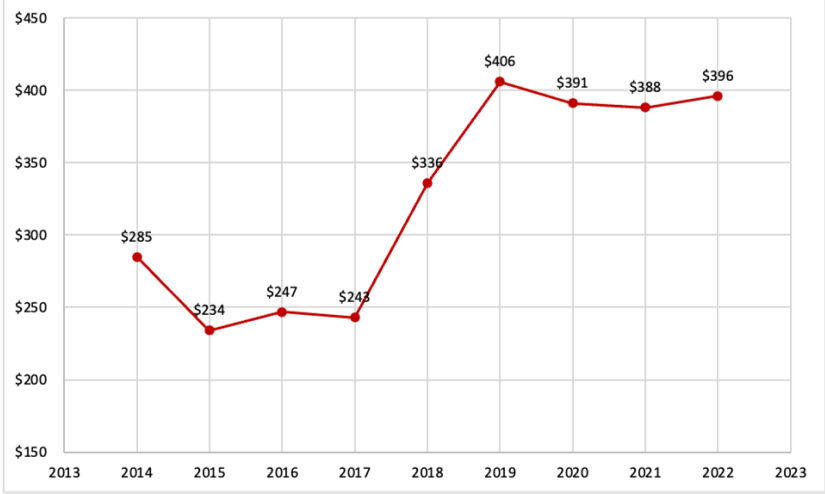
Health prices are at a boiling point

- WA residents are experiencing ever-increasing health costs
- Higher costs are contributing to uninsurance and underinsurance
- Price transparency alone has not addressed the issue

Unsubsidized individuals face average benchmark premiums that are **39%** higher than 2014.

For 2023, pre-subsidy Exchange premium rates will increase by over 8% on average.

Average Benchmark Premiums - WA Exchange



Sources: KFF Marketplace Average Benchmark Premiums, www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premium. Average second-lowest cost silver premium for a 40-year-old in each county, weighted by county plan selections; WA Office of the Insurance Commissioner *(see Appendix for year-over-year average change for individual market)*

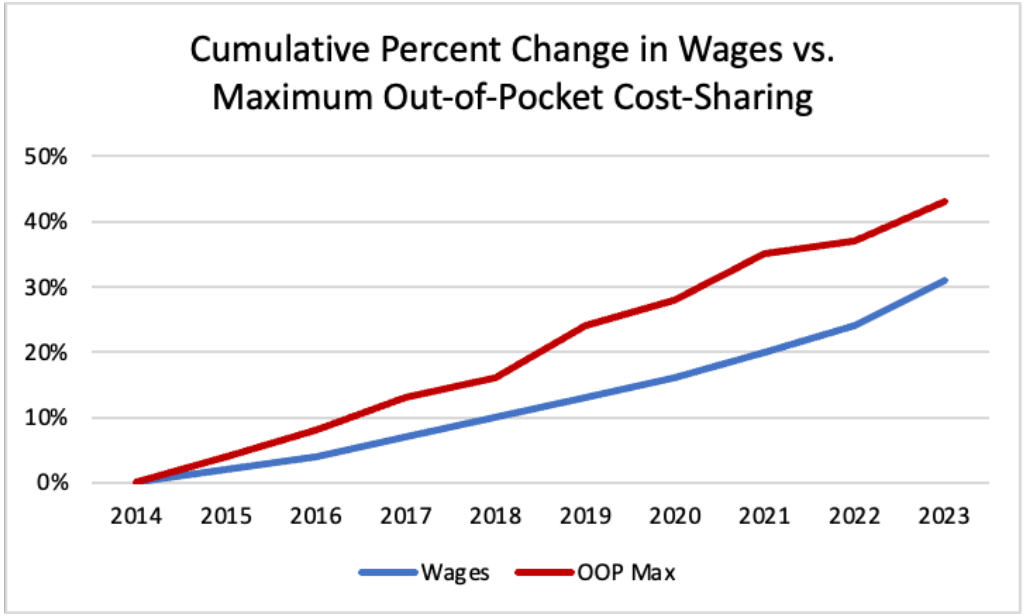
WA businesses and workers have seen **double-digit cost increases** for employer-based insurance over the last decade.

WA Employer-Sponsored Insurance Costs

	2010	2020	% increase
Total Average Premium (Single)	$4,981	$7,400	**49%**
Total Average Premium (Family)	$14,188	$19,476	**37%**
Employee Average Deductible	$975	$1,470	**51%**

Source: Commonwealth Fund (2022)
https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020
(see Appendix for year-over-year average change for small group market)

Out-of-pocket cost-sharing is rising faster than wages



Source: Peterson-KFF Health System Tracker, https://www.healthsystemtracker.org/brief/aca-maximum-out-of-pocket-limit-is-growing-faster-than-wage

Claims trend pushes cost-sharing upward

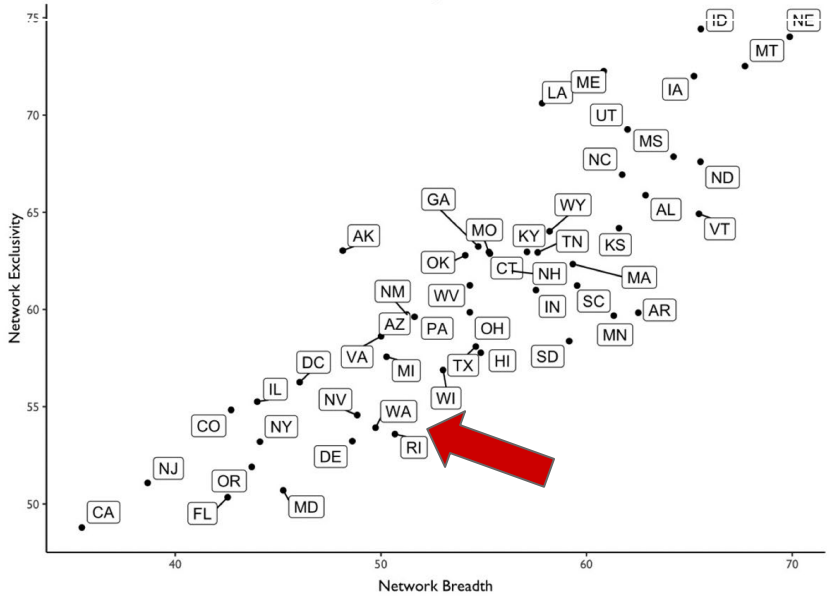
- Underlying spending trend drives increased consumer cost-sharing
- For individual & small group market, claims trend is reflected in federal plan design tools, forcing annual changes to consumer cost-sharing

ACA Maximum Out of Pocket Limit	2014	2023	% increase
Individual MOOP	$6,350	$9,100	43%
Family MOOP	$12,700	$18,200	

Source: HHS annual Notice of Benefit & Payment Parameters & Federal Actuarial Value Calculator

Even as costs rise, access to in-network providers has narrowed, squeezing consumers on two fronts

Average Network Breadth & Exclusivity by State: Primary Care Networks



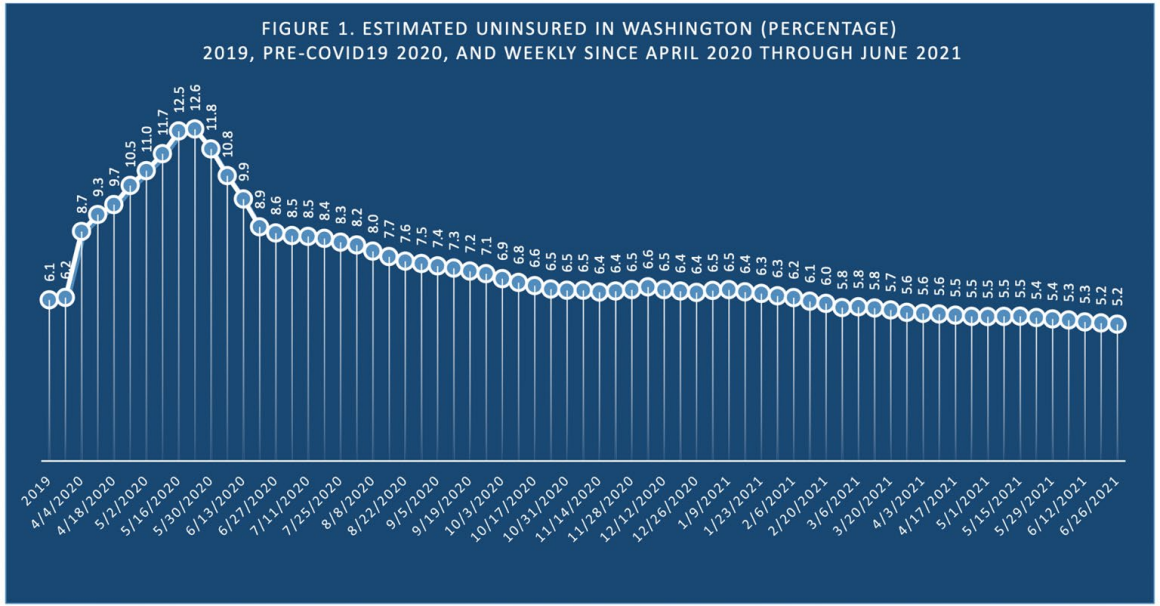
Breadth = % of in-network primary care providers located within a 60-minute drive of a hypothetical patient in a zip code

Exclusivity = % of a given network's providers that overlap with other carriers' networks

Source: Graves JA, Nshuti L, Everson J, et al. Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets. *JAMA Netw Open.* 2020;3(12):e2029419. doi:10.1001/jamanetworkopen.2020.29419 (Exhibit 25)

The Results of High Prices in WA

An estimated 5-6% of WA residents remain uninsured

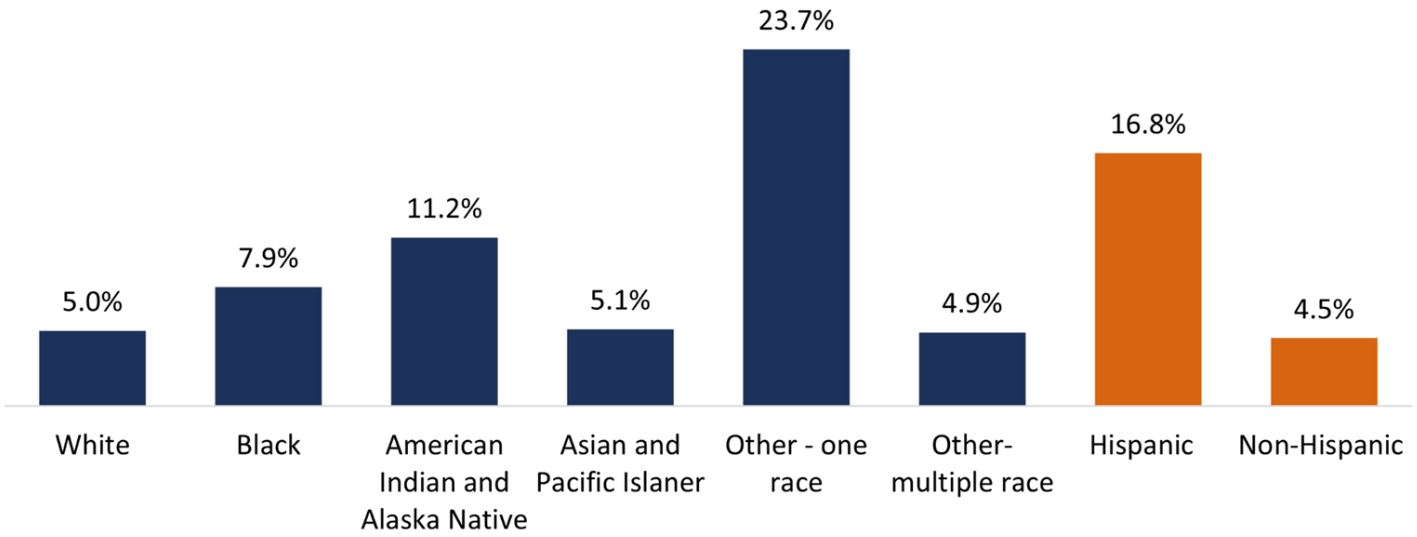


While the pandemic spike in uninsurance seems to have stabilized, more coverage losses are expected when the Public Health Emergency ends

Source: OFM (2021), https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/healthcoverage/COVID-19_impact_on_uninsured.pdf
See also: Medicaid Forecast Council estimates of post-PHE impact: https://www.cfc.wa.gov/default.htm

Uninsurance disproportionately affects WA communities of color

Percentage Uninsured By Race and Hispanic Origin, WA State (2019)



Source: OFM (2020) https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief098.pdf

An estimated **5%** of WA residents have medical debt that is in collections.

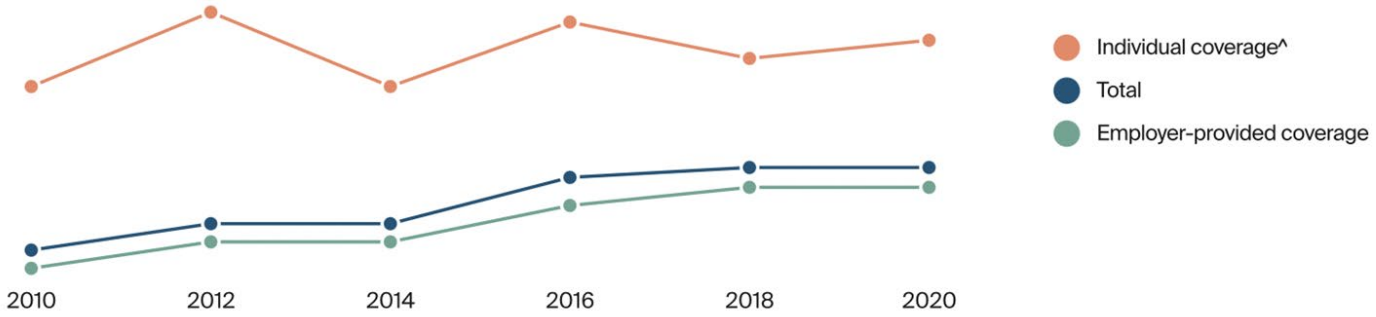
Source: Urban Institute (2022), https://datacatalog.urban.org/dataset/debt-america-2022

"I thought it was going to cover me. Because I was paying a lot... I thought that because I have insurance it's going to help me and it doesn't help me. I have diabetes. I tried to get medicine, the insulin was costing me $1,800. I don't have a lot of money, I have to pay rent, I have to pay for my car, the insurance. I have to have a phone and I have to eat."

– Nora, Chelan County, sued for medical debt
translated from Spanish

Nationally, 41% of those with individual plans and 26% of those with employer plans are considered “underinsured”

Percent of adults ages 19-64 with private coverage who were insured all year and were underinsured



“Underinsured” = adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

Source: Commonwealth Fund (2020), www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial

WA Underinsurance: Consumer Health Experience Survey

- WA lacks state-specific data on underinsurance
- A forthcoming survey will offer information about the experience of 1,000+ WA residents with health care affordability
- Survey will include demographic breakdowns to gauge equity differences

The Challenge with Price Transparency

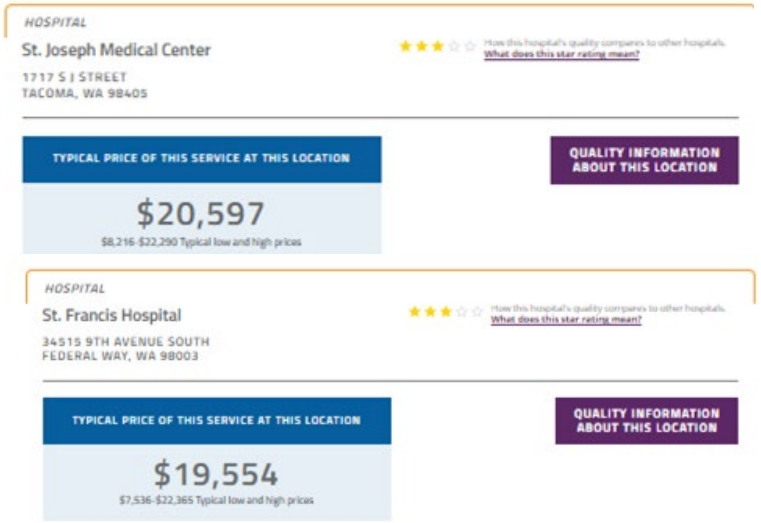
Price transparency Is not a panacea

- Existing tools like www.wahealthcompare.com offer some price transparency, and new federal rules require hospitals and health plans to make more price comparison information available
- While transparency is critical, early efforts in WA demonstrate challenges in consumers' ability to act on the data

Challenge #1: Unknown medical journey

Vaginal delivery?

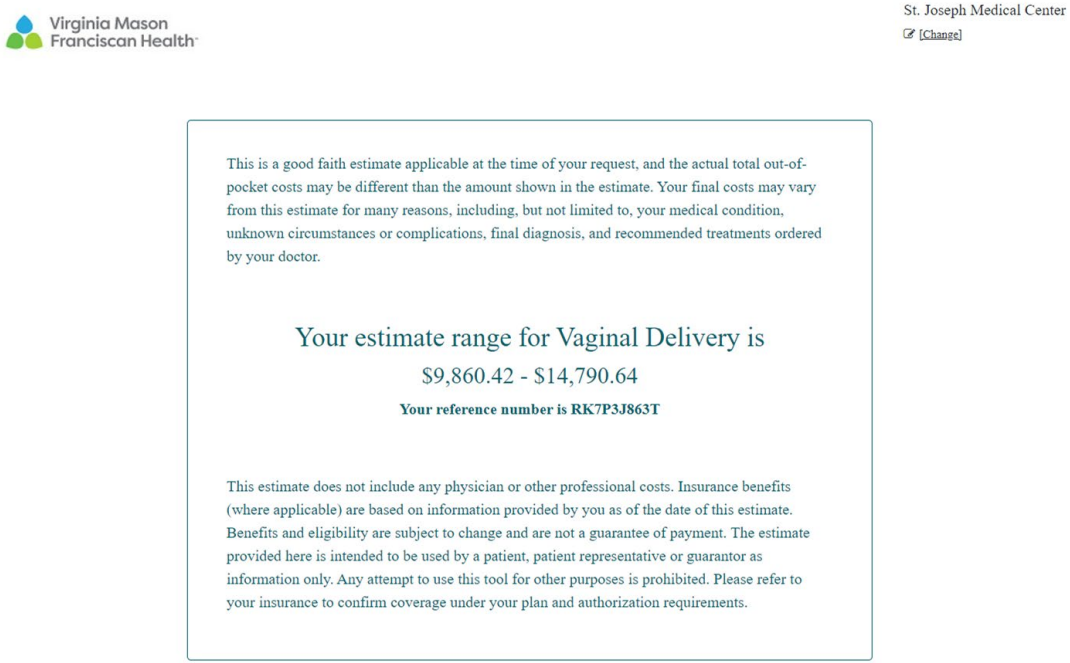
Caesarean delivery?



Using CY 2020 data for commercially contracted hospital inpatient payments negotiated between insurers and providers, including physician and facility fees, Washington Health Compare, https://wacommunitycheckup.org/reports/price-variation-for-inpatient-treatments-in-washington-state/, accessed 9/4/22.

Challenge #2: Incomplete price information

The estimate "does not include any physician or other professional costs."



Virginia Mason Franciscan Health

St. Joseph Medical Center
[Change]

This is a good faith estimate applicable at the time of your request, and the actual total out-of-pocket costs may be different than the amount shown in the estimate. Your final costs may vary from this estimate for many reasons, including, but not limited to, your medical condition, unknown circumstances or complications, final diagnosis, and recommended treatments ordered by your doctor.

Your estimate range for Vaginal Delivery is

$9,860.42 - $14,790.64

Your reference number is RK7P3J863T

This estimate does not include any physician or other professional costs. Insurance benefits (where applicable) are based on information provided by you as of the date of this estimate. Benefits and eligibility are subject to change and are not a guarantee of payment. The estimate provided here is intended to be used by a patient, patient representative or guarantor as information only. Any attempt to use this tool for other purposes is prohibited. Please refer to your insurance to confirm coverage under your plan and authorization requirements.

Virginia Mason Franciscan Health, Estimate Your Costs, https://www.vmfh.org/billing-insurance/estimate-your-costs.html, accessed 9/4/22.

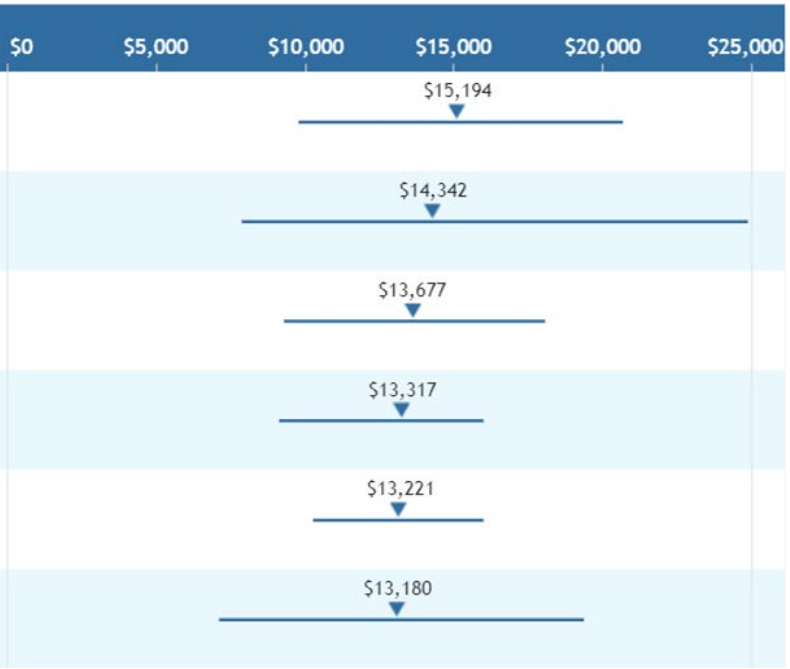
Challenge #3: Glitchy or inaccessible tools

“An error occurred” when insurance information was added.

Virginia Mason Franciscan Health, Estimate Your Costs, https://www.vmfh.org/billing-insurance/estimate-your-costs.html, accessed 9/4/22.

Challenge #4: What does price variation signify for a patient?

Admitting Hospital	Low	Median	High
FRANCISCAN HOSPITAL	$9,818	$15,194	$20,711
ST JOSEPH MEDICAL CENTER	$7,897	$14,342	$24,894
MULTICARE HOSPITAL	$9,312	$13,677	$18,085
MULTICARE GOOD SAMARITAN HOSPITAL	$9,174	$13,317	$15,998
LEGACY SALMON CREEK MEDICAL CENTER	$10,276	$13,221	$16,017
SWEDISH MEDICAL CENTER	$7,146	$13,180	$19,402

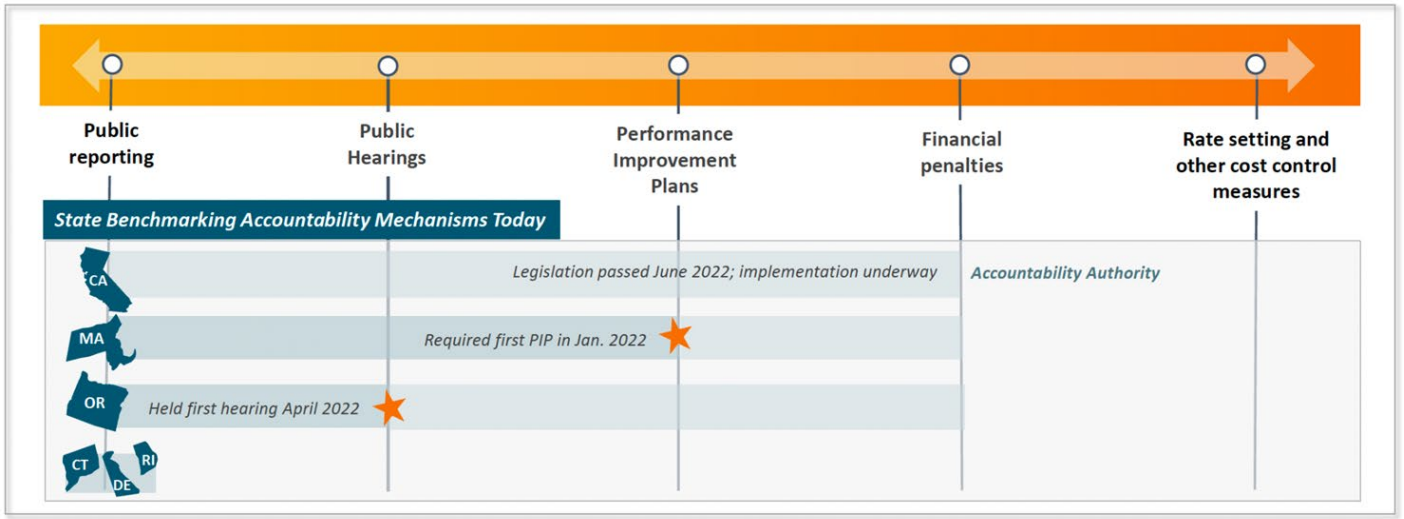


Using CY 2016 data for commercially contracted hospital inpatient payments negotiated between insurers and providers, including physician and facility fees, Washington Health Alliance, https://wacommunitycheckup.org/reports/price-variation-for-inpatient-treatments-in-washington-state/, accessed 9/4/22.

Lessons from Other States

Peer states are moving beyond price transparency

Of the 10 states with health care cost benchmark programs, some are exploring a continuum of accountability mechanisms:



Advancing a National Health Data Agenda: New Strategies to Drive Transparency and Accountability | July 21, 2022 | Manatt Health

manatt

Source: https://www.manatt.com/insights/webinars/state-health-care-cost-growth-benchmarking-new-st

Questions?

Emily Brice, Northwest Health Law Advocates
emily@nohla.org

Sam Hatzenbeler, Economic Opportunity Institute
sam@opportunityinstitute.org

Jim Freeburg, Patient Coalition of Washington
jifreeburg@yahoo.com

Appendix: Average Premium Rate Changes

Average Premium Rate Changes (WA Individual)

Plan Year	Requested	Approved
2015	8.3%	1.8%
2016	4.2%	3.8%
2017	13.8%	14.1%
2018	27.4%	35.0%
2019	19.4%	13.6%
2020	1.0%	-3.3%
2021	-1.8%	-3.2%
2022	5.5%	4.1%

Source: WA Office of the Insurance Commissioner, on file

Average Premium Rate Changes (WA Small Group)

Plan Year	Requested	Approved
2015	3.9%	3.2%
2016	1.5%	1.4%
2017	7.9%	7.1%
2018	8.8%	8.1%
2019	0.3%	-0.2%
2020	6.7%	6.4%
2021	3.5%	3.4%
2022	4.1%	2.3%

Source: WA Office of the Insurance Commissioner, on file

Washington State Health Care Authority

Public comment

TAB 5

Public comment

Washington State Health Care Authority

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Pharmacy pricing, purchasing, and access

TAB 6

Health Care Cost Transparency Board: Pharmacy Pricing, Purchasing, and Access

September 21, 2022

Washington State Health Care Authority

Learning Objectives

- Explain how drug purchasing for federal programs gave rise to the current structure of drug pricing.
- Understand how monopolistic competition and market incentives lead to drugs being priced at what the market will bear.
- Recognize options states have in addressing drug affordability.

Our Goal:

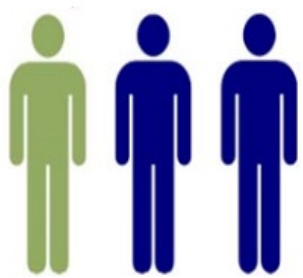
All Washingtonians to have access to prescription drugs at an affordable price.

What We Do at HCA

State's largest health care purchaser:

- Medicaid (Apple Health)
  - 2.22 million people
- Public Employees Benefits
  - 386,000 people
- School Employees Benefits
  - 270,000 people

We purchase care for 1 in 3 non-Medicare Washington residents with an annual spend over $14B, $2.5B is drug costs



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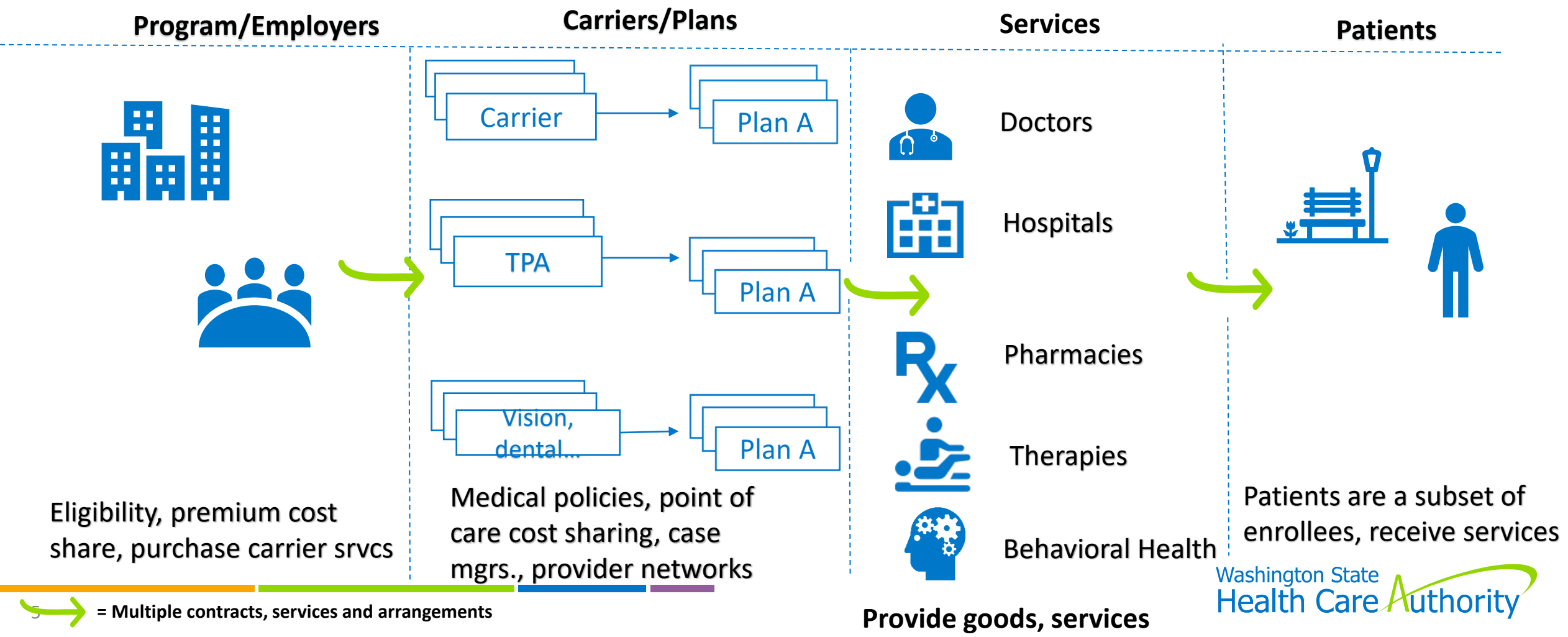
Simplified-US Healthcare System Overview



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All Types of Payers purchase drugs

- Public, privates, and uninsured purchase drugs from the same drug distribution system.
  - From manufacturer to wholesaler to pharmacy to patient.

- Federal laws regulate how federal programs reimburse for drugs based off pricing benchmarks, using percentages off prices that manufacturers set.

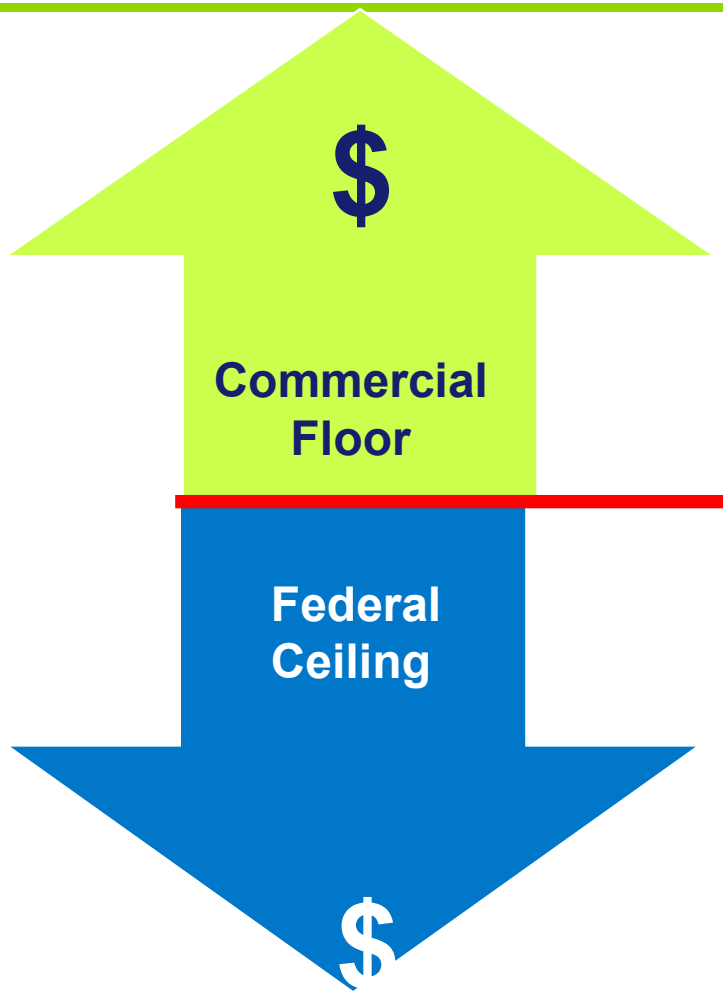
- Manufacturers can set prices high enough to ensure revenue from payers will compensate for discounts required under federal programs (Medicaid).

Pricing Dynamics

Drug Price Benchmarks

- **Wholesale Acquisition Cost (WAC)**
  - Manufacturer-reported prescription drug "list price" for sale to wholesalers.
  - Not accurate representation of what wholesaler or end provider actually pays; WAC does not include discounts such as rebates, volume purchase agreements, or prompt-pay agreements.
- **Average Manufacturers Price (AMP)**
  - Average price paid by wholesalers to manufacturer for drugs distributed to the retail class of trade net of customary prompt pay discounts.
- **Medicaid Best Price**
  - Lowest price available from manufacturer to any wholesaler, retailer, health care provider, HMO, non-profit or government entity except IHS, 340b, FSS, Medicare Part D and Medicaid during the rebate period (typically less than AMP – 23.1%).
- **Consumer Price Index (CPI) Penalty**
  - AMP rises 1% faster than inflation; manufacturer must pay the difference in additional rebates.
- **Federal Supply Schedule (FSS)**
  - Participation required to be eligible for Medicaid.
  - Available to all direct federal purchasers; intended to be no more than AMP.
- **Federal Ceiling Price (FCP) or "Big Four Prices"**
  - Available only to DOD, VA, PHS, US Coast Guard.
  - By law, are 24% lower than AMP; Generally do not apply to generic drugs (38 U.S.C §8126(a)(2)).
- **340B**
  - Available to qualifying entities (safety net providers).
  - Ceiling price: the most a manufacturer can charge a 340B entity is 24% lower than AMP.

Impact of Medicaid Best Price



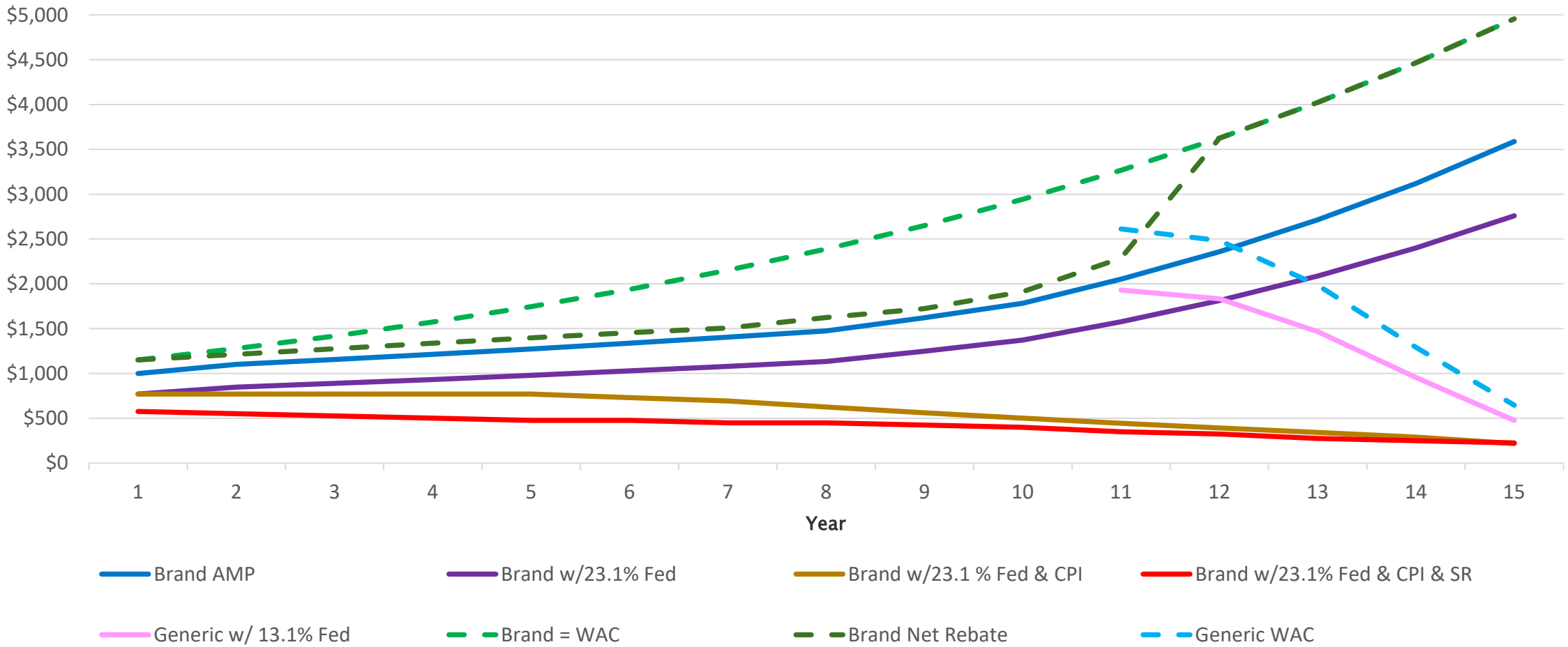
Non-government programs

- Fully-insured commercial plans
- Self-insured employers
- Medicaid managed care

Average manufacturer's price (AMP)

- AMP – 23.1% (Medicaid Drug Rebate Program (MDRP)
- 340B ceiling price cannot exceed AMP-fed rebate
- AMP – 24% = Veterans Affairs pricing
- Federal Supply Schedule

Drug Price Increases Over Time



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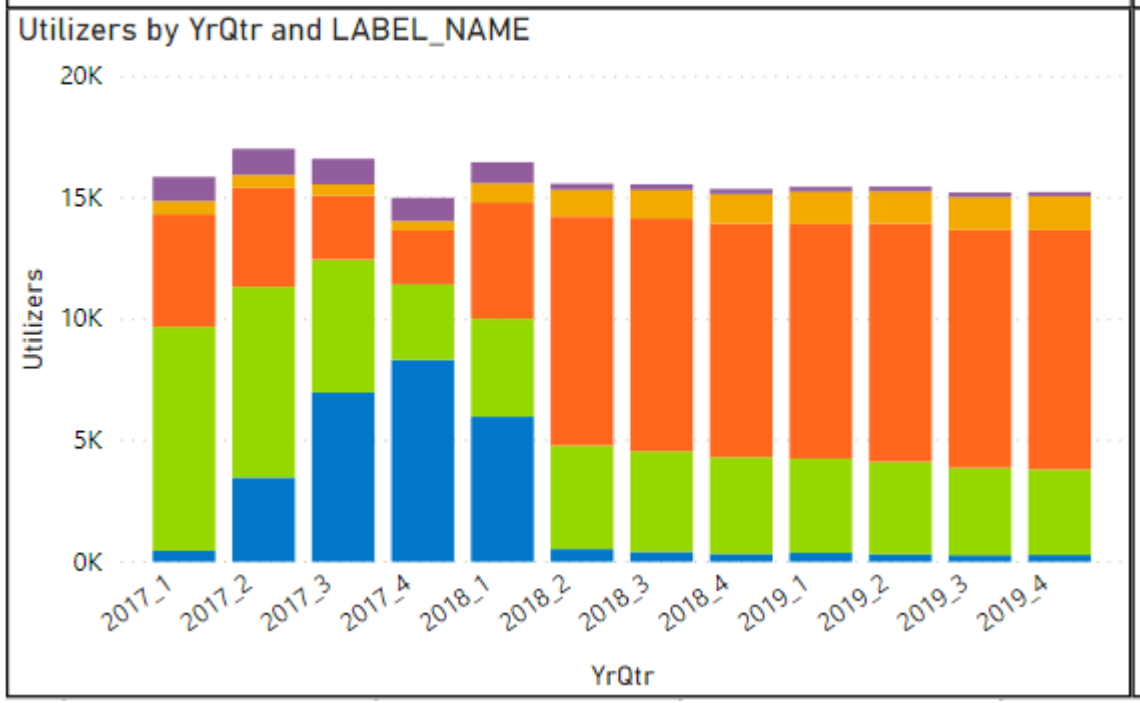
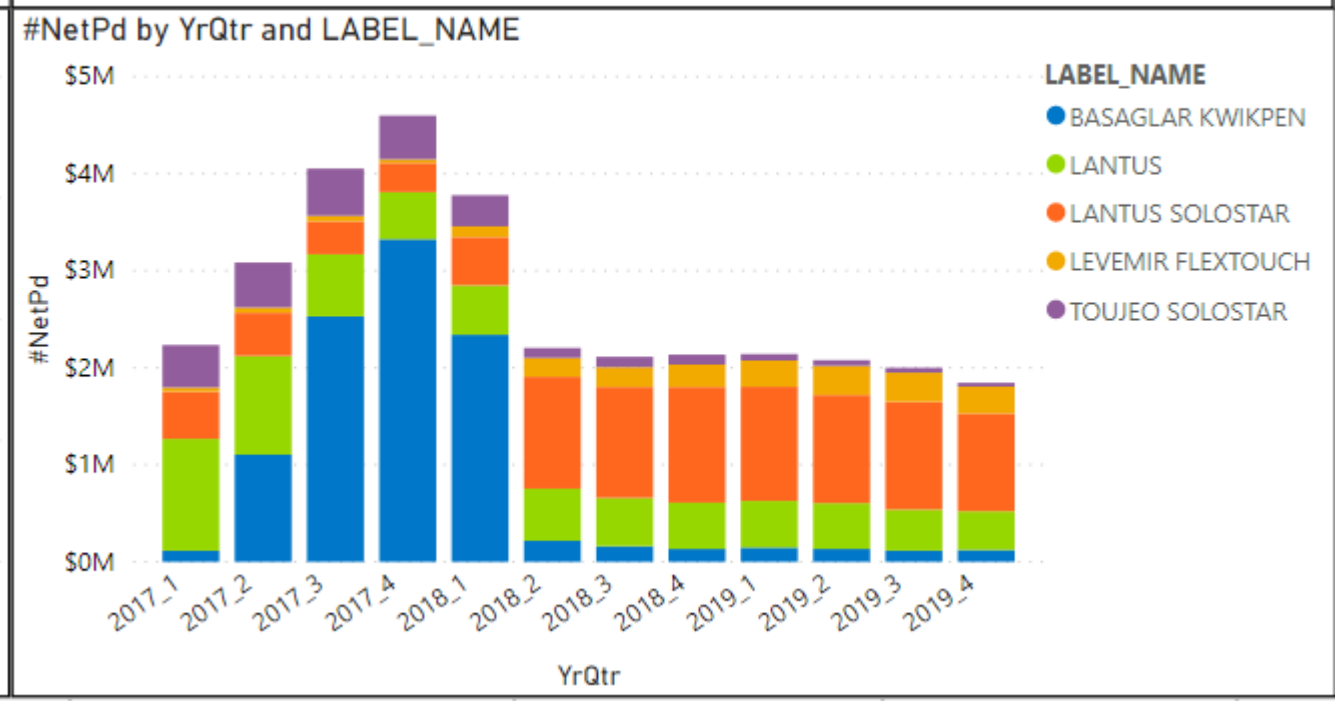
Antidiabetics : Insulin – Long Acting – Implemented Q1 2018, GF 1/2018 to 3/2018

Total Utilizers for Top 5 Label Names with Highest Cost



Total Net Paid for Top 5 Label Names



*Disclaimer: Data reported Q3 and Q4 2019 are incomplete due to rebate lag. In addition, all data points may experience some degree of change after the creation of this presentation.

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Drug Purchasing Channel

Pharmacy Distribution/Purchasing Overview – Simplified

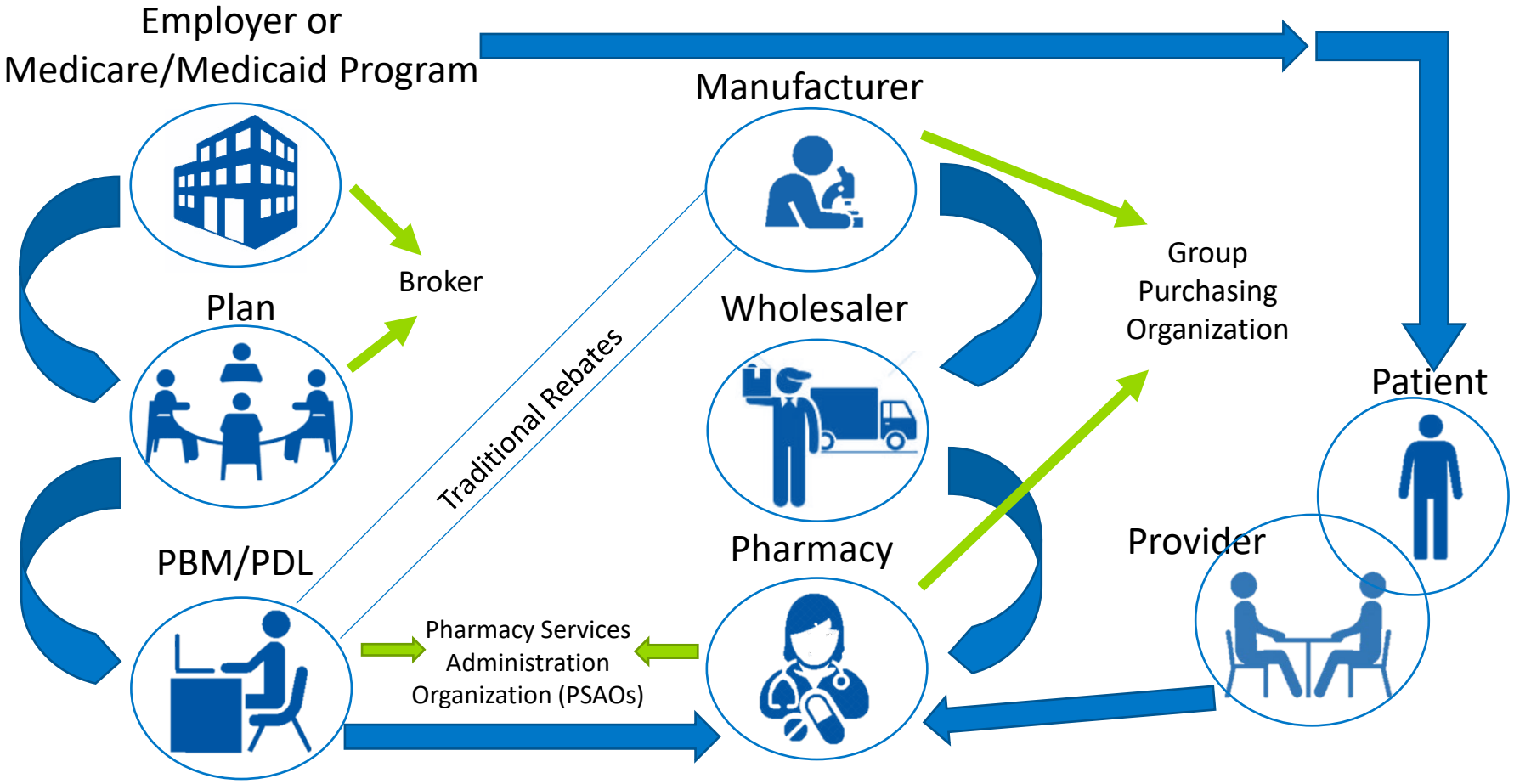

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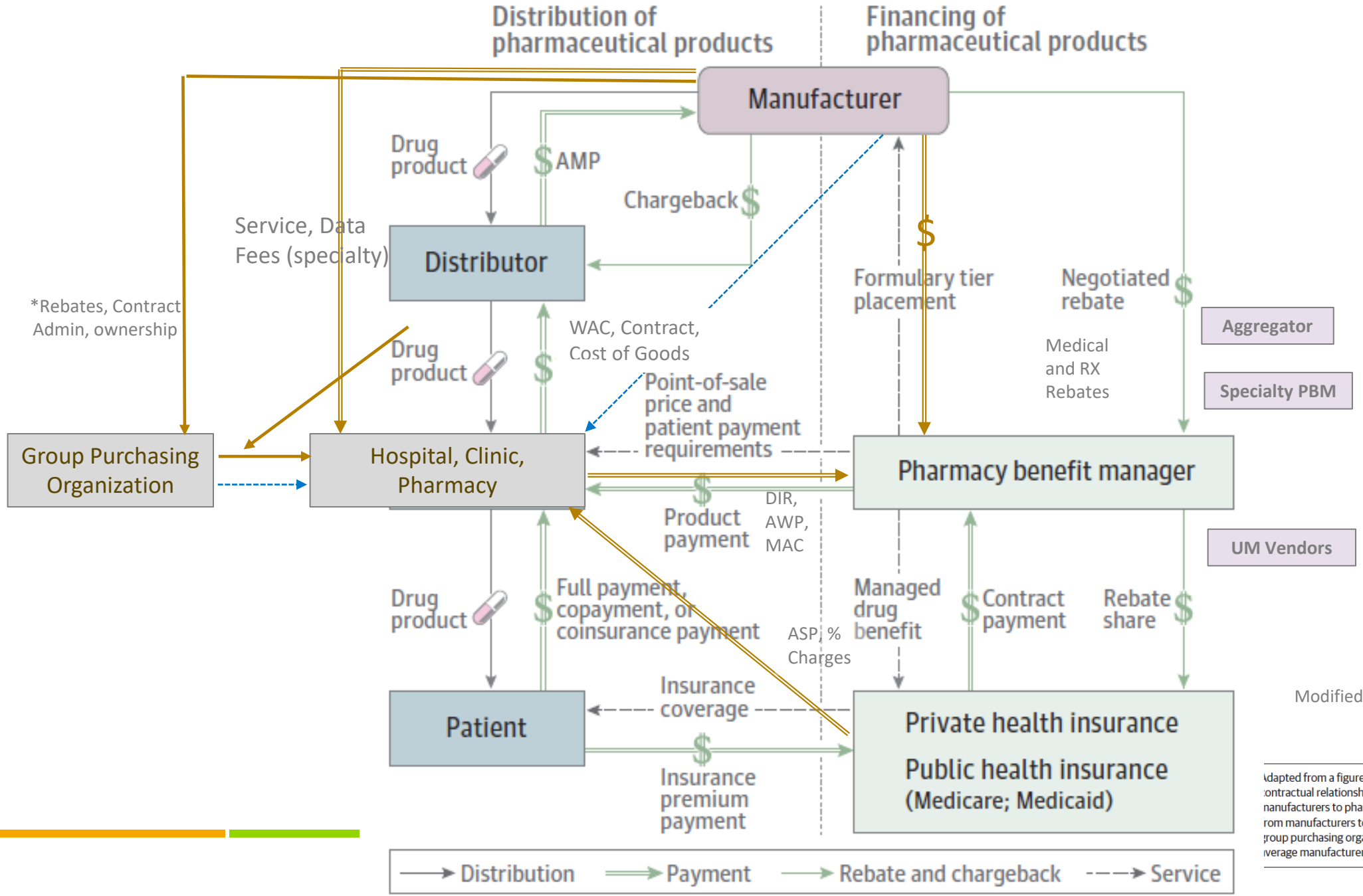
Figure. Flow of Pharmaceutical Funds, Products, and Services



Modified MM 1/2021

Adapted from a figure by the Congressional Budget Office.[1] Services represent contractual relationships between entities. Rebates are payments from manufacturers to pharmaceutical benefit managers. Chargebacks are payments from manufacturers to distributors. Retailers include pharmacies, hospitals, group purchasing organizations, and mail-order programs. AMP indicates average manufacturer price; WAC, wholesale acquisition cost.

Cost to the Dispensing Pharmacy

- Simplest design:
  - Manufacturer makes the product.
    - For brand-name drugs, this manufacturer holds the patent.
  - Wholesalers buy the products in bulk from manufacturers and are the logistical agents to get the drugs to pharmacies.
  - Wholesalers sells to pharmacies:
    - Receive and offer volume discounts.
    - Can have different contracts based on the pharmacy's (dispenser's) "class of trade".
    - May get a "charge back" from the manufacturer if they bought the drug at a price higher than what is paid by the pharmacy.

Cost to the Dispensing Pharmacy

- Group Purchasing Organizations:
  - GPOs aggregate drug purchasers (pharmacies) to get a volume discount. Negotiate on behalf of the pharmacy to receive a steeper discount which the GPO negotiated using both upfront discounts and back-end rebates from the manufacturer.
  - The degree of the discount is tied volume and to a manufacturer's defined class of trade (hospital, LTC facility, outpatient clinic, etc).
  - Some GPOs designate the wholesaler/distributor the pharmacy must use in exchange for discounts to the wholesaler's administration fee.
  - The pharmacy pays the wholesaler/distributor the GPO negotiated price plus the wholesaler's admin fee.
  - If the wholesaler paid the manufacturer more than the GPO price then the wholesaler charges-back to the manufacturer the difference between the GPO price and what the wholesaler originally paid.

The Billing of Prescription Claims

- **Health plan** contracts with PBM to administer pharmacy benefit.
- **PBMs** contract with pharmacies and set reimbursement rates.
  - Administers the plan design including clinical policy and patient cost share.
  - Negotiates rebates with manufacturer which is usually based on WAC.
  - Invoices and rebates from manufacturer and pass on to purchaser.
  - establishes a pharmacy network and set the amount paid to the pharmacies typically a percentage of WAC or AWP.
- **Pharmacies bill PBM** their usual and customary charge based on what they paid the wholesaler plus their overhead and desired profit (administrative fee).
  - **PBM pays the pharmacies** their contracted amount less patient cost share.
  - Note: In Medicaid fee-for-service the Pharmacy Unit is the PBM and HCA's Finance team develops the rates paid to pharmacies. There is no patient cost share.
- **The PBM bills the health plan** what they paid the pharmacy less plus their administrative fee.
- **The health plan bills the employer/program** what they paid the PBM plus their administrative fee via the premiums they charge.

What does it cost the patient?

- Health plan determines the pharmacy benefit (copay/coinsurance/deductible).
- Patient Cost Depends on the type of plan.
  - Uninsured pays full usual and customary retail price.
  - WA Medicaid has no cost share, although nominal copays are allowed federally.
  - High deductible plans will have higher upfront costs for its members. Members pay 100% of cost of drug as negotiated by the PBM until deductible is met. Typical HDHP deductibles are $5000/year.
  - Traditional health plan with flat dollar copays or percentage coinsurance, typically have a lower deductible, if any, for prescription drugs (hundreds of dollars per year).

The Cost of One Month Supply of Lantus
(commonly used insulin)

Member pays 100%

Retail Cash Prices

✓Costco = $ 321.36

✓Walmart = $304.99

✓WDPD Discount Card = $277.89

Annual cost = $3,334.68

Uninsured

No member cost sharing

Cost to the Medicaid =

NADAC + Dispensing Fee =

$272.00 + 4.25 = $276.25

Net of federal rebate cost to Medicaid is nominal.

Medicaid

Deductible = $1,400 per year

PBM negotiated price to pharmacy = $277.89/mo

Member pays $277.89/mo x5.3, then $13.89/mo after deductible. Member has $700 HSA contribution to use.

Annual cost is $865.89

UMP CDHP 2020
($300 Annual Premium)

Deductible = $100 per year

PBM negotiated price to pharmacy = $277.89/mo

Member pays $108.89 for first month then $13.89/mo after meeting deductible.

Annual cost is $261.68

UMP Classic 2020

($1,248 Annual Premium)

How plans manage the pharmacy benefit

Strategies of Cost Management

- US payers manage drug spend by limiting access to certain drugs when there are equally effective, less costly alternatives.
  - Creates delays or barriers to access and causes providers to do additional work for prior authorization.
  - Creates system where manufacturers offer rebates for more favorable access.
- Pharmacy expenditure is the product of prescription drug pricing (few management options) and prescription drug utilization (more options).
- Price strategies: negotiating supplemental rebates or discounts.
- Plan design strategies: cost sharing to incentivize choices.
  - Higher patient cost when accessing higher cost drugs and there is an equally effective and lower cost alternative.
  - Lower patient prices when the specialty pharmacy is accessed.
  - These strategies are not typically available in the Medicaid program.
- Access strategies: creates financial incentives based on how drugs are received (mail order, specialty, physician offices, carve out networks…)

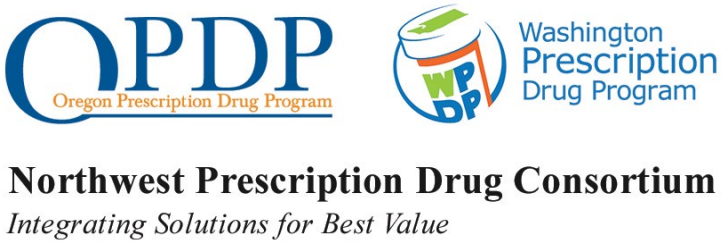
Utilization Management

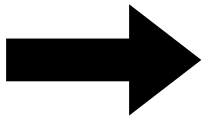
- The purpose of utilization management is:
  - to ensure appropriate use of drugs;
  - preferred drug lists (formularies) – to direct patients and providers to the most cost-effective, clinically appropriate drugs; also established patient cost-share.
  - help reduce fraud, waste, and abuse.
- Payers develop clinical policies
  - Based on evidence comparative safety, effectiveness, and value.
  - FDA approves drugs based on safety and efficacy.
- Clinical policy strategies can include:
  - prior authorization – clinical appropriateness is reviewed prior to fill
  - step therapy – patient is required to try and fail in accordance with clinical protocol more conservative options before moving to other, potentially more expensive options

Step Therapy - Example

- If a member has a prescription history for a first line drug then the second line drug is usually covered without further authorization requirements.
- If there is not a prescription history for a first line drug the second line drug is not covered unless the member:
  - Has previously tried the first line drug and had an adverse outcome (did not adequately treat the intended condition, side effects, drug interactions, etc)
  - Is allergic to the drug
  - Has a medically necessary reason why the first line drug is not appropriate for them

Working strategies: ArrayRx





- An inter-state agreement between the States of Oregon and Washington designed to meet the pharmacy program needs of public and private entities.
- Overseen by WPDP and OPDP, ArrayRx offers services including:
  - PBM services (network management, rebating, claims payment, billing and reconciliation)
  - GPO Program (managed via a national GPO, aggressive class of trade pricing, integration with PBM services where applicable, r egular market checks)
  - A discount card program (Discount card offers individual consumers pricing comparable to participating groups under the NW Consortium.
- There is a legislative requirement for state purchasers to participate in the Consortium unless they are receiving a better price (RCW 70.14.060).
- Participation in the Consortium is available for other states and organizations.

Washington State Health Care Authority

Program services

PBM Services	Discount Card	Voucher Programs	ASO Rebate Services	Medicaid Programs

Oversight and governance focused on transparency, auditability and collaboration

True pass-through program pricing

Custom formulary & clinical services

Fixed administration fee

Industry relations & rebates

Annual market checks

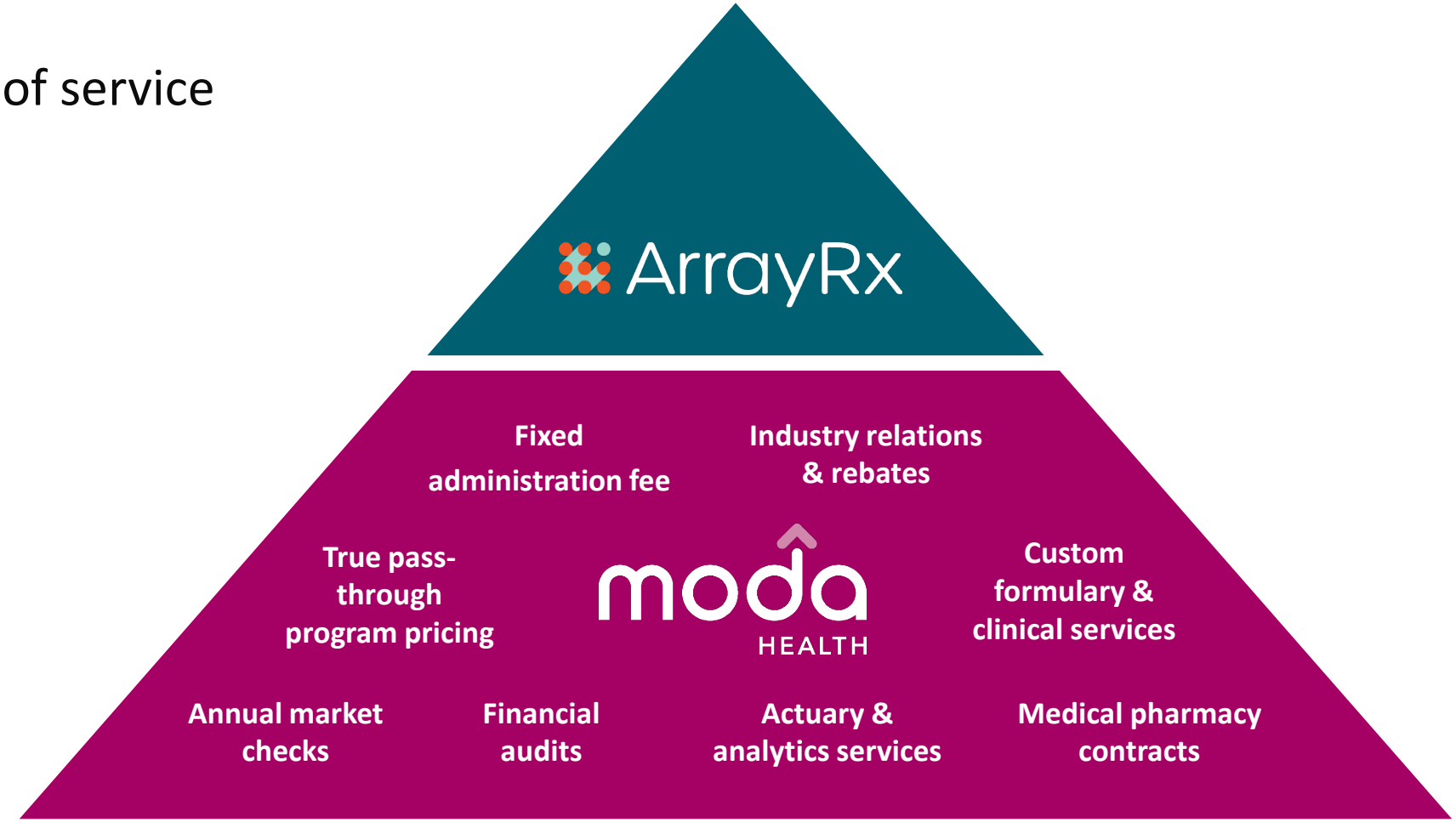
Medical pharmacy contracts

Financial audits

Actuary & analytics services

PBM Services	Discount Card	Voucher Programs	ASO Rebate Services	Medicaid Programs
Group Rx Benefits	State-Sponsored Discount Cards	Corrections	Group Rx Benefits	Managed Medicaid
Workers' Comp		State Hospitals	Workers' Comp	Fee-for-Service Medicaid
		County Health Departments	Medicaid Programs	

Delivery of service



NAVITUS PHARMACY BENEFITS REINVENTED™

- Point of service (POS) claims platform
- National PBM network – narrow and broad networks
- Industry relations services

The next generation of transparency

Predictability

- Most favored nation
- Fixed administration fee
- Aggressive network guarantees

Transparency

- Pass-through pricing
- 100% rebate pass-through
- Comprehensive reporting

Auditability

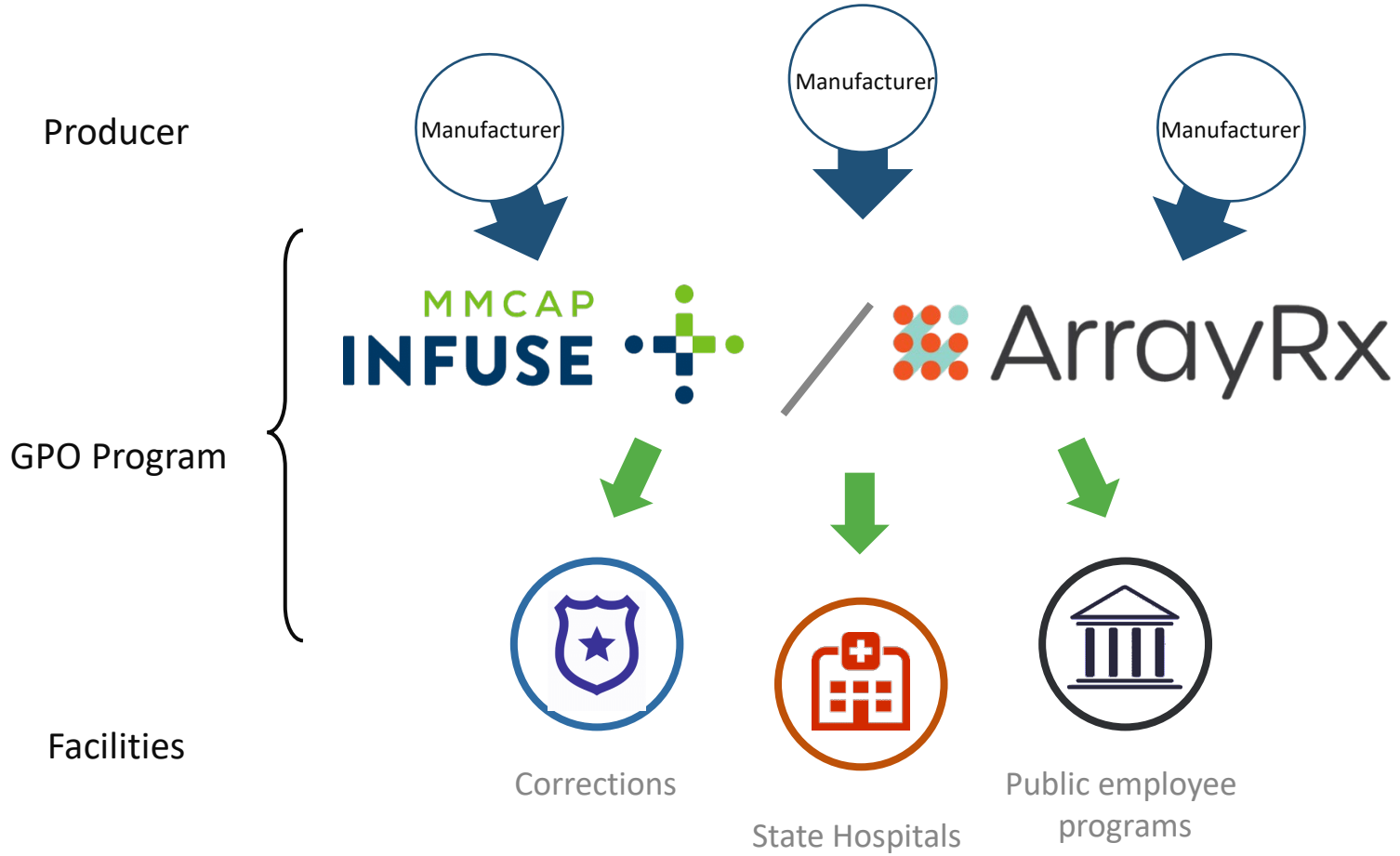
- State oversight and governance
- Annual market checks
- Financial audits

= Working for States

Saves money | **Increases understanding** | **Builds confidence** | **Maximizes potential** | **Validates savings** | **Peace of mind**

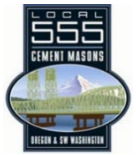
ArrayRx

ArrayRx GPO Services



- Partner to provide GPO services via national public sector GPO partner
- Class of trade pricing
- Partner to provide PBM services where applicable
- Regular market checks to ensure competitiveness

Program participants



Working strategies: Modified Subscription Model

- Direct negotiations with the manufacturer which allows HCA and other state agencies to pay a discount over previous prices.
- For Medicaid, the drug price is negligible once a target threshold is reached. Due to Medicaid Best Price regulations, manufacturers will only offer this to Medicaid.
- HCA, based on a Governor's Directive, signed a first-in-nation arrangement with AbbVie for the treatment of HCV using its Mavyret product under this model.
- The AbbVie contract also requires AbbVie to provide outreach and training support in alignment with DOH's public health outreach campaign.

Working strategies: Apple Health Single PDL

- All AH clients are on a single formulary
- Creates simplicity for the providers
- Minimizes disruption when clients change plans
- Allows us to set the policy based on considering all of the rebates the state is eligible to receive, specifically penalty rebates.

Challenges to managing the pharmacy benefit

Patent Expiration/Patent Purchase

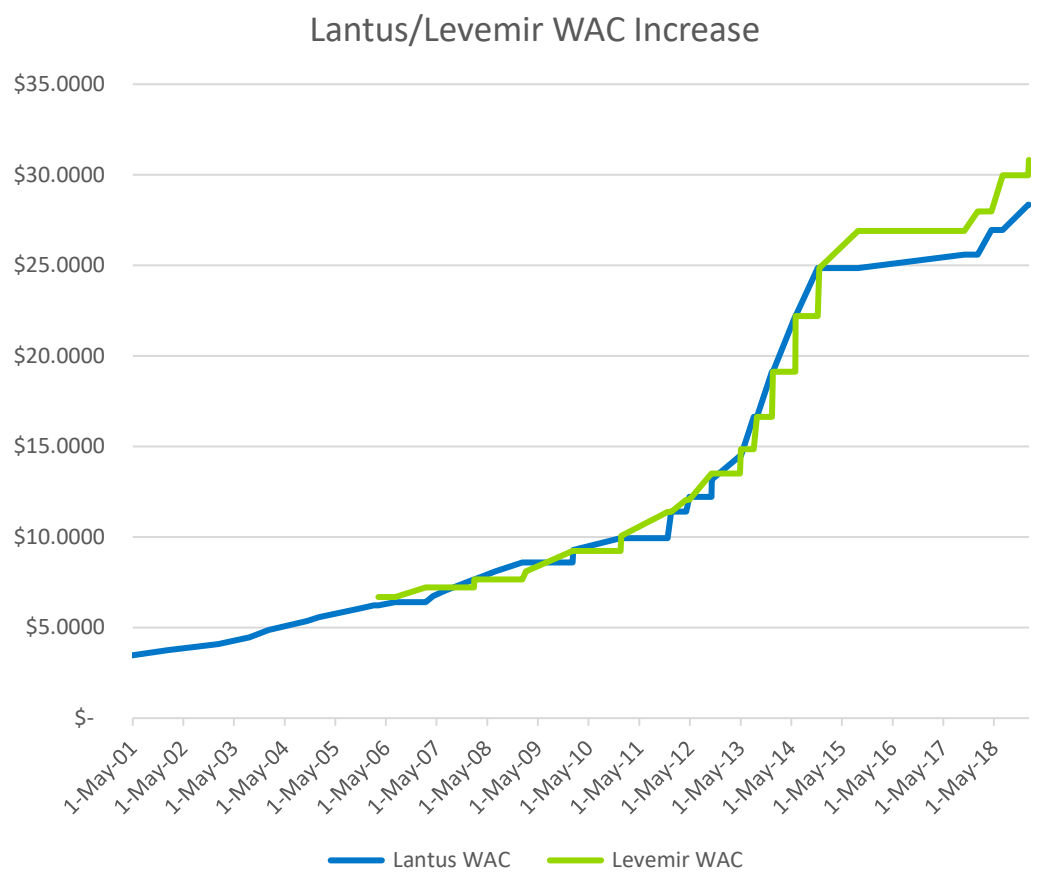
- Revenue from drug innovation is essentially limited to patent period where manufacturer can recover “sunk costs” in R&D.
  - Manufacturers who create novel drugs or originator products are granted a monopoly for their work where they can charge any dollar amount for the drug.
- Manufacturers are incentivized to maximize profits during their limited patent exclusivity before “free market” competition with generics begins.
  - Manufacturers will set the price of a drug on what the market will bear, not related to the “clinical value” of the drug like how other countries negotiate prices.
  - Patent exclusivity depends on when the patent is granted and how long it takes to gain FDA approval.

Patent Expiration/Patent Purchase

- Drug Changes:
  - Manufacturer makes a relatively small change such as a change in dosage form (e.g. extended release tablets) to the drug and pursue a new patent and NDC.
  - The NDC is specific to the dosage form of the drug therefore changes to the NDC creates a new opportunity to re-price the drug.
  - They may then discontinue making the previous drug in its previous dosage form so only the higher cost version of the drug is available.
  - Additionally, the new drug is not considered equivalent therefore substitutions are no longer allowed at the pharmacy level. For example, a cream became available as a lotion with the same strength, however the pharmacist can't substitute the significantly cheaper cream for the lotion.
- Patent Purchase
  - Manufacturers may buy the patent of an old formula and based on the lack of competition, significantly increase the price. Example: Daraprim.

Price Increases

- As manufacturers determine the WAC they'd like to charge; the impacts are felt throughout the system, especially if there are no other comparable drugs.
- No control over price. Purchasers can only negotiate rebates and manage utilization.
- 258 NDCs had a price increase in July 2021. Ranging from a 1% increase to a 908% increase.



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Manufacturer Tools for Circumventing the PDL

- Coupons: Since plans impose cost sharing based on the amount paid for equally effective drugs, manufacturers offer coupons to circumvent that cost control. (Prohibited in gov't programs).
- Advertising – Allowing direct consumer advertising is unique to the US.
- Partnering with advocacy groups to apply political pressure.

New Drugs to Market

- To incentivize manufacturers to invest in drugs to treat rare diseases and pediatric indications, the federal government has created incentives including lower Medicaid rebates, extended patent life, fast track approval, and a voucher for a future drug to be fast tracked. This voucher can be sold.
- FDA Approval:
  - FDA approval does not consider the drug effectiveness relative to other options.
  - The FDA can also allow for single arm trials (i.e. there is no comparator group).
  - Accelerated approval may be based on interim outcomes such as ability to increase production of a protein, without evidence of clinical benefit (Aduhelm).
  - FDA approval may be for usage in a broader population that what was included in the trial (Exondys51, Spinraza).

Where we go from here…

- We're implementing 5195 and 5203.
  - GPO, manufacturer, PBM, wholesaler, pharmacy.
- There are limited levers we have as a state to lower the drug costs.
- We are here to provide technical assistance.
  - Do not hesitate to use us as a resource.
- In the mean-time we will continue to innovate within our operating framework.

Questions?

Appendix: Acronyms and Definitions

- **AMP-** the WAC that includes the discounts and compensation received by wholesalers. Reported by the manufacturers to CMS.
- **APCD-** All Payer Claims Database. A tool used to collect health care claims data for reporting, analytics, and help the public make health care decisions.
- **AWP-** Average Wholesale Price. An average of what pharmacies pay wholesalers
- **CFR-** Code of Federal Regulations. The set of regulations used to govern Medicaid that is updated by CMS.
- **CPI-** Consumer Price Index. Measures recent and historical drug price inflation.
- **FFS**- Fee-For-Service. Is a model that healthcare providers and physicians are reimbursed on the basis of the number of services using ProviderOne System.

Appendix: Acronyms and Definitions

- **FUL-** Federal upper limit. A ceiling price set by the federal government as the highest amount they will pay for a drug; Medicaid can limit the amount paid to more than this amount. It equals no less than 175% of the weighted avg of the most recently reported AMP.
- **GNUP-** Guaranteed Net Unit Price. What the PBM negotiates with the manufacturer as the maximum they will pay for the drug net of all rebates
- **GPI**– generic product identifier which is a standardized enumeration of drugs by their ingredients or "unique interchangeable product" as developed by MediSpan
- **GPO**- group purchasing organization where serval hospitals/pharmacies jointly negotiate wholesale prices
- **MAC-** Maximum Allowable Cost. Amount a payer will spend for a generic drug regardless of how much the pharmacy bills for the drug

Appendix: Acronyms and Definitions

- **MCO**- Managed Care Organization. A managed care organization (MCO) is a health care provider or a group or organization of medical service providers who offers managed care health plans.
- **MME-** Milligram Morphine Equivalent. A value assigned to opioids to represent their relative potencies.
- **NADAC**- National Average Drug Acquisition Cost. Another ways to calculate what the pharmacies pay on average to the wholesalers. Created from surveys of prices reported by pharmacies to CMS
- **NCD-** National Coverage Determination. A nationwide determination as to whether an item or service is paid for by Medicare.
- **NDC**- a 10 digit code that enumerates the manufacturer, drug and quantity.
- **NPI-** National Provider Identifier. A billing number used by healthcare providers.

Appendix: Acronyms and Definitions

- **PBM-** Pharmacy Benefit Manager. They are companies that manage prescription drug benefits on behalf of health insurers, Medicare part D drug plans, large employers, and other payers.
- **PMP-** Prescription Monitoring Programs. A state-run program which collects and distributes data about the prescription and dispensing of federally controlled substances
- **POS-** Point of Sale System. A pharmacy claims processing system capable of receiving and adjudicating claims online.
- **PSAO-** Pharmacy Services Administrative Organization. They are cooperative networks for independent pharmacies.
- **340B-** A program that provides discounts on outpatient drugs to certain safety net health providers, including Title X agencies.

Appendix: Acronyms and Definitions

- **SSA-** Social Security Act. Federal law that established Medicare and Medicaid and set out the basic rules for each program around services and eligibility.
- **TPA**- Third-Party Administrators. A third-party administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity.
- **URA-** Unit Rebate Amount Calculation. This is the unit amount computed by the Centers for Medicare & Medicaid Services to which the Medicaid utilization information may be applied by States in invoicing the Manufacturer for the rebate payment due.
- **WAC-** Wholesale Acquisition Cost. Manufactures published price and basis of what wholesalers pay to the manufacturers

Washington State Health Care Authority

Influence of health workforce trends on health spending growth

TAB 7

Influence of health workforce trends on health spending growth

Health Care Cost Transparency Board Meeting
August 17, 2022

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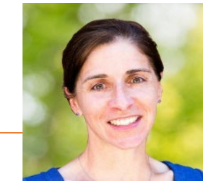
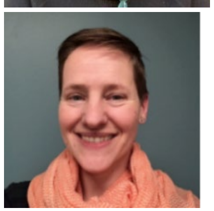
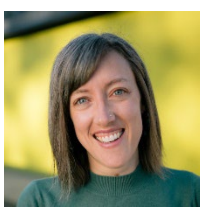
UW Center for Health Workforce Studies

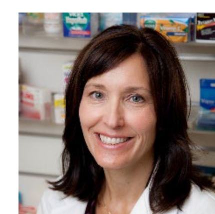
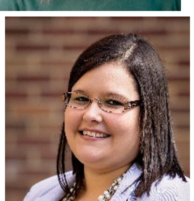



- Established in the Department of Family Medicine in School of Medicine in 1998
- Conducts health workforce research to inform health workforce planners and policy makers
- Supported by multiple grants/contracts including two center grants from the Health Resources and Services Administration with focus on:
  1) Allied health workforce
  2) Health equity & workforce diversity

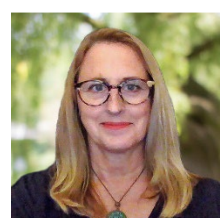








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Objectives

- Defining the health workforce
- Understanding the health workforce connection to health spending
- Identifying COVID effect on health workforce
- Determining whether a workforce shortage exists
- Monitoring strategies to support the health workforce

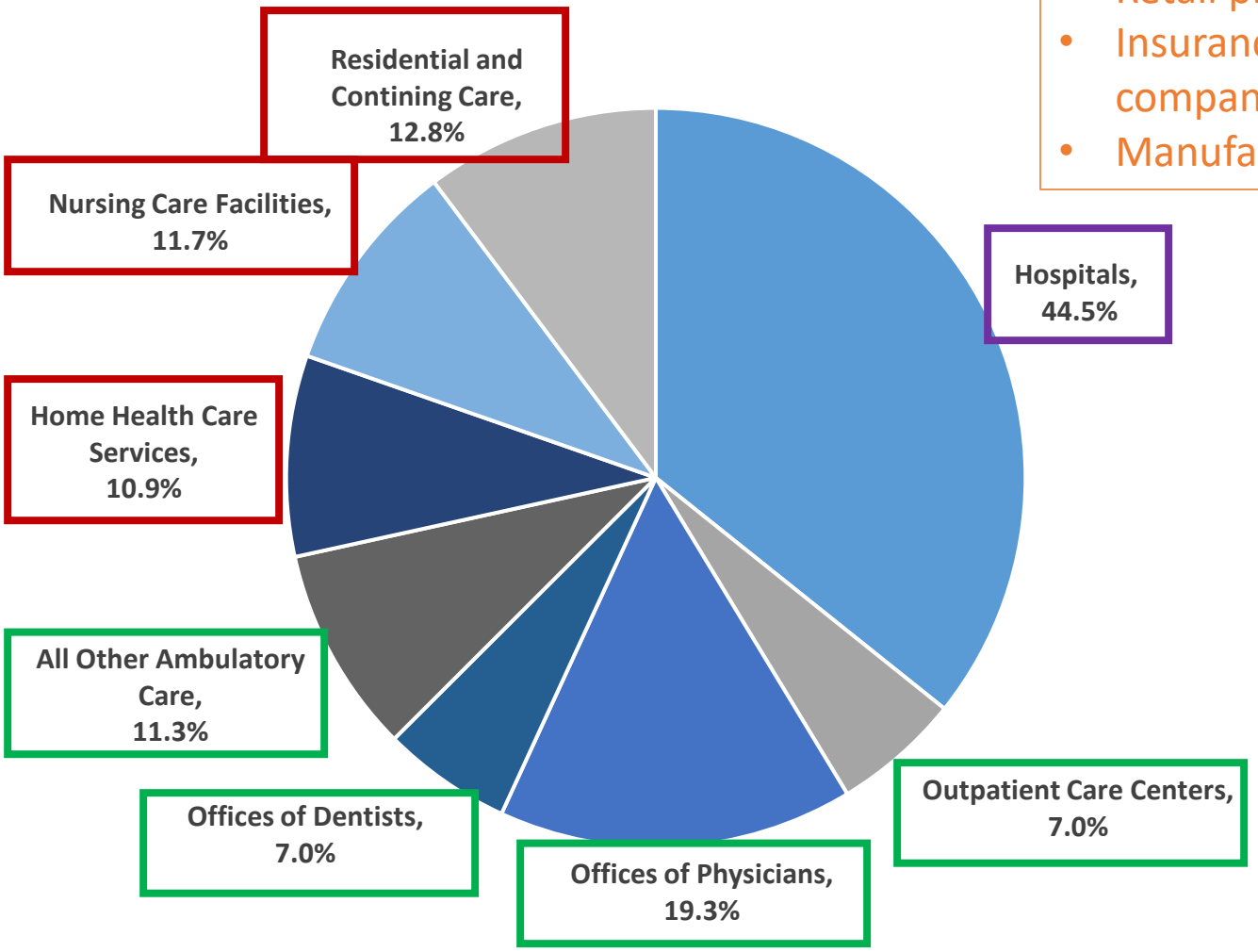
Who makes up the health workforce?

Defining Industries and Occupations

Sectors within Health Care Industry, 2019 (n=17,054,890)

Not captured:

- Retail pharmacies
- Insurance companies
- Manufacturing



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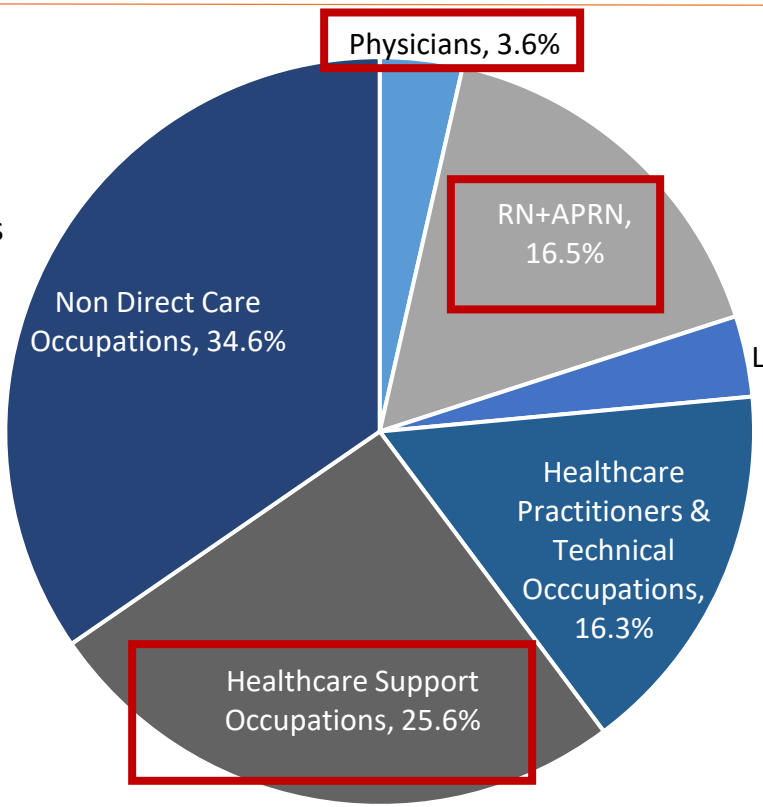
Source: Frogner calculation of Bureau of Labor Statistics, Occupational Employment & Wage Statistics, 2019

Occupations within Health Care Industry, 2019 (n=17,054,890)



Examples:
Community Health Workers
Social Workers
Administrative/Financial/ Management
Grounds/Maintenance
Food Preparation

Examples:
Dentists
Pharmacists
Therapists
Physician Assistants

Examples:
Nursing Assistants
Home Health Aides
Home/Personal Care Aides

Medical Assistants
Pharmacy Aides
Dental Assistants
OT/PT Assistants

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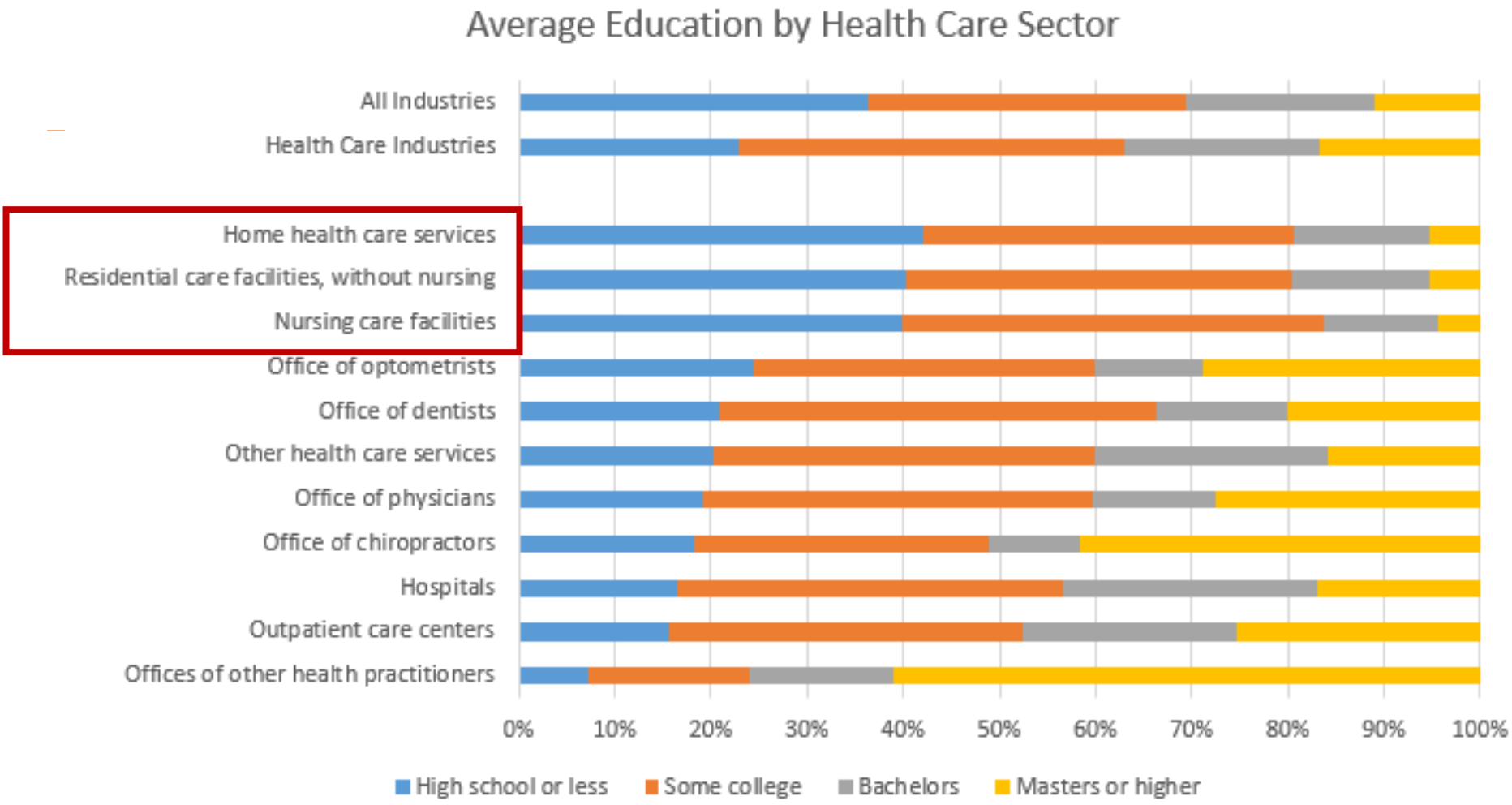
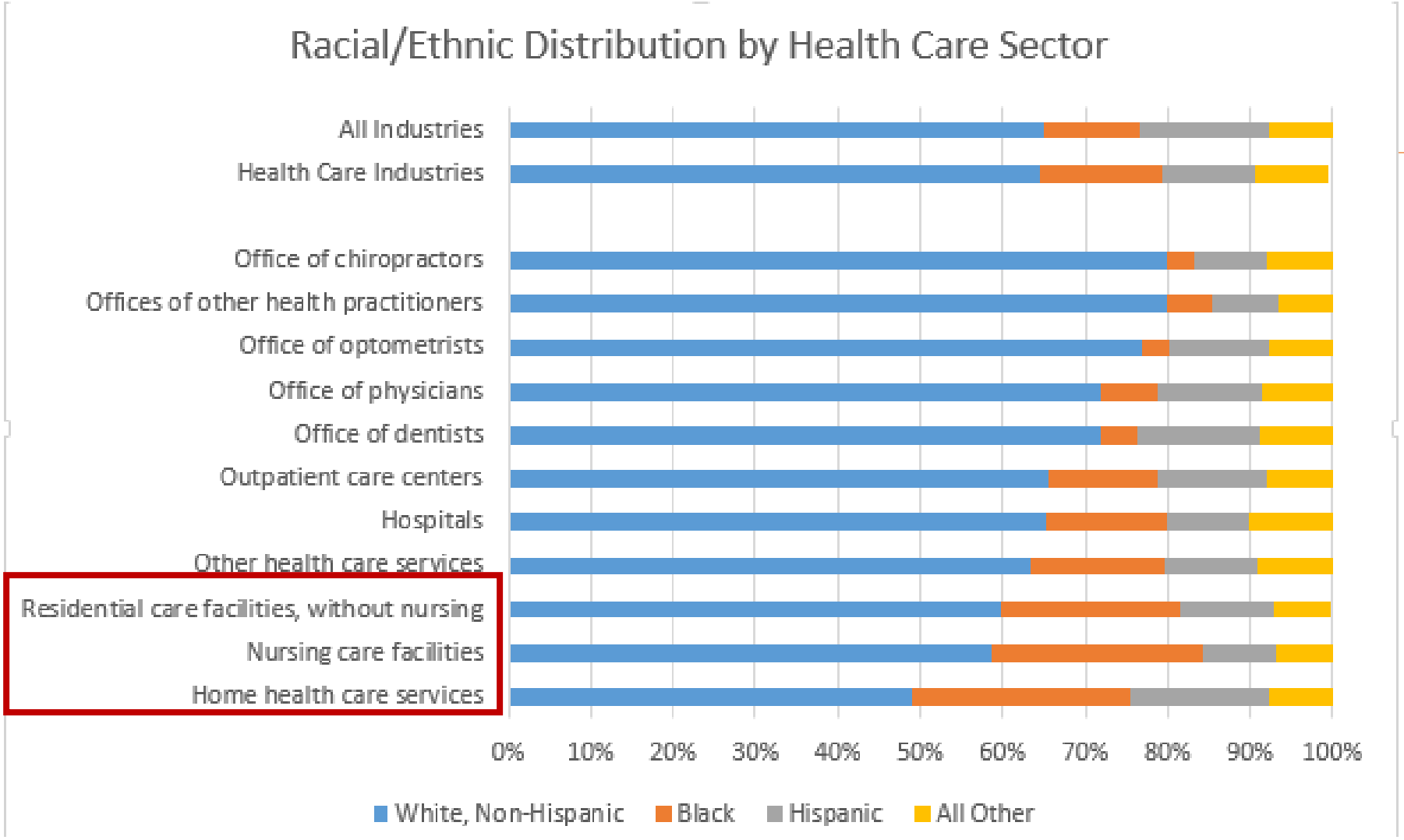
Source: Frogner calculation of Bureau of Labor Statistics, Occupational Employment & Wage Statistics, 2019



Source: Frogner BK, Spetz J, Parente ST, and Oberlin S (2015). "The Demand for Health Care Workers Post-ACA," *International Journal of Health Economics and Management*, 15(1): 139-151.



Source: Frogner BK, Spetz J, Parente ST, and Oberlin S (2015). "The Demand for Health Care Workers Post-ACA," *International Journal of Health Economics and Management*, 15(1): 139-151.

Key Points

- Many different types of workers in health care
- Fairly even distribution of workers across 3 major sectors: hospitals, ambulatory care, long-term care
- Industry includes some of the most well-educated (high paid) workers, but also includes many jobs with low educational requirements with low pay *(more on wages soon…)*
  - Worth noting the high level of diversity in long-term care

Connecting the Health Workforce to Spending

Understanding Dynamic Relationships

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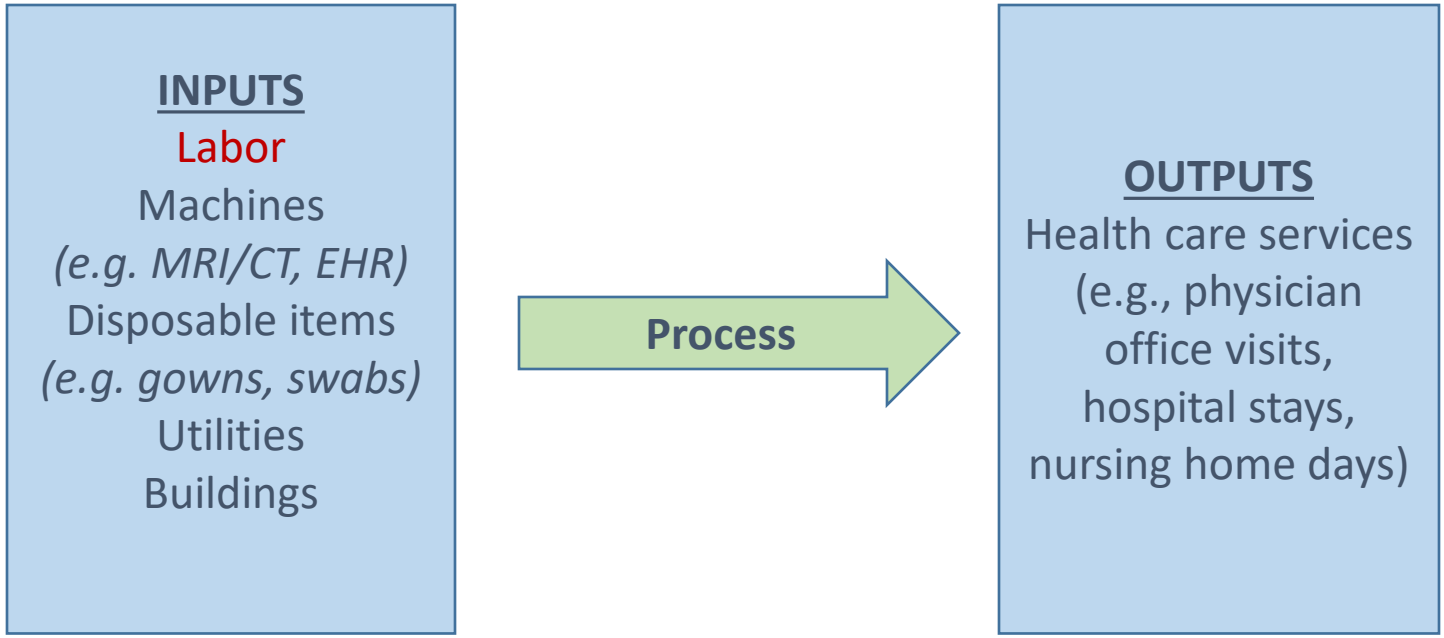
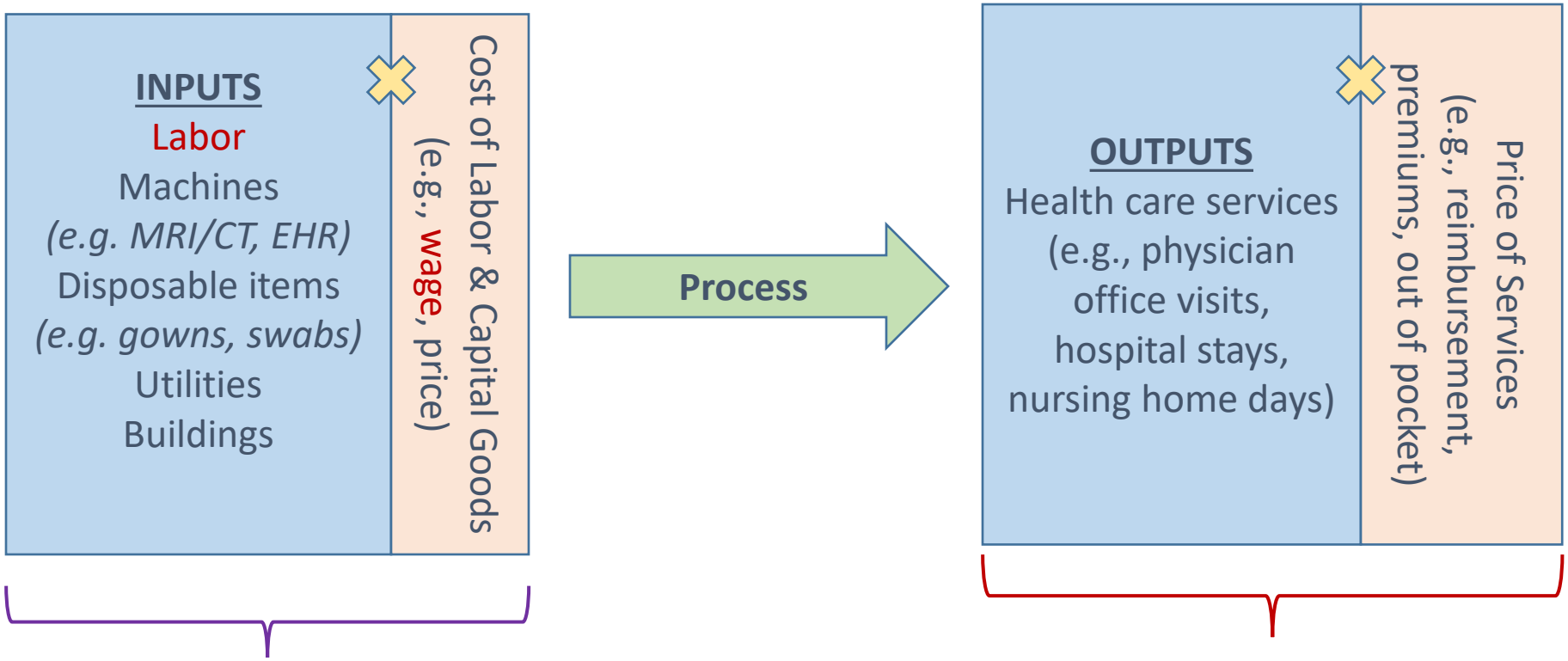
A Simple Input-Output Model of Health Care Spending

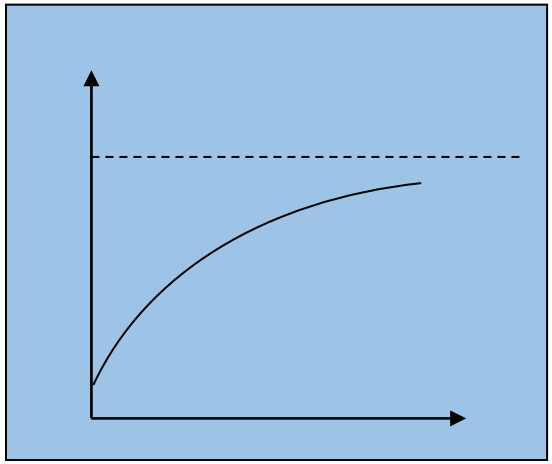


A Simple Input-Output Model of Health Care Spending

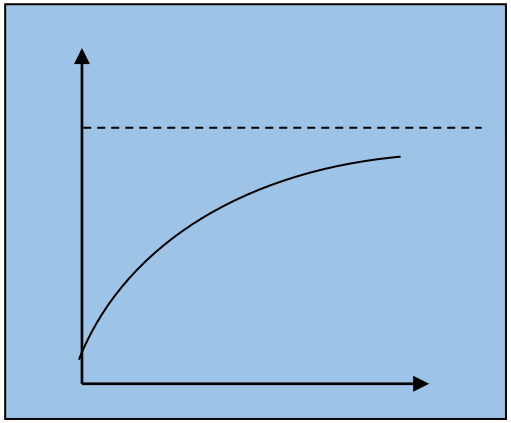


Bending the Cost Curve = Curbing Labor or Wage Growth?

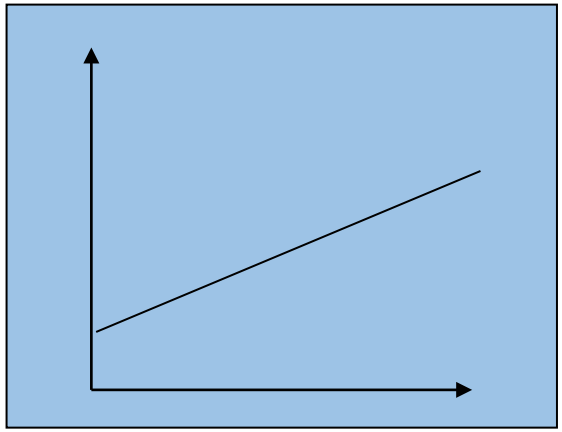
Health Spending Growth



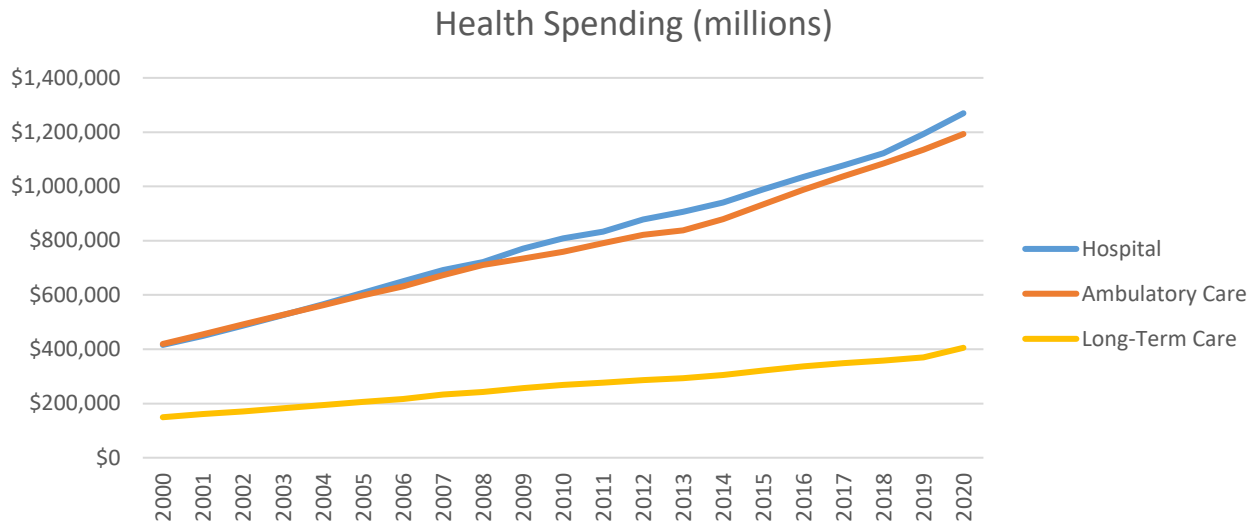
Health Care Labor Force

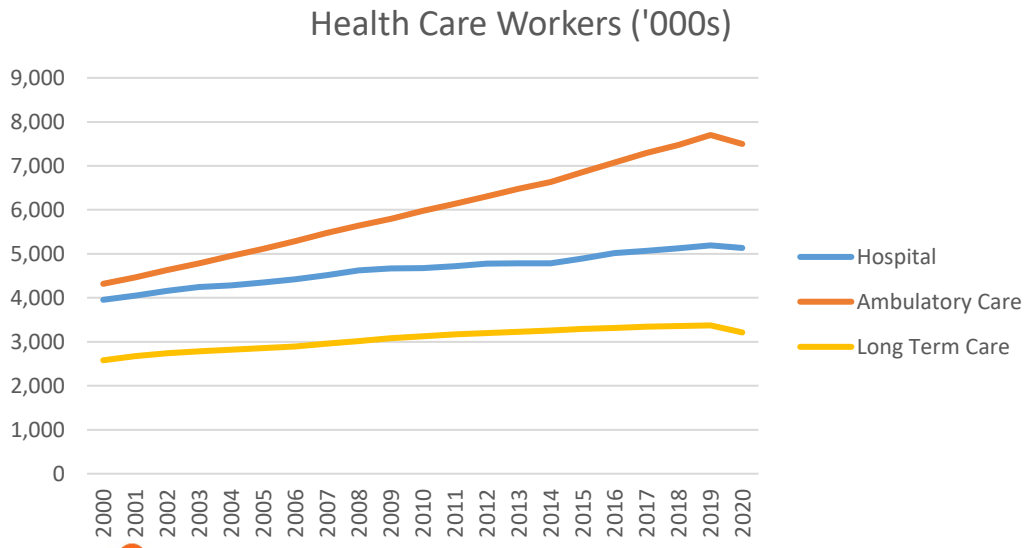


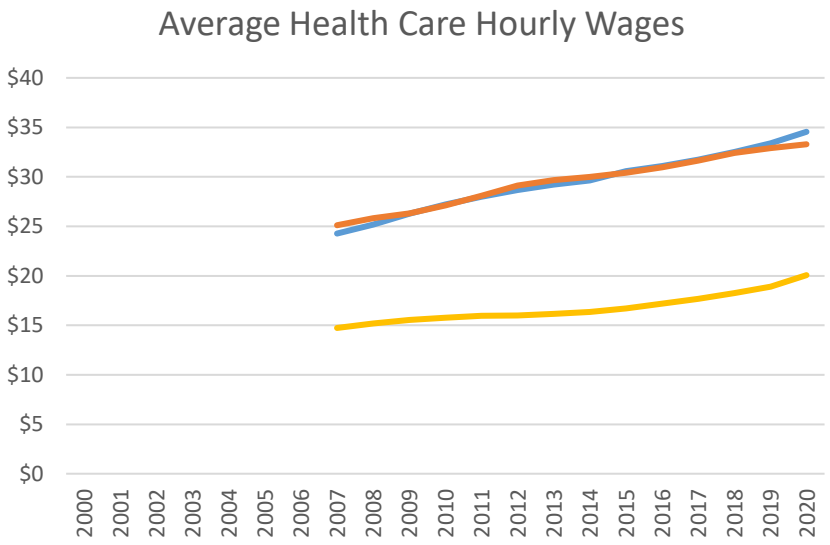
Health Care Wage Rate



National Health Spending Relative to Employment and Wage Growth







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Sources: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical; https://data.bls.gov/cgi-bin/dsrv?ce

Key Points

- National health care labor and wage rates have grown fairly smooth
- Contribution of health care labor & wages relative to total health spending, including translation into prices of health care services, not well understood
  - Even less clear at the state level
- Slowing health care spending will affect total number of workers and/or wages

How COVID Affected Health Workforce Trends

Employment, Wages, and Competition

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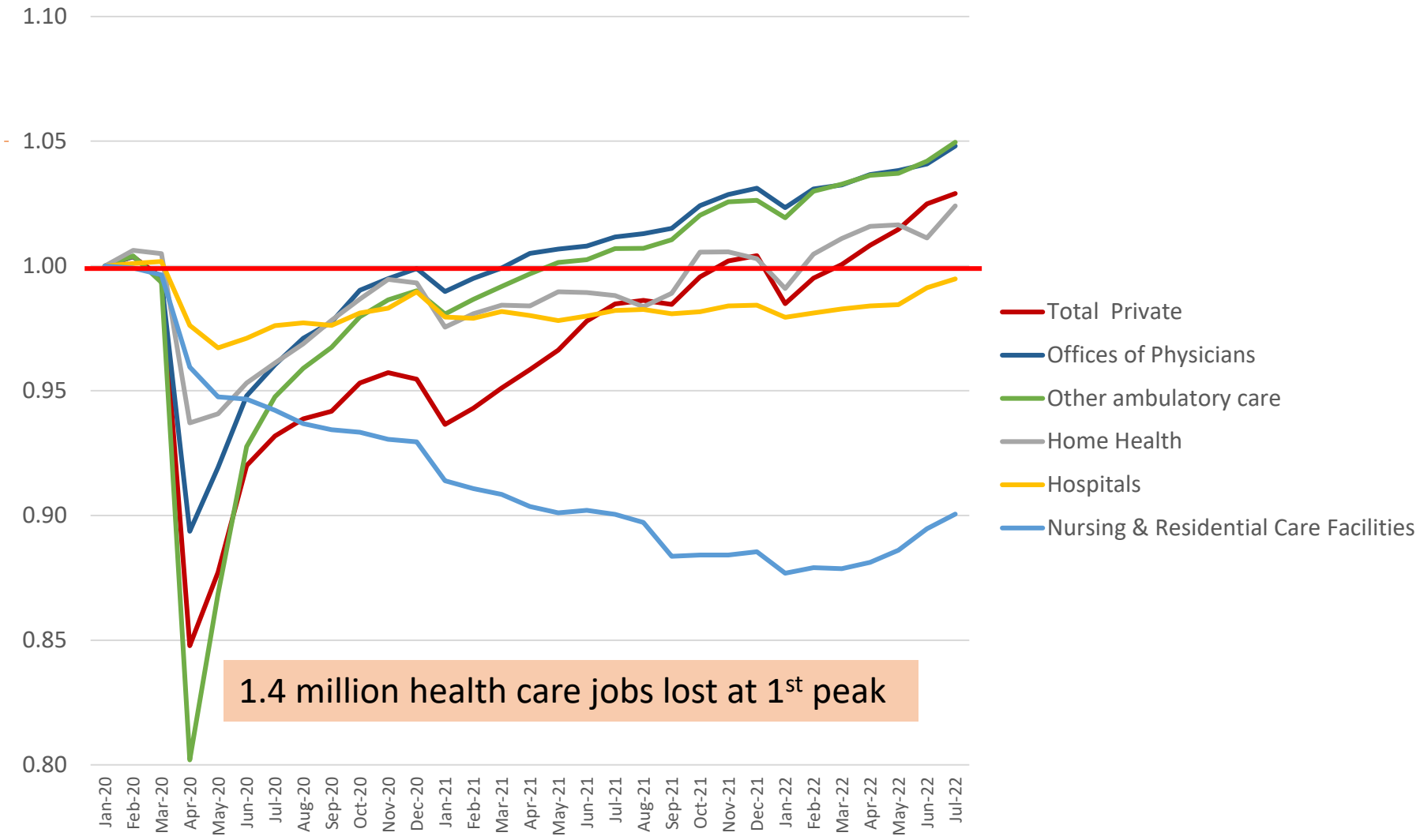
Relative Number of Employees by Sector, Jan 2020 to Jul 2022 (Jan 2020=1.00)



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Source: Author calculation of Table B-1 Employees on nonfarm payrolls by industry sector and selected industry detail, Bureau of Labor Statistics, https://www.bls.gov/news.release/empsit.t17.htm

Tracking Turnover among Health Care Workers During the COVID-19 Pandemic

- Data: Current Population Survey, Jan 2019 – Oct 2021
  - Monthly household survey collected by Bureau of Labor Statistics
  - Complex sampling frame allowing to follow individuals across months
- Sample: Health care workers
- Outcome: Turnover = employed in one month then reported as unemployed or out of the labor force in consecutive month
- Approach: Random effects logistic regression to examine leaver rates across 3 time periods:
  - Pre-Period: Jan 2019 to March 2020
  - Post-Period 1: April 2020 to December 2020
  - Post-Period 2: January 2021 to October 2021

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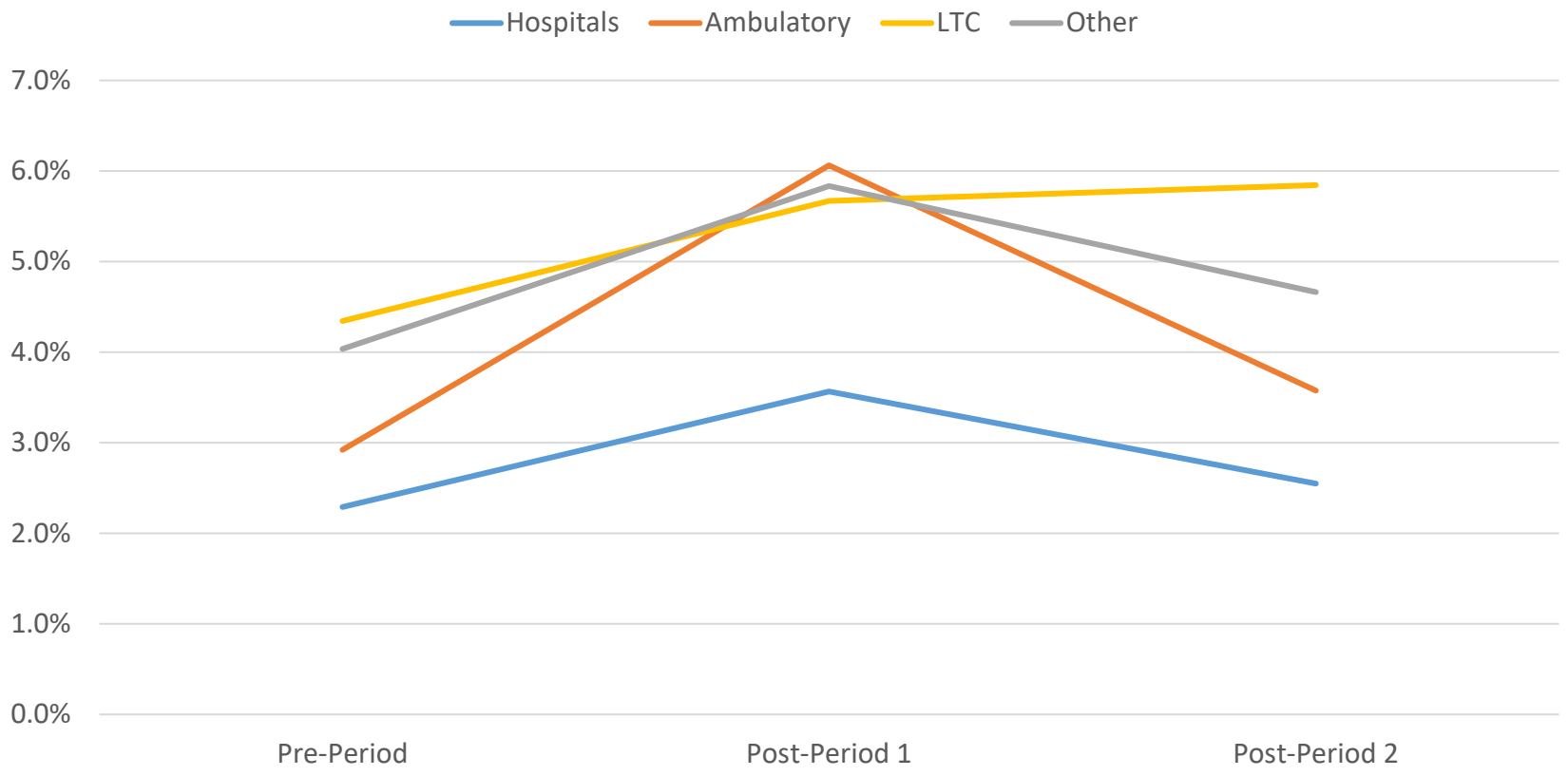
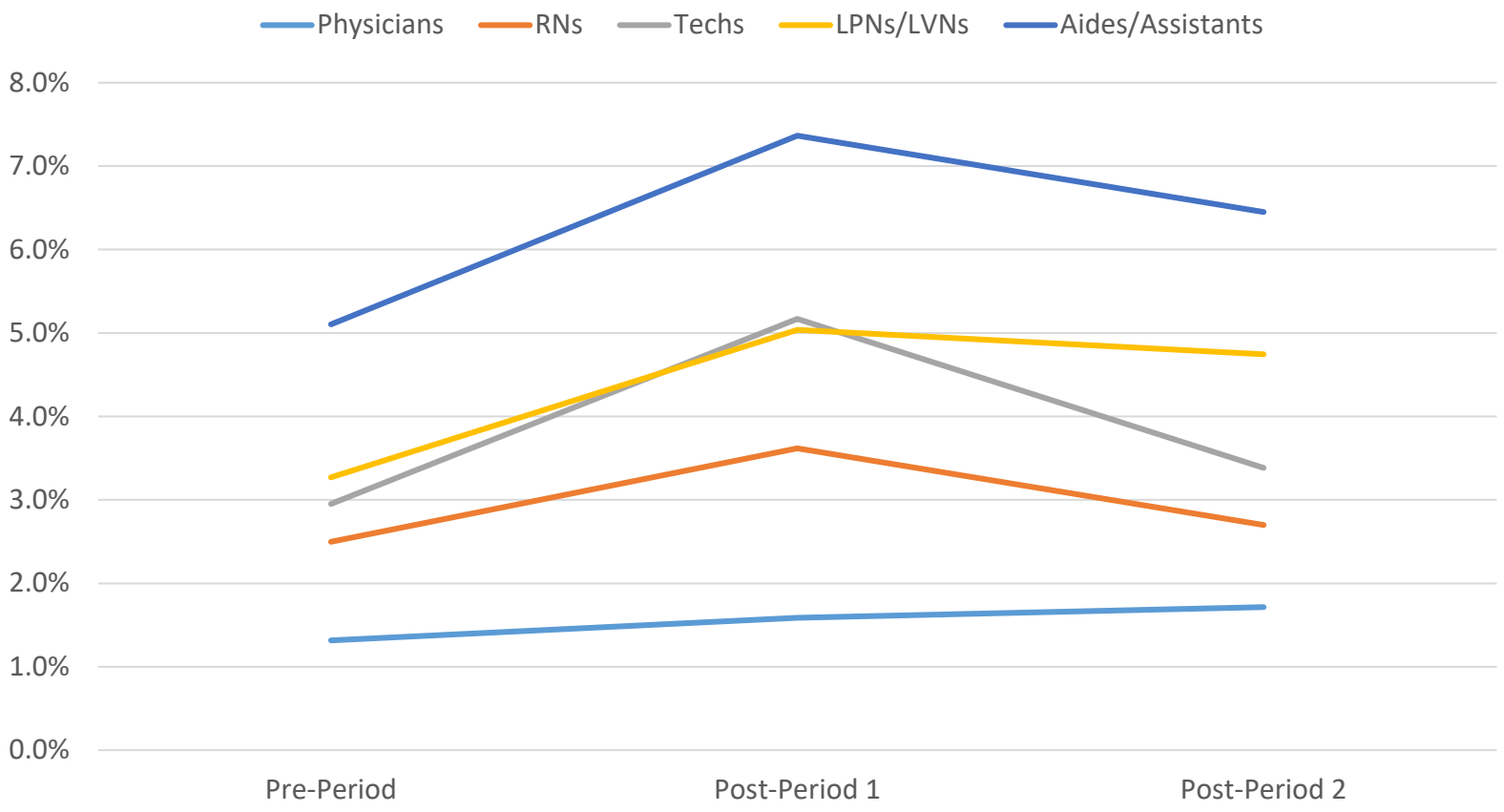
Turnover Rates by Sector and COVID Phase



LTC = long-term care; Other includes all other industries outside health care
Predicted probabilities reported controlling for gender, having child under 5 in HH, race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

Turnover Rates by Occupation and COVID Phase



RN = Registered Nurse; LPN/LVN = Licensed Practical Nurse/Licensed Vocational Nurse
Predicted probabilities reported controlling for gender, having child under 5 in HH, race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

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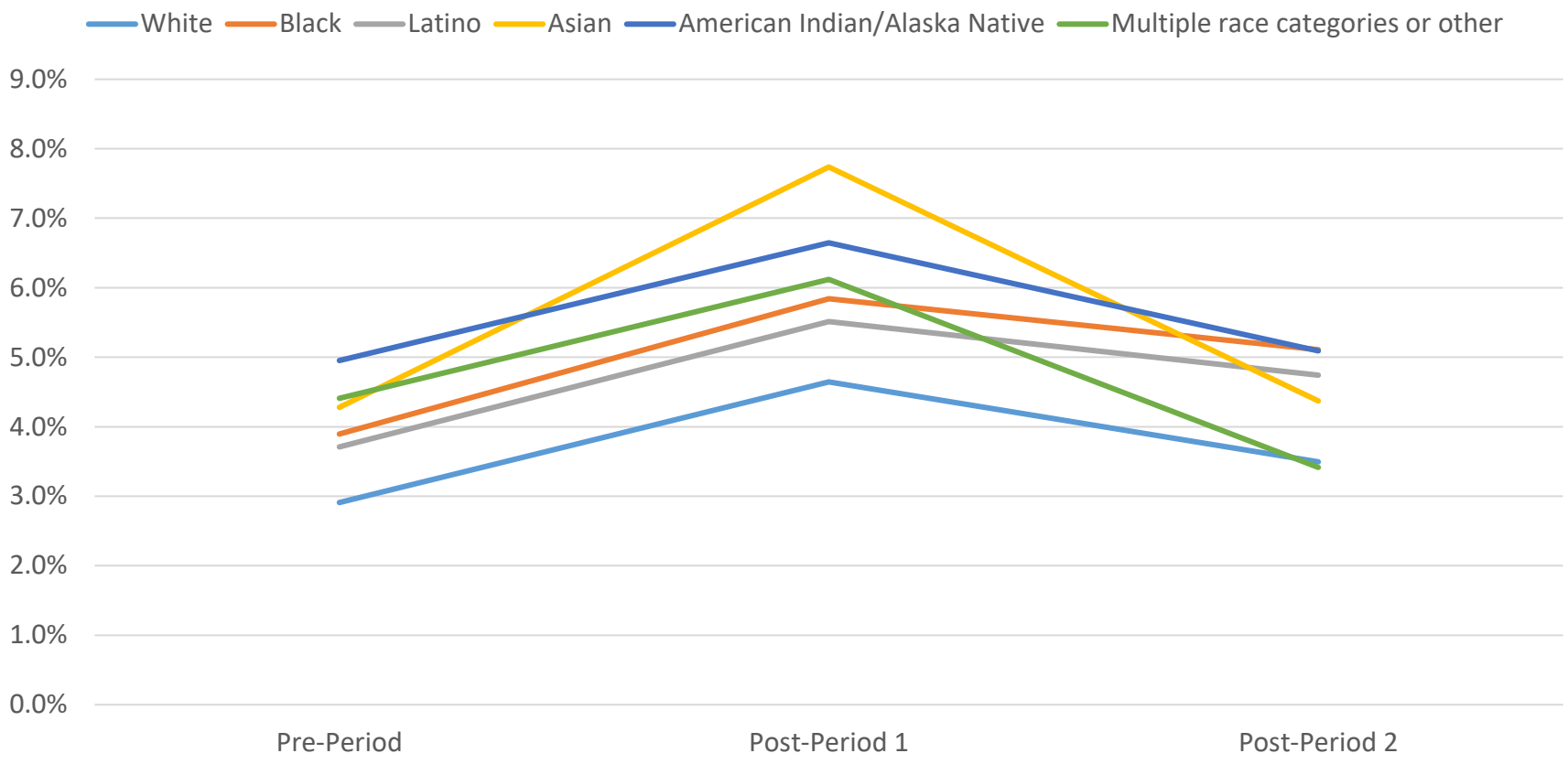
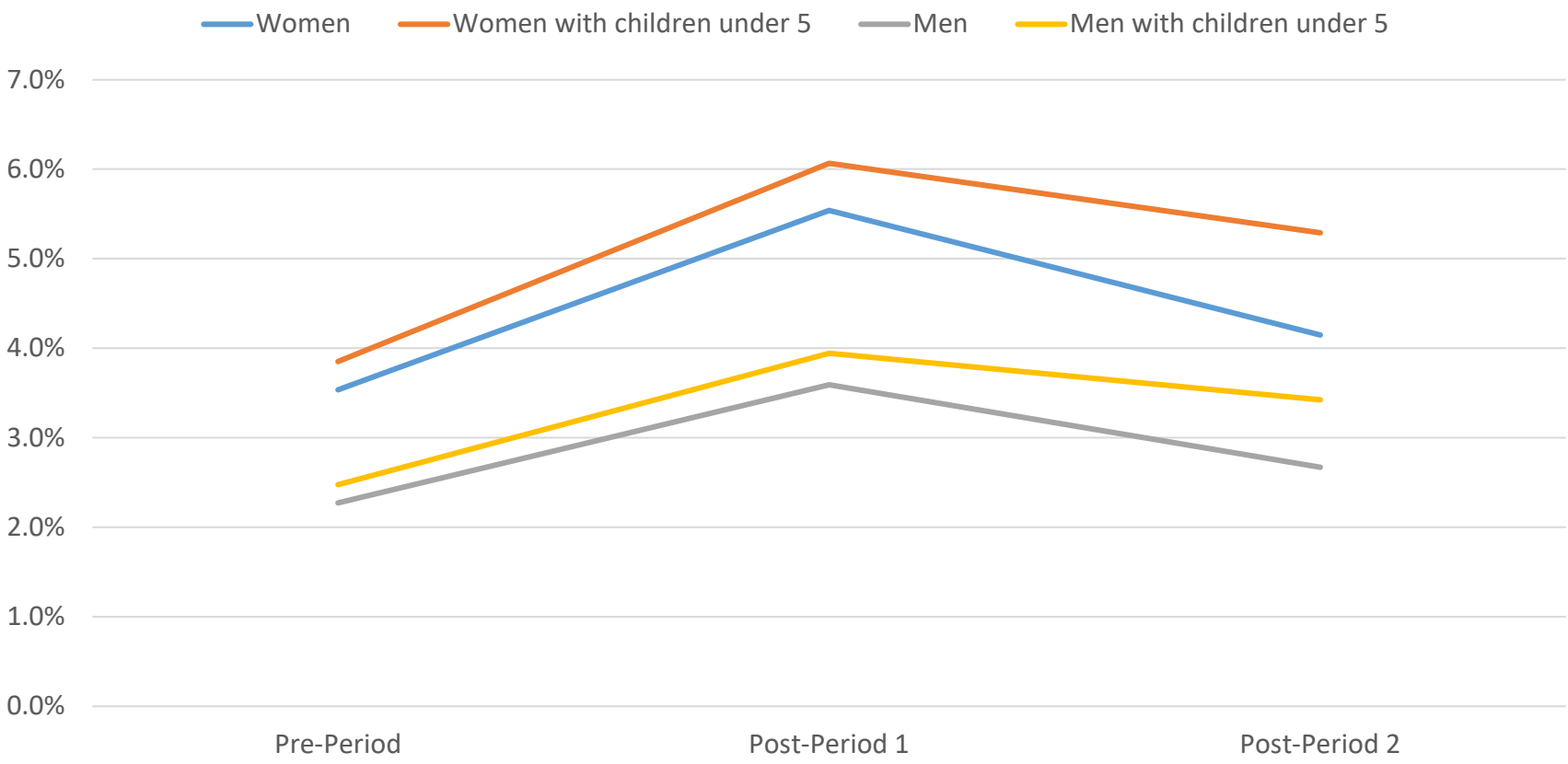
Turnover Rates by Race/Ethnicity and COVID Phase



Race/ethnicity groups are mutually exclusive
Predicted probabilities reported controlling for gender, having child under 5 in HH, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

Turnover Rates by Gender/Parenthood and COVID Phase



Predicted probabilities reported controlling for race/ethnicity, age, age sq, education, marital status, COVID cases/deaths, indicator for April 2020

National Distribution and Wages of Select Health Care Occupations

2021	Distribution			Median Hourly Wage		
	Amb	Hosp	LTC	Amb	Hosp	LTC
N	7,747,840	6,104,540	3,062,530	7,747,840	6,104,540	3,062,530
Chief Executive	0.08%	_NA	0.09%	$ 85.73	>$100	$ 60.92
Physician	5.1%	2.9%	0.08%	>$100	$ 79.98	$ 76.54
RN	7.2%	30.5%	3.6%	$ 36.88	$ 37.53	$ 30.51
LPN	2.7%	1.5%	5.1%	$ 22.92	$ 22.60	$ 23.61
Nursing Assistant	1.5%	6.9%	15.8%	$ 14.29	$ 17.25	$ 14.38
Medical Assistant	7.2%	1.8%	0.9%	$ 17.85	$ 18.17	$ 14.42
2019	**Distribution**			**Median Hourly Wage**		
	Amb	Hosp	LTC	Amb	Hosp	LTC
N	7,608,860	6,094,940	3,351,090	7,608,860	6,094,940	3,351,090
Chief Executive	0.08%	0.09%	0.07%	$ 88.87	>$100	$ 65.05
Physician	_NA	_NA	_NA	_NA	_NA	_NA
RN	7.3%	29.8%	6.1%	$ 33.81	$ 36.07	$ 31.85
LPN	2.9%	1.7%	8.2%	$ 22.31	$ 21.90	$ 23.48
Nursing Assistant	1.6%	6.7%	22.3%	$ 14.21	$ 14.96	$ 13.84
Medical Assistant	7.1%	1.8%	0.7%	$ 16.70	$ 17.35	$ 13.99

Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

National Distribution and Wages of Select Health Care Occupations: Comparing with Temporary Services

2021	Distribution				Median Hourly Wage			
	Amb	Hosp	LTC	Temp	Amb	Hosp	LTC	Temp
RN	557,844	1,861,885	110,251	66,790	$ 36.88	$ 37.53	$ 30.51	$ 31.63
LPN	209,192	91,568	156,189	20,660	$ 22.92	$ 22.60	$ 23.61	$ 27.57
Nursing Assistant	116,218	421,213	483,880	31,690	$ 14.29	$ 17.25	$ 14.38	$ 17.13
Medical Assistant	557,844	109,882	27,563	10,130	$ 17.85	$ 18.17	$ 14.42	$ 17.85
2019	**Distribution**				**Median Hourly Wage**			
	Amb	Hosp	LTC	Temp	Amb	Hosp	LTC	Temp
RN	555,447	1,816,292	204,416	47,110	$ 33.81	$ 36.07	$ 31.85	$ 33.68
LPN	220,657	103,614	274,789	17,170	$ 22.31	$ 21.90	$ 23.48	$ 23.60
Nursing Assistant	121,742	408,361	747,293	31,460	$ 14.21	$ 14.96	$ 13.84	$ 14.38
Medical Assistant	540,229	109,709	23,458	5,900	$ 16.70	$ 17.35	$ 13.99	$ 16.92

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Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

Wages of Select Health Care Occupations: National v. Washington

2021	Median Hourly Wage			WA
	Amb	Hosp	LTC	
RN	$ 36.88	$ 37.53	$ 30.51	$46.63
LPN	$ 22.92	$ 22.60	$ 23.61	$29.40
Nursing Assistant	$ 14.29	$ 17.25	$ 14.38	$17.86
Medical Assistant	$ 17.85	$ 18.17	$ 14.42	$22.82

2019	Median Hourly Wage			WA
	Amb	Hosp	LTC	
RN	$ 33.81	$ 36.07	$ 31.85	$40.14
LPN	$ 22.31	$ 21.90	$ 23.48	$27.80
Nursing Assistant	$ 14.21	$ 14.96	$ 13.84	$15.97
Medical Assistant	$ 16.70	$ 17.35	$ 13.99	$20.90

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Source: Bureau of Labor Statistics. Occupation Employment and Wage Statistics: https://www.bls.gov/oes/tables.htm

Key Points

- COVID has had largest effect on long-term care, particularly SNF, employment
  - Disproportionate burden on low wage workers, women with young children and workers of color
  - Turnover in low wage jobs and SNF may have ripple effects on the entire system
- Wage rates have increased since start of COVID, appearing to be faster in WA
  - Poor data for highly paid workers in national datasets
- How many work as travelers, as well as their pay, is hard to identify
  - Relatively small number of workers
  - Pain may be temporary (more on this soon)

Are we facing a health workforce shortage?

Speculating on the Future

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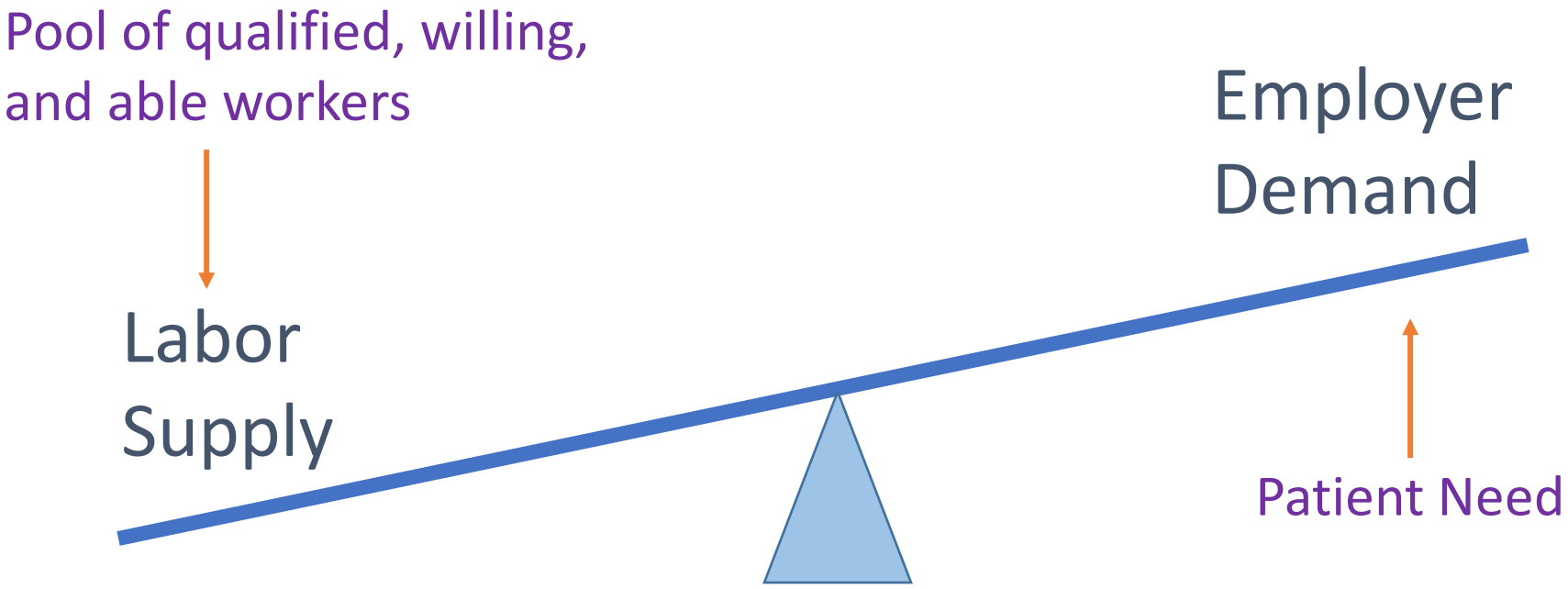
Very Basic Definition of a Shortage



Pre-COVID: Long-Term Care Jobs Projected as Fastest Growing, 2019 to 2029

OCCUPATION	GROWTH RATE, 2019-29	2019 MEDIAN PAY
Wind turbine service technicians	61%	$52,910 per year
Nurse practitioners	52%	$109,820 per year
Solar photovoltaic installers	51%	$44,890 per year
Occupational therapy assistants	35%	$61,510 per year
Statisticians	35%	$91,160 per year
Home health and personal care aides	34%	$25,280 per year
Physical therapist assistants	33%	$58,790 per year
Medical and health services managers	32%	$100,980 per year
Physician assistants	31%	$112,260 per year
Information security analysts	31%	$99,730 per year

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Source: https://www.bls.gov/ooh/fastest-growing.htm

Pre-COVID Headlines on Health Workforce


Health & Science

The disabled and the elderly are facing a big problem: Not enough aides

The Washington Post
Democracy Dies in Darkness


Forbes

7,265 views | Apr 18, 2018, 02:05pm

The Shortage Of Home Care Workers: Worse Than You Think


Home Health Care News

STAFFING

Caregiver Shortage Could Mean 7.8 Million Unfilled Jobs By 2026

By **Bailey Bryant** | January 28, 2019

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COVID Headlines on Health Workforce: 2020

NURSING HOMES

NY Nursing Homes Struggle With Severe Staffing Shortages Amid COVID Outbreaks

4 NEW YORK

At least 1,700 residents with COVID-19 have died in nursing homes since Dec. 1, according to a state count that likely understates the number of fatalities, and federal records show at least 13 staff members at the state's 600 nursing homes have died in that same time as a result of the virus

Published January 26, 2021 • Updated on January 27, 2021 at 1:36 am

The New York Times

A Parallel Pandemic Hits Health Care Workers: Trauma and Exhaustion

Vaccines may be on the way, but many on the front-lines are burned out. Has the government done enough to help alleviate their stress?

The Washington Post
Democracy Dies in Darkness

Nursing home workers now have the most dangerous jobs in America. They deserve better.

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COVID Headlines on Health Workforce: 2021

FORTUNE

HEALTH · HOSPITALS

Hospitals struggle to match Walmart pay as staff leave workforce due to Omicron

BY JOHN TOZZI AND BLOOMBERG
January 7, 2022 9:11 AM PST

wbur CONSIDER THIS

Consider This: Hospital staffing crisis sends demand for travel nurses to all-time high

11:21

February 01, 2022

The Atlantic

HEALTH

WHY HEALTH-CARE WORKERS ARE QUITTING IN DROVES

About one in five health-care workers has left their job since the pandemic started. This is their story—and the story of those left behind.

By Ed Yong

POLITICO

HEALTH CARE

Health care workers are panicked as desperate hospitals ask infected staff to return

While most health workers are vaccinated, many are still falling sick, exacerbating a staff shortage as more Americans seek hospital care.

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Current Contributors to Low Labor Supply

Pool not available to work because:

- Directly affected by COVID illness (sickness and death)
- Childcare and other caregiving responsibilities

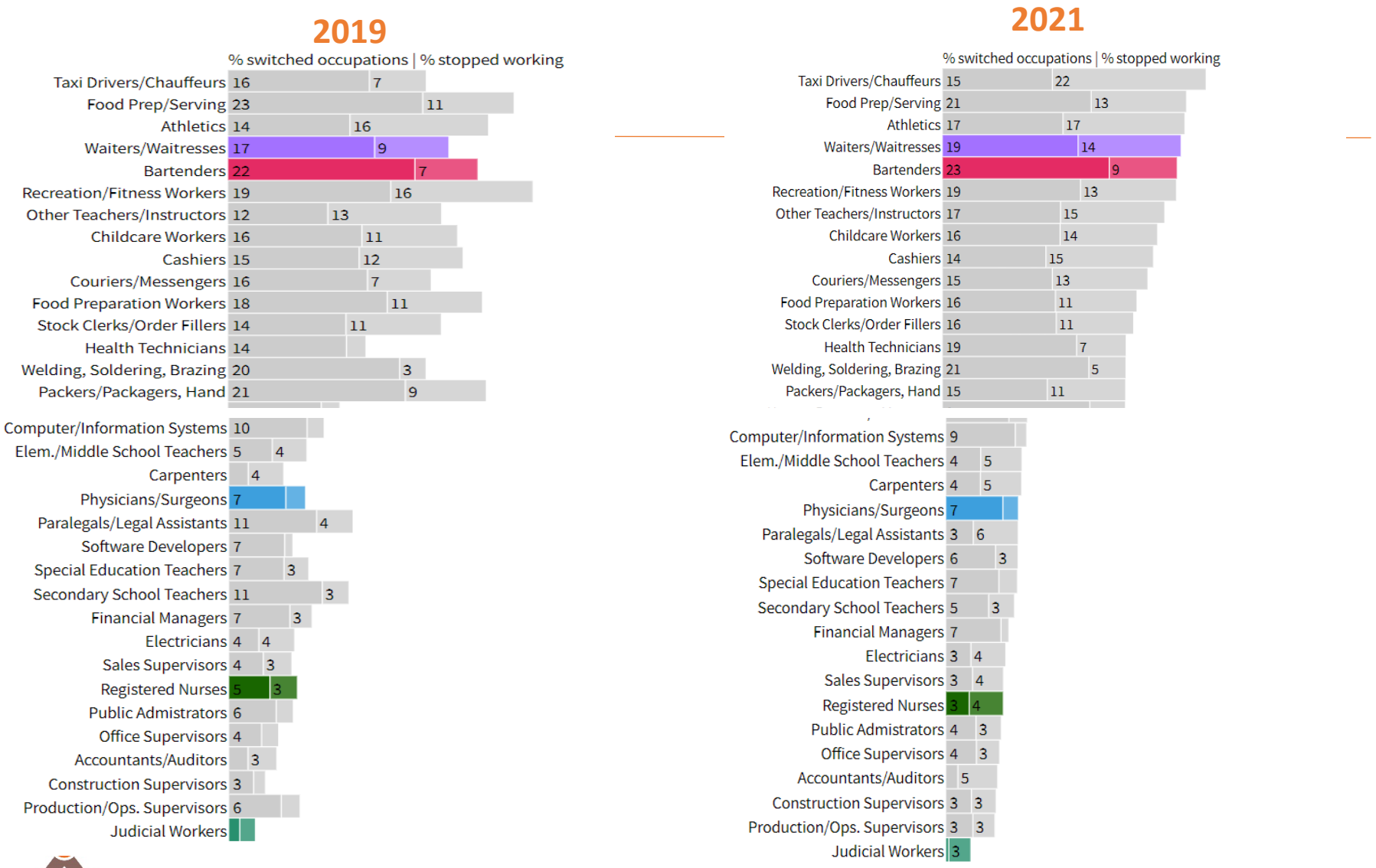
Pool not willing to work:

- Burnout/moral distress/moral injury
- Safety concerns

Lack of qualified applicants

- Training unavailable, slow and expensive to complete
- Restrictive practice policies

Workers who left their jobs for another occupation or stopped working entirely (interactive data)



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Source: https://usafacts.org/projects/jobs/who-leaves?utm_source=Mailchimp&utm_medium=Email&utm_campaign=Aug-8-reconciliation&utm_content=leaving-jobs-viz-text

Ten Most Common Prior Year Industry for Entrants and Current Year Industry for Leavers of the Health Care Industry Between 2003 and 2013

Entrants' Prior Year Industry (N=15,742,141)		Leavers' Current Year Industry (N=23,729,493)	
Not in the labor force or unemployed (excluding in school)	13.0%	Not in the labor force	34.7%
Leisure and hospitality	11.0	Unemployed	18.6
Retail trade (excluding pharmacies and drug stores)	8.8	Educational services	5.6
Educational services	8.4	Leisure and hospitality	4.6
In school	6.9	Professional, scientific and technical services	4.3
Professional, scientific and technical services	6.3	Retail trade (excluding pharmacies and drug stores)	4.0
Public Administration	6.0	Public Administration	3.9
Management, administrative and support, and other services	5.7	Management, administrative and support, and other services	3.8
Finance and Insurance	5.1	Social Assistance	3.2
Social Assistance	5.0	Finance and Insurance	2.9

Source: Frogner BK. (2017) "The Health Care Job Engine: Where Do They Come From and What Do They Say About Our Future?" *Medical Care Research and Review*, DOI: 10.1177/1077558716688156

Among those who continued to work yet made a job change, common non-health care sectors to which health care workers moved (as of March 2021)

Physicians	Registered Nurses	LPNs/LVNs	Nursing & Home Health Aides
Education*	Education	Individual and family services	Individual and family services
Pharmacy/ Drug stores	Public administration	Pharmacy/ Drug stores	"Other" services
Finance	Management	Public administration	Education

Of those that made change in last year, LPNs/LVNs and nursing/home health aides experienced high attrition (75-80%) from their occupation:

- ~25% of LPNs who left went on to become a registered nurse
- ~25% of nursing and home health aides became a personal care aide

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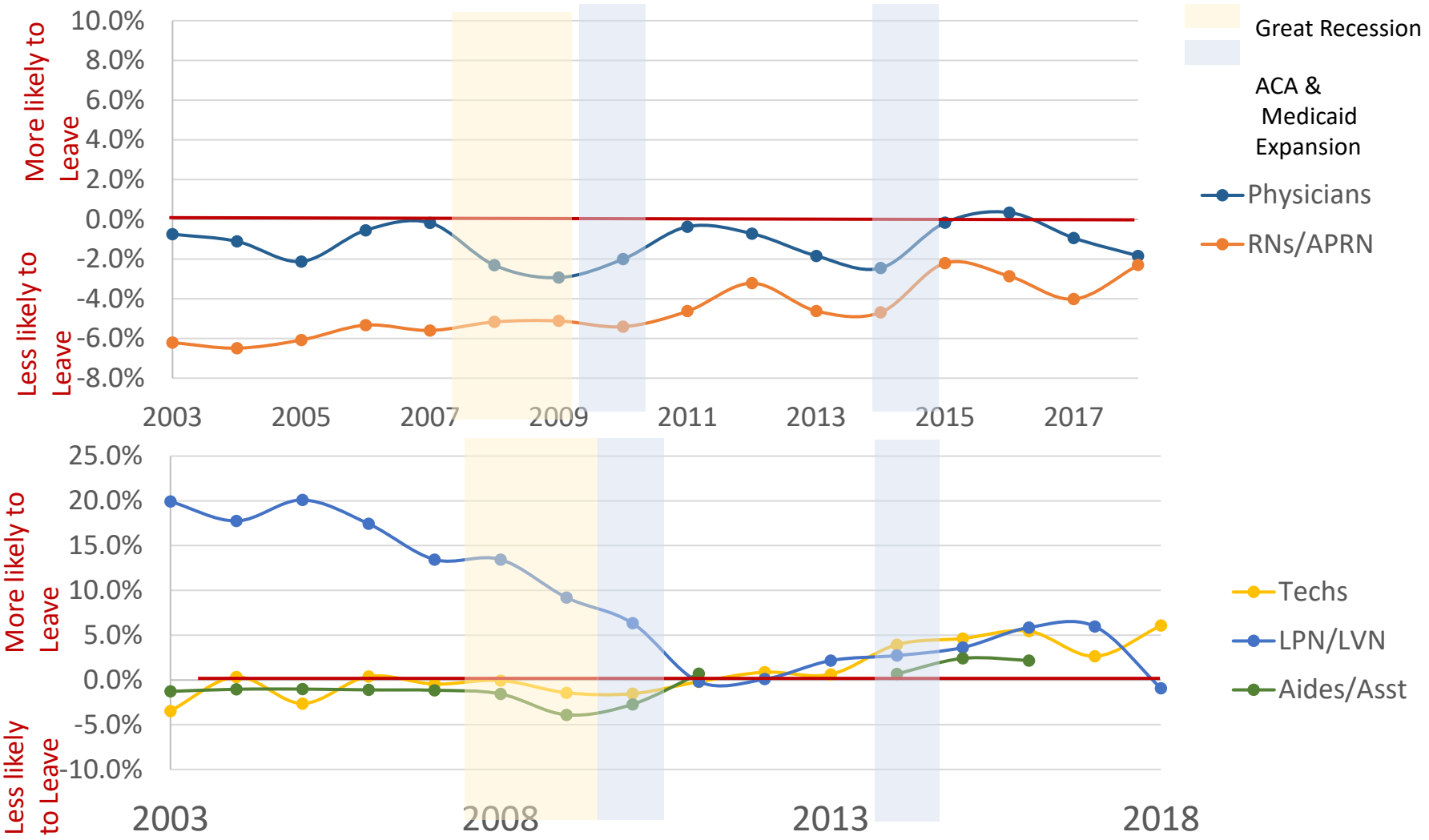
Note: Unpublished results – do not cite; Results based on Frogner's calculation based on data from March 2021 CPS supplement; Compared job/industry in current year with prior year.
*Education does not mean going back to school but rather working in the education sector (e.g., teacher)

Brief Look at Leaver Trends During Recessions



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Source: Frogner, Is Health Care a Desirable Place to Work? Examining Trends in Competition for Health Care Labor. Work in Progress

Key Points

- Health care jobs have long been in high demand
- Competition within health care as well as outside health care, particularly for low wage with low educational requirements workers
- Recessions generally have been “good” for health care labor

How do we address these problems?

Ongoing Efforts and Reimaging the Future

Tipping the Scale

Pool of qualified, willing, and able workers

Labor Supply

Employer Demand

Patient Need

Wages
Policies
Technology
Distribution
Available substitutes

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Contributors to Low Labor Supply Need to Be Addressed

Pool not available to work because:

- Directly affected by COVID illness → paid sick leave
- Childcare and other caregiving responsibilities → childcare/dependent benefits

Pool not willing to work:

- Burnout/moral distress/moral injury → address workplace culture
- Safety concerns → adequate PPE, vaccine education/availability

Lack of qualified applicants

- Training unavailable, slow and expensive to complete → invest in education/training programs
- Restrictive practice policies → relax training requirements, scope of practice regulations

Re-examine general scope of practice rules

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PERSPECTIVE

Patients Receive Flexible And Accessible Care When State Workforce Barriers Are Removed

Bianca K. Frogner

AFFILIATIONS

PUBLISHED: AUGUST 2022 Full Access https://doi.org/10.1377/hlthaff.2022.00759

Perspective

Ensuring and Sustaining a Pandemic Workforce

Erin P. Fraher, Ph.D., M.P.P., Patricia Pittman, Ph.D., Bianca K. Frogner, Ph.D., Joanne Spetz, Ph.D., Jean Moore, Dr.P.H., Angela J. Beck, Ph.D., M.P.H., David Armstrong, Ph.D., and Peter I. Buerhaus, Ph.D., R.N.

The NEW ENGLAND JOURNAL of MEDICINE

Article Figures/Media Metrics

4 References 4 Citing Articles

CURRENT EFFORTS TO fight the Covid-19 pandemic aim to slow viral spread and increase testing, protect health care workers from infection, and obtain ventilators and other equipment to prepare for a surge of critically ill

Audio Interview

Interview with Dr. Erin Fraher on opportunities for expanding health workforce capacity during the Covid-19 pandemic. (13:32)

Download

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Source: https://www.healthaffairs.org/do/10.1377/hblog20200624.983306/full/; https://www.nejm.org/doi/full/10.1056/NEJMp2006376

wa.sentinelnetwork.org

What is the Health Workforce Sentinel Network?

How is the Health Workforce Sentinel Network used?

The Sentinel Network is an initiative of Washington's Health Workforce Council, conducted collaboratively by Washington's Workforce Board and the University of Washington's Center for Health Workforce Studies. Funding to initiate the Sentinel Network came from the Healthier Washington initiative, with ongoing support from Governor Inslee's office and the Washington State Legislature.

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Workforce Training & Education Coordinating Board

Nursing homes & skilled nursing facilities

To what extent has your organization used recruitment incentives like sign-on bonuses during the pandemic? What recruitment strategies have been most successful?

Most respondents reported using bonuses, but with very limited success. Other strategies were often more effective.

We have implemented a $15K/$5K sign-on bonus for majority of staff. Implementing CMA and NAR to CNA career path. Working on an LPN apprenticeship program. Working with Next Step as a feeder pool for trained CNAs.

Sign on bonuses have shown to be inadequate. People would rather have higher hourly wages than a sign on bonus.

Small hospitals

What are your top workforce needs that could be alleviated by policy, regulatory, and/or payment changes?

- *More funding for the training programs.*
- *Better reimbursement rates.*

Primary care offices

Have you implemented new retention strategies during the pandemic? Please describe.

Many strategies were reported, with pay increases less commonly mentioned than we heard from other settings.

Improving our medical benefit offerings and reducing the cost of care to our employees and the practice

Staff care and team building and supports. Weekly compliments/prizes, workplace wellness.

Final thoughts

- Availability of health care workers has significantly fluctuated over the pandemic and has not yet returned to pre-pandemic levels.
  - Hard to predict long-term changes to health care delivery due to COVID that may influence demand for health care workers, but trajectory suggests that most sectors are on path to recovery.
  - Skilled nursing facilities are struggling and without recovery, ripple effects may be seen across health system.
- As economy recovers, we will see competition rise from other industries – health care sectors are also competing with each other. [1]
  - Particularly true for aides/assistants who have low barriers to entry.
  - Critical to focus on aides/assistants who provide much needed support to health care teams, but also need to consider support for physicians
- Strategies to retain health care workers exist and if deployed effectively, may be able to prevent severe shortage.
  - Raise wages, but also address disparities in wages. [2]
  - Yet wages often limited by insurance structure and not easy to pass on costs to consumers, but fortunately not the only solution.

1. Frogner, The Health Care Job Engine: Where Do They Come From and What Do They Say About Our Future? Medical Care Research and Review, 2018
2. Frogner BK, Schwartz M. Examining Wage Disparities By Race And Ethnicity Of Health Care Workers. Medical Care. Oct 2021 Volume 59 - Issue - p S471-S478

Thank you!

Contact me with questions at:

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Follow on Twitter @biancafrogner @uwchws

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Washington State Health Care Authority

INDEX: Draft legislative report

TAB 8

Washington State Health Care Authority

Report to the Legislature

Health Care Cost Transparency Board

Annual Report

Second Substitute House Bill 2457; Section 7(1); Section 7(2); Chapter 340; Laws of 2020

August 1, 2022

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Executive summary

House Bill (HB) 2457 (2020) established the Health Care Cost Transparency Board (board) under the Health Care Authority (HCA). The board is responsible for reducing Washington's health care cost growth by:

- Determining Washington's total health care expenditures.
- Identifying cost trends and cost drivers in the health care system.
- Setting a health care cost growth benchmark for health care providers and payers.
- Reporting annually to the Legislature on benchmark performance and cost drivers.

The board made significant progress in its work since the initial legislative report, including:

- Finalizing Washington's cost growth benchmark values for years 2022-2026.
- Completing the design of the benchmark data call and completion of the 2022 data call technical manual and submission template.
- Securing grant funding for the development of the cost driver analysis tool, with a comprehensive report expected in December 2022.
- Analyzing Washington hospital cost and profit through a contract with independent consultants.
- Issuing the first cost benchmark data call to 11 carriers and two state agencies, with a comprehensive report expected in early 2023.
- Doing initial project planning work for new legislative assignment on primary care measurement.
- Participating with other states engaged with the Peterson-Milbank Program on Sustainable Health Care Costs.

Background

Nationally, health care spending is growing at a faster pace than other measures of our economy, including gross domestic product and annual wages.[1] Washington is the sixth state in the nation to adopt a cost growth benchmark and be accepted into the Peterson Milbank Program for Sustainable Health Care Costs.

The board's primary objective is to set a target for future cost growth and collect Washington-specific data on total health care expenditures. The board will also report on growth trends in the state and by insurance market, and in future years by health insurance carrier and large provider. Benchmark data and the cost driver analysis will inform recommendations from the board on how to lower spending and curb health care cost growth.

In 2022, the board has established a solid foundation for future recommendations. They established the two required advisory committees to assist with its work. The Advisory Committee for Health Care Providers and Carriers provides expert advice from the provider and carrier perspective and supports the creation of the benchmark and cost driver data calls. The Advisory Committee on Data Issues provides expert advice on many aspects of the benchmark data call, and in the analysis of existing data sources to determine cost drivers.

The board also conducted an environmental review of health care costs in Washington and nationally. This included the programs intended to impact cost growth or reduce cost, including market consolidation oversight, price growth caps, and prescription drug pricing legislation. The board selected three priority areas for further analysis and review:

- Hospital costs
- Pharmacy costs
- Relationship of value-based payments compared to cost reduction

This year, the board initiated these reviews, starting with an expert and independent analysis of Washington hospital cost and profit.

The board selected OnPoint, the data vendor for the Washington State All Payer Claims Database (WA-APCD). OnPoint is creating an interactive analysis of cost drivers using WA-APCD aggregate data. The board has also determined areas of comparative analysis for OnPoint to include in the eventual reporting:

- Spend and trend by geography
- Trends in price and utilization
- Spend and trend by health condition
- Spend and trend by demographics

[1] Health care cost growth per capita between 2018-2019 was 4.1%. Centers for Medicare & Medicaid Services, National Health Expenditure Accounts. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical. GDP growth between 2018-2019 was 4.0%. U.S. Bureau of Labor Statistics, Average Hourly Earnings of All Employees, Total Private, Federal Reserve Bank of St. Louis. https://fred.stlouisfed.org/series/CES0500000003. Average wage growth between 2018-2019 was 3.3%. U.S. Bureau of Economic Analysis, Gross Domestic Product [GDP]. Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/GDP.

Achievements

The board achieved four significant milestones that support the board's goals of reducing health care cost growth and increasing price transparency. These include:

- Establishing Washington's health care cost growth benchmark
- Initiating the cost driver analysis, including establishing cost driver analysis focus areas
- Designing and issuing the first benchmark data call
- Understanding variation in all market sectors, including Medicaid, Medicare, and commercial (both self-and fully insured).

Washington's health care cost growth benchmark

The benchmark is a specific rate that carriers and providers' expenditure performance will be measured against. The goal of the benchmark is to lower health care cost growth and make health care more affordable. The board implemented a benchmark covering a five-year period, so that providers and policymakers can rely and plan on it.

Table 1: historical health care spending growth in states with cost growth benchmarks

	5-year average (2010-2014)	10-year average (2005-2014)	20-year average (1995-2014)	Cost growth benchmark
Massachusetts	3.0%	4.7%	5.1%	3.6% for 2013-2017 3.1% for 2018-2022
Delaware	5.1%	5.7%	5.6%	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023
Rhode Island	2.6%	3.7%	5.3%	3.2% for 2019-2022
Oregon	5.3%	5.9%	5.7%	3.4% for 2021-2025 3.0% for 2026-2030
Connecticut	2.4%	3.9%	4.8%	3.4% for 2021 3.2% for 2020 2.9% for 2023-2025
Washington	**4.1%**	**5.8%**	**6.7%**	**TBD**

In those states (listed above) that have implemented a benchmark, the rate of health care spending growth has reduced. Recognizing that a cost benchmark alone is not expected to result in market transformation, successful benchmarks in other states have been paired with other transparency, accountability, and quality measures.

Many similar efforts are already underway in Washington, including the transition to value-based payments and requiring increased levels of primary care investment. Two states, Massachusetts and Oregon, have also imposed consequences, including fines for failure to meet the benchmark without rational after a reasonable period.

The board reviewed how other states created their benchmarks and considered many different factors that might influence their choice. The board considered how current economic indicators, such as wages

and inflation, would impact the benchmark. In designing Washington's benchmark methodology, the board examined rates of health care inflation in other states with cost growth benchmarks, as well as those states' benchmark methodologies.

Research shows that the rate of health care inflation is higher in Washington compared to the majority of other states with a health care cost growth benchmark. (See Table 1[2]). Additionally, Washington's aggregate health care costs have outpaced the rate of inflation and wages, which means consumers spend more of their income on health expenses.

In September 2021, the board approved Washington's cost growth benchmark for years 2022-2026. This benchmark is based on a hybrid of median wage and potential gross state product (PGSP) at a 70:30 ratio.[3]

By 2026, Washington will have set a lower target compared to other states.[4]

Table 2: cost growth benchmark for Washington State

Years	Target
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

In March, the board reviewed impacts of inflation on spending trends in 2020 and 2019, and in June invited the Washington State Hospital Association to present on cost challenges, including the impact of COVID-19 and increasing labor costs.

While the board recognized the significant impacts of the pandemic, it also considered the impact of increasing cost to citizens, and the need for an aspirational cost growth target to support more affordable access. To date, the board—like all other benchmark states—decided to maintain the current benchmark target. The current benchmark target represents an important goal for consumers and the overall health of Washington State's economy.

Cost driver analysis (what is driving up the cost of claims?)

While the benchmark uses payer-collected aggregate data to identify trends, the cost driver analysis examines granular claims and encounter data to analyze cost. However, there is a relationship between the cost growth benchmark and the cost driver analysis. The benchmark identifies trends, while the cost

[2] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: National Health Expenditures by State of Residence, June 2017.

[3] Median wage was selected to link the measure to consumer affordability, and PGSP as a reflection of business cost and inflation.

[4] The Board also determined mechanisms for review, if necessary, assessing the benchmark and strategies for improving the reliability and validity of the measurement.

driver analysis helps determine the cost drivers of those trends. The cost driver analysis also helps identify opportunities for reducing cost growth and informs policy decisions.[5]

The board selected the WA-APCD as the primary data source for the cost driver analysis, after assessing the limitations and benefits of available data sources. The board examined other states' areas of focus, such as Connecticut, which focused on trends in price and utilization. This approach allowed Connecticut to decipher whether increasing costs were due to increased utilization or increased payment per unit of service (price).

In addition to utilization and price, the board focused on the importance of better understanding how Washington's geographic environment impacts cost and access to care. The board also received feedback from their Advisory Committee for Health Care Providers and Carriers on possible consequences of transparency and cost reduction efforts and recommended areas for monitoring.

The board decided on the following areas of focus for the analysis:

- Spend and trend by geography
- Trends in price and utilization
- Spend and trend by health condition
- Spend and trend by demographics
- Monitoring of potential unintended adverse consequences.

These metrics will best position the board to develop robust data and reporting on cost drivers, which will create a solid foundation for future areas of focus and recommendations to the Legislature.

Cost driver areas of focus

To prepare for the cost driver analysis in December 2022, research demonstrates that Washington's health care cost trends—particularly hospital and pharmacy costs—outpace other states and the national average (see Table 2).

The board identified hospital costs, pharmacy costs, and value-based payment (as a cost containment tool) as priority areas in their work to develop cost growth mitigation strategies, including those that reduce the total cost of care.

Tables 3 & 4: Washington's commercial health care spending compared to the U.S.

Per-person spending (2018)	
Washington	**U.S. average**
$5,772	$5,892

Cumulative growth (2014-2018)		
	Washington	**U.S. average**

[5] Phase 1 consists of standard analytic reports produced annually at the state and market levels. Phase 2 will contain supplemental in-depth analyses developed based on results from standard reports and Board discussion.

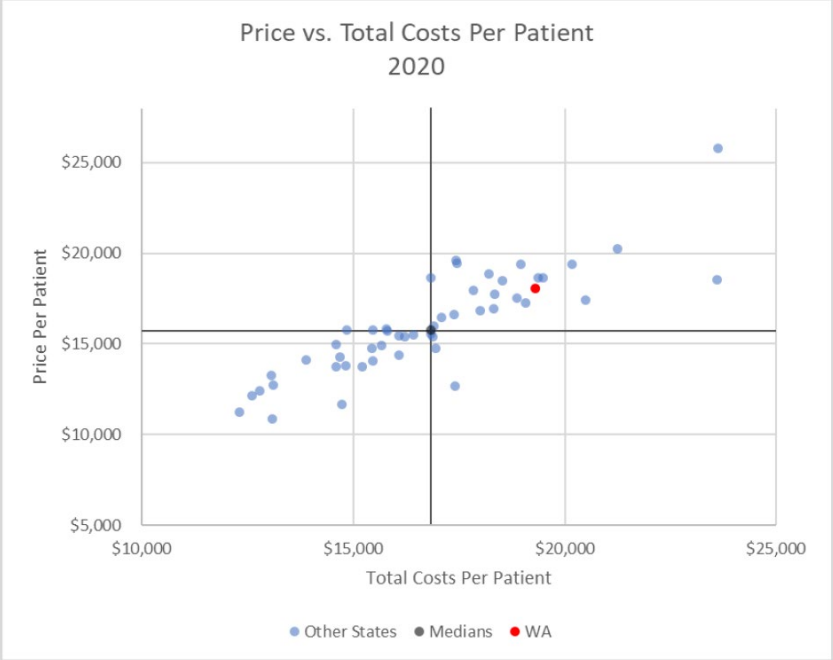
Spending	21.1%	18.4%
Utilization	4.4%	3.1%
Price	16.3%	15.0%

Hospital costs

In June 2022, Bartholomew-Nash & Associates presented Washington hospital costs, price, and profit analysis to the board.[6] Their research was based entirely on Medicare Cost Reports, submitted annually to the federal government by hospitals as a condition of participation in Medicare. The reports contain information about facilities and cost data, including utilization, charges by cost center in total and for Medicare, and financial statement data.

Table 3 shows that the price of services versus total costs of patient care in Washington hospitals is **above** the national average. Additionally, hospital-only operating expense per patient is much higher in Washington compared to the national average (see Table 4). The board will continue to review additional analysis and findings from this study as they continue to better understand the trends.

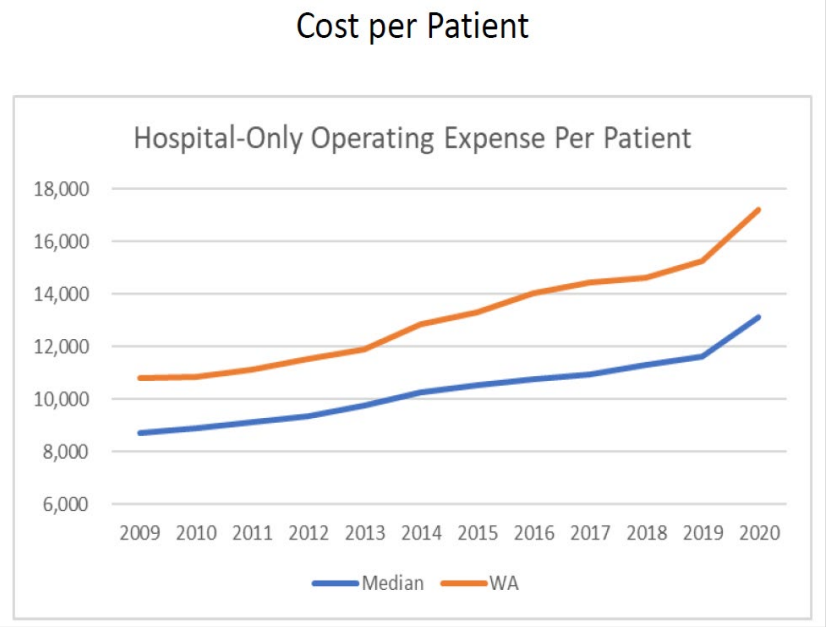
Table 5: price vs. total costs per patient



Washington Hospital Costs, Price, and Profit Analysis. John Bartholomew & Tom Nash Bartholomew-Nash & Associates. 2022.

[6] Analysis was conducted by the Colorado Department of Health Care Policy and Financing and presented by John Bartholomew, former Chief Financing Officer of Medicaid, Colorado.

Table 6: cost per patient



Washington Hospital Costs, Price, and Profit Analysis. John Bartholomew & Tom Nash Bartholomew-Nash & Associates. 2022.

Pharmacy costs

Another area of concern for cost growth is pharmacy costs. In March 2022, Onpoint presented the WA-APCD tool, which captured service category trends in the state for the commercially insured.[7]

Pharmacy costs for this population continue to increase in Washington. However, cost growth is not always driven by increased utilization. For instance, Table 4 illustrates a decrease in pharmacy utilization between 2018 and 2019, yet price and per member per month (PMPM) cost continued to increase.

Table 7: pharmacy percentage change from 2016

WA-APCD tool capturing service category trends in the state for the non-PEBB commercially insured.

Value-based payment as a cost containment tool

In examining areas that may impact cost growth, the board is looking at other efforts under way in Washington. HCA is a leader in value-based purchasing (VBP) to achieve better quality, experience, and equity in care, while at the same time reducing

[7] Washington All-Payer Claims Database (WA-APCD). Cost Trend Analysis. Non-Public Employee Benefits Board commercially insured.

the total costs of care.[8] VBP cost savings are not as easily quantifiable as many other changes to system cost (such as reduction of a Rx price, since VBP savings may show up as broader societal savings resulting from improved access, quality and overall public health. , The board is interested in exploring and researching with VBP staff to see if potential objective evidence can demonstrate whether and/or how VBP reduces costs.

Data call

Historically, Washington State's individual health care purchasers (employers or agencies) have kept their own health care spending data. It was necessary for the Health Care Cost Transparency Board to collect and centralize these separate spending data from all coverage markets (e.g., commercial, individual, employer-sponsored coverage).[9]

To obtain necessary data to calculate Washington's total health care expenditures and observe growth trends, HCA issued a benchmark data call on July 1, 2022. The board requested data from 11 insurance carriers and two state agencies (Department of Corrections and Labor & Industries). The data collected should include about 90 percent of aggregate health care spending in Washington. The board requested data for 2017-2019 to set a baseline for tracking spending growth in future years.

To prepare for the data call, the board decided that analysis of health care spending will, to the extent practical, be inclusive of all populations and all categories of spending. The board also determined how the total health cost expenditures for each qualified health care provider and payer would be measured against the benchmark. In March and April of this year, carriers participated in a survey about total cost of care contracts, which helped identify the providers who, in future years, will be the subject of public reporting on the benchmark.

The board also worked closely with its Advisory Committee on Data Issues on the data call technical manual.[10] The technical manual defines the following parameters of the data call:

- Which insurers are required to submit data
- Large provider entities for which insurers will submit spending data
- Data specifications[11]
- Data submission processes
- Data submission template

HCA anticipates that results from the first data call will be available to the board in January 2023. Data collected next year and beyond will be measured against the benchmark.

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[8] Paying for Health and Value. Health Care Authority's Long-term Value-based Purchasing Roadmap. 2022-2025 https://www.hca.wa.gov/assets/program/vbp-roadmap.pdf

[9] Coverage markets collected for the data call include Medicaid, Medicare, commercial (both self- and fully insured), Department of Corrections, and Labor & Industries.

[10] In developing the technical manual and at the request of the Advisory Committee on Data Issues, the Board conducted a survey about truncation in Washington to understand risk adjustment.

[11] Data specifications include population inclusion/exclusion criteria, categories of claims and non-claims spending (including code-level definition for primary care) to report, adjustments needed (including high-cost outlier truncation and estimates for partial claims data), and attribution methodology.

Next steps

Primary care report

Senate Bill (SB) 5589 requires the board to submit a preliminary report on primary care by December 1, 2022. HCA will include this report with the Health Care Cost Transparency Board Annual Report next August (2023).

The primary care report will include:

- The definition of primary care
- How to achieve Washington's target to increase primary care expenditures to 12 percent of total health care expenditures
- How to effectively measure primary care, including identifying any barriers to access and use of data, and how to overcome them

The board began the planning work for this primary care report, including a future discussion with the Advisory Committee for Health Carriers and Providers. The board is also set to approve a new ad-hoc committee devoted to forming recommendations in support of this work.

HCA and the board are currently identifying these new committee members and scheduling meetings where existing advisory committees can provide recommendations.

Comprehensive data deliverables

The board expects to review reports from the cost driver analysis in December 2022 and results from the benchmark data call in March 2023. These reports will be updated annually and will provide information on cost trend and performance at the state, market, carrier, and provider levels. The initial cost driver analysis will help the board identify additional specific areas of focus beyond larger market segments, that are driving cost, such as particular conditions or treatments. The cost driver analysis will also support the development of cost mitigation strategies and other recommendations by the board.

Now that the board has completed a full year of developmental work, the work will continue to mature and evolve. This includes:

- Refining the planning processes of the two advisory committees.
- Continuing to engage with the stakeholders who are interested in the board's work. This includes partnerships with the Association of Washington Healthcare Plans (AWHP), Washington State Hospital Association (WSHA), Washington State Medical Association (WSMA), and consumers and advocacy groups.
- Synthesizing additional data sources (e.g., public health data, insurance data, and other public sources) to provide better and clearer insight into health care spending.

These activities will support more robust reporting and effective recommendations for the Legislature. If we are serious about controlling rising health cost in our state, we must understand it. The work of the board will provide a data-based and common understanding, preparing a solid foundation for the work of reducing future cost.

Additional Information

For additional information on the board and committees, including membership rosters, meeting materials and schedules, and the benchmark data call specifications, visit the website.

Washington State Health Care Authority

INDEX: Article – What is driving health care spending up?

TAB 9

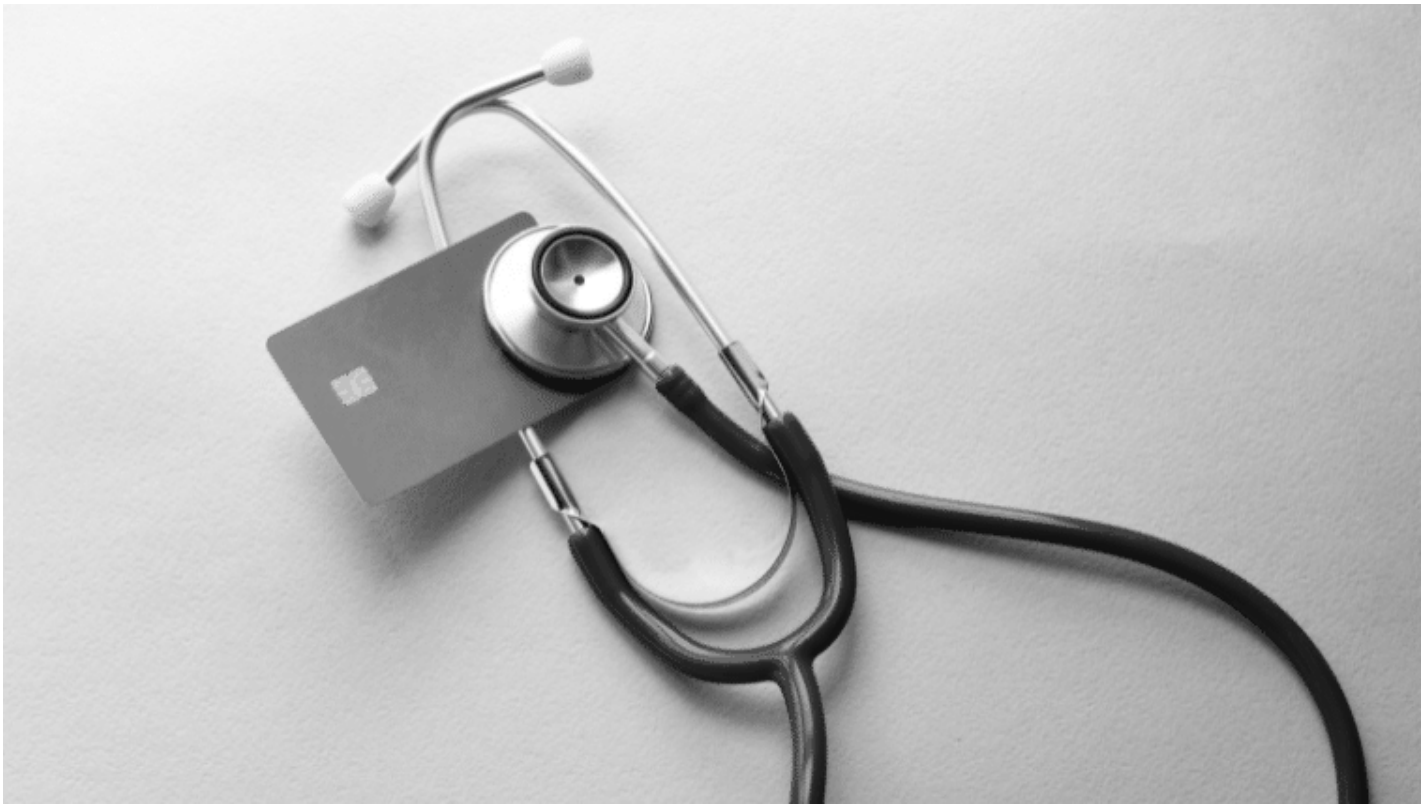
HEALTH AFFAIRS FOREFRONT | CONSIDERING HEALTH SPENDING

RELATED TOPICS:
COST GROWTH | COSTS AND SPENDING | MARKETS | MEDICAID | MEDICARE | PER CAPITA SPENDING | PAYMENT | COMPUTED TOMOGRAPHY

What Is Driving Health Care Spending Upward In States With Cost Growth Targets?

Michael Bailit

AUGUST 9, 2022 **DOI:** 10.1377/forefront.20220805.244579



In 2021, the Peterson Center on Health Care and the Milbank Memorial Fund partnered to support state efforts to slow health care spending growth. Six states participating in the Peterson-Milbank Program for Sustainable Health Care Costs <https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/> have established per capita cost growth targets as a tool to enhance transparency and encourage reductions in the rate of health care spending growth across all payers and providers.

The six states (Connecticut, New Jersey, Nevada, Oregon, Rhode Island and Washington) are complementing their cost growth targets and public reporting of performance relative

to the target with a series of supporting activities. These include: in-depth analysis of claim data to provide greater insight into spending patterns and cost growth drivers; identification of opportunities to target action that will help achieve the cost growth target; and adoption and implementation of cost growth mitigation strategies.

Some of the states have started publicly reporting per capita spending growth relative to their targets, including a breakdown of spending growth by service category within different markets (i.e., commercial, Medicaid, Medicare) (Exhibit 1). In addition, the states have been designing and implementing standard analyses using claims databases to gain greater insight.

Exhibit 1. Four Peterson-Milbank States have publicly reported cost growth targets and/or cost growth driver analysis

State	Reported Cost Growth Target Performance?	Reported Cost Growth Driver Analysis?
CT	Yes (2018-19)	Yes
NV	No	Yes
RI	Yes (2017-20)	Yes
WA	No	Yes

Notes: All states besides Nevada used All-Payer Claims Databases to analyze cost growth drivers. Nevada used Medicaid and State Employee Health Plan data. Oregon published a cost growth driver analysis and was preparing to report baseline cost growth target performance as of July 2022. New Jersey was planning to take both actions in early 2023.

Source: Authors' analysis based on public presentations published by Connecticut <https://portal.ct.gov/-/media/OHS/HBI/October-25-2021/Connecticut-HCBI-

Steering-Committee-10-25-2021.pdf> (2 <https://portal.ct.gov/-/media/OHS/HBI/March-28-2022/Steering-Committee-meeting-5-2022-328.pdf>), Nevada <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/Nevada_Medicaid_Cost_Drivers_Analysis_2022_for_PPC-ADA.pdf> (2 <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/PEBP_Cost_Driver_Analysis_2022-revised.pdf>), Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> and Washington <https://public.tableau.com/app/profile/onpointhealthdata/viz/WashingtonStateCommercialTrendsinCost2016-2019/TotalTrends?publish=yes> , and an unpublished analysis shared with the author by Rhode Island.

While states are at varying points in the implementation of these analytic activities, there is now enough publicly reported data to identify systemic cost drivers across four of the six states. Overall cost growth in these states is driven largely by growth in the commercial market, as opposed to Medicare and Medicaid. Across both public and private markets, hospital and pharmacy care are areas of highest growth. Price appears to be the primary cost driver in the commercial market.

What Have These State Analyses Revealed?

Several themes have emerged as states have begun to publish their aggregate health care spending analyses. These findings are consistent with national trends reported elsewhere. There is some variation across states, which suggests that cost mitigation strategies need to be customized to individual state dynamics.

Health Care Spending Growth Has Been Highest In The Commercial Markets

While there is variation from state to state, per capita spending growth in the commercial market has generally been higher than in the Medicaid and Medicare markets (Exhibit 2).

Exhibit 2. Annual per capita health care cost growth trend by Commercial, Medicaid and Medicare markets, CT, NV and RI, 2018-19

State	Commercial Trend	Medicaid Trend	Medicare Trend
Connecticut	6.1%	-0.9%[a]	2.2%
Nevada[b]	9.2%[c]	9.2%	N/A
Rhode Island	4.7%	4.1%	1.3%

Notes: [a] Connecticut's negative trend for Medicaid in 2019 was driven by a reduction in long-term care spending growth. With long-term care spending removed, Connecticut's Medicaid trend was 2.2%.

[b] While commercial and Medicaid trend were equal in Nevada were equal in 2019, between 2017 and 2020 Medicaid trend was approximately three percentage points lower than trend in the public employee health plan.

[C] Data are for the public employee health plan only.

Source: Authors' analysis based on public presentations published by Connecticut <https://portal.ct.gov/-/media/OHS/HBI/January-24-2022/Steering-Committee-meeting-4-2021-124.pdf> , Nevada <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/Nevada_Medicaid_Cost_Drivers_Analysis_2022_for_PPC-ADA.pdf> (2 <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/PEBP_Cost_Driver_Analysis_2022-revised.pdf>), and Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> .

This pattern of commercial spending growth exceeding public payer spending growth is consistent with national trends of the past 12 years. Nationally <https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/> , between 2008 and 2020, per capita commercial spending grew 46.8 percent, compared to 28.2 percent and 21.2 percent for Medicare and Medicaid, respectively, despite a decrease in commercial growth in 2020. The Centers for Medicare and Medicaid Services project that this pattern will continue.

For two of the three states, the observed rates of commercial health care spending growth in 2019 far exceeded wage growth, indicating that health care spending was displacing wages for workers (Exhibit 3).

Exhibit 3. Median wage growth and commercial spending growth, CT, NV and RI, 2018-19

State	2018-19 Wage Growth	Commercial Trend
Connecticut	3.4%	6.1%
Nevada[a]	2.4%	9.2%
Rhode Island	5.1%	4.7%

Notes: [a] Data are for the public employee health plan only.

Source: Author's analysis of public presentations and reports published by Connecticut <https://portal.ct.gov/-/media/OHS/HBI/January-24-2022/Steering-Committee-meeting-4-2021-124.pdf> , Nevada <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/PEBP_Cost_Driver_Analysis_2022-revised.pdf> , and Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> , and of per capita wage growth in each state as published by the Bureau of Labor Statistics Occupational Employment and Wage Statistics <https://www.bls.gov/oes/tables.htm> for 2018 and 2019.

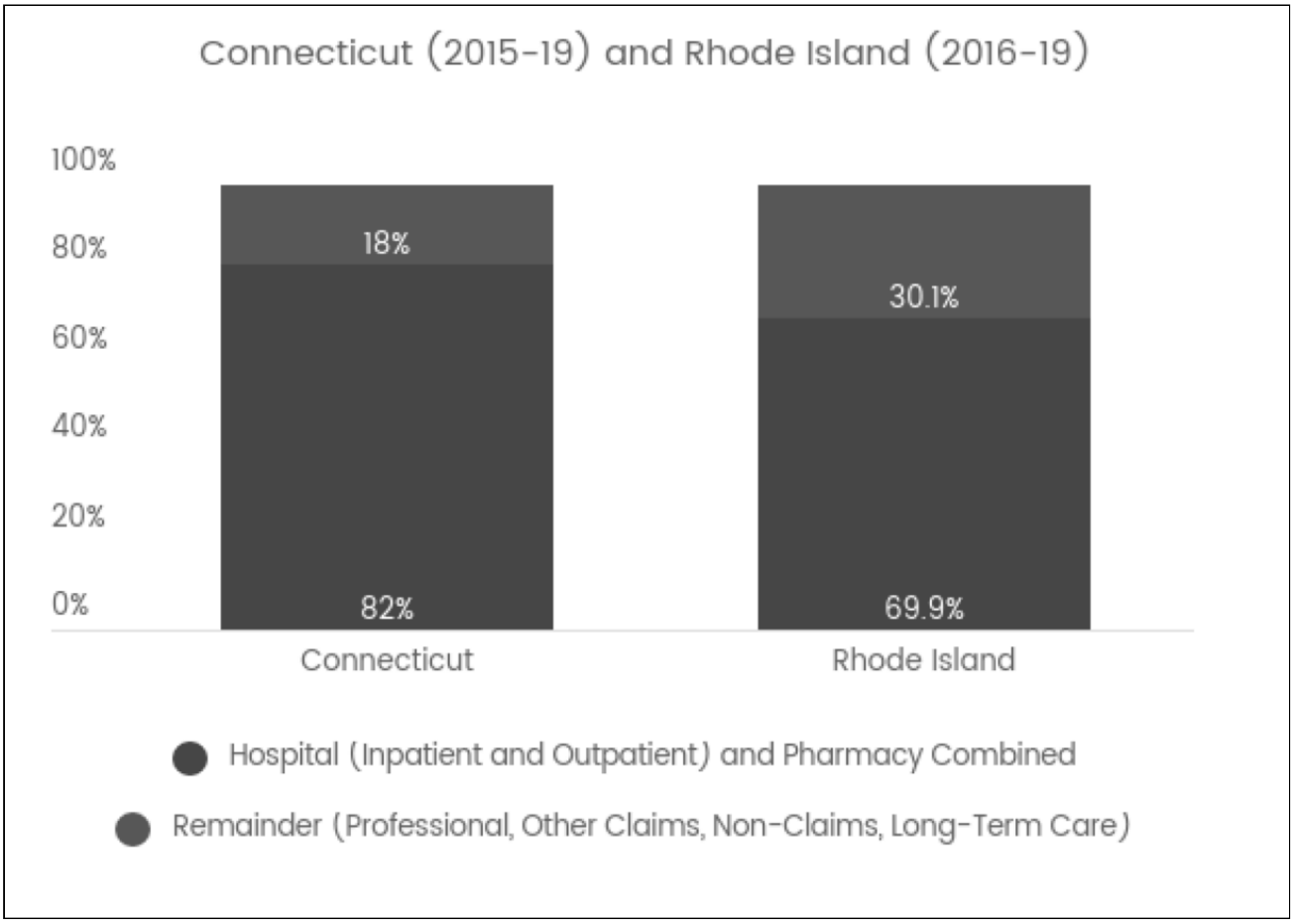
Takeaway message: While high per capita spending growth is a concern in any market, limiting spending growth in the commercial market warrants special state attention.

Hospital Spending And Pharmacy Have Been Major Drivers Of Spending Growth

This pattern has appeared across commercial, Medicaid, and Medicare markets, although there is annual variation by state, and within states by market. Evidence of this pattern appears in analysis performed by Connecticut, Nevada and Rhode Island.

For example, hospital spending and retail pharmacy have been the largest drivers of trend in both Connecticut <https://portal.ct.gov/-/media/OHS/HBI/March-28-2022/Steering-Committee-meeting-5-2022-328.pdf> and Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> (Exhibit 4), although the role of inpatient versus outpatient hospital spending has varied between the states. Connecticut hospital outpatient and pharmacy trends each averaged over 7 percent in the commercial market between 2015 and 2019 (and inpatient hospital trend was only slightly lower, at 6 percent). Rhode Island hospital outpatient trend averaged 5 percent, and pharmacy trend averaged over 6 percent between 2017 and 2019. Retail pharmacy was the only service category with spending growth in Rhode Island in 2020.

Exhibit 4. Hospital and Retail Pharmacy Contribution to Spending Growth in the Commercial Market, CT (2015-19) and RI (2016-19)



Source: Author's analysis of a public presentation published by Connecticut <https://portal.ct.gov/-/media/OHS/HBI/March-28-2022/Steering-Committee-meeting-5-2022-328.pdf> and an unpublished analysis shared with the author by Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> .

Between 2017 and 2020, Nevada's average annual rate of per capita growth for retail pharmacy in its state employee health plan was 16 percent. The corresponding figure was 15 percent for Medicaid. Hospital spending patterns were different for these market segments. Inpatient per capita spending grew 14 percent per year between 2017 and 2019 in Nevada's state employee health plan <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/PEBP_Cost_Driver_Analysis_2022-revised.pdf> while hospital outpatient spending grew 6 percent per year for Medicaid <https://ppc.nv.gov/uploadedFiles/ppcnvgov/content/Meetings/2022/Nevada_Medicaid_Cost_Drivers_Analysis_2022_for_PPC-ADA.pdf> .

Hospital outpatient spending and retail pharmacy were also the largest drivers of trend for the commercial market in Washington

<https://public.tableau.com/app/profile/onpointhealthdata/viz/WashingtonStateCommercialTrendsinCost2016-2019/TotalTrends?publish=yes> between 2016 and 2019.

Takeaway message: In at least some states, cost growth mitigation work—across markets—should focus on hospital and pharmacy services, as these sectors account for a disproportionate percentage of total spending growth.

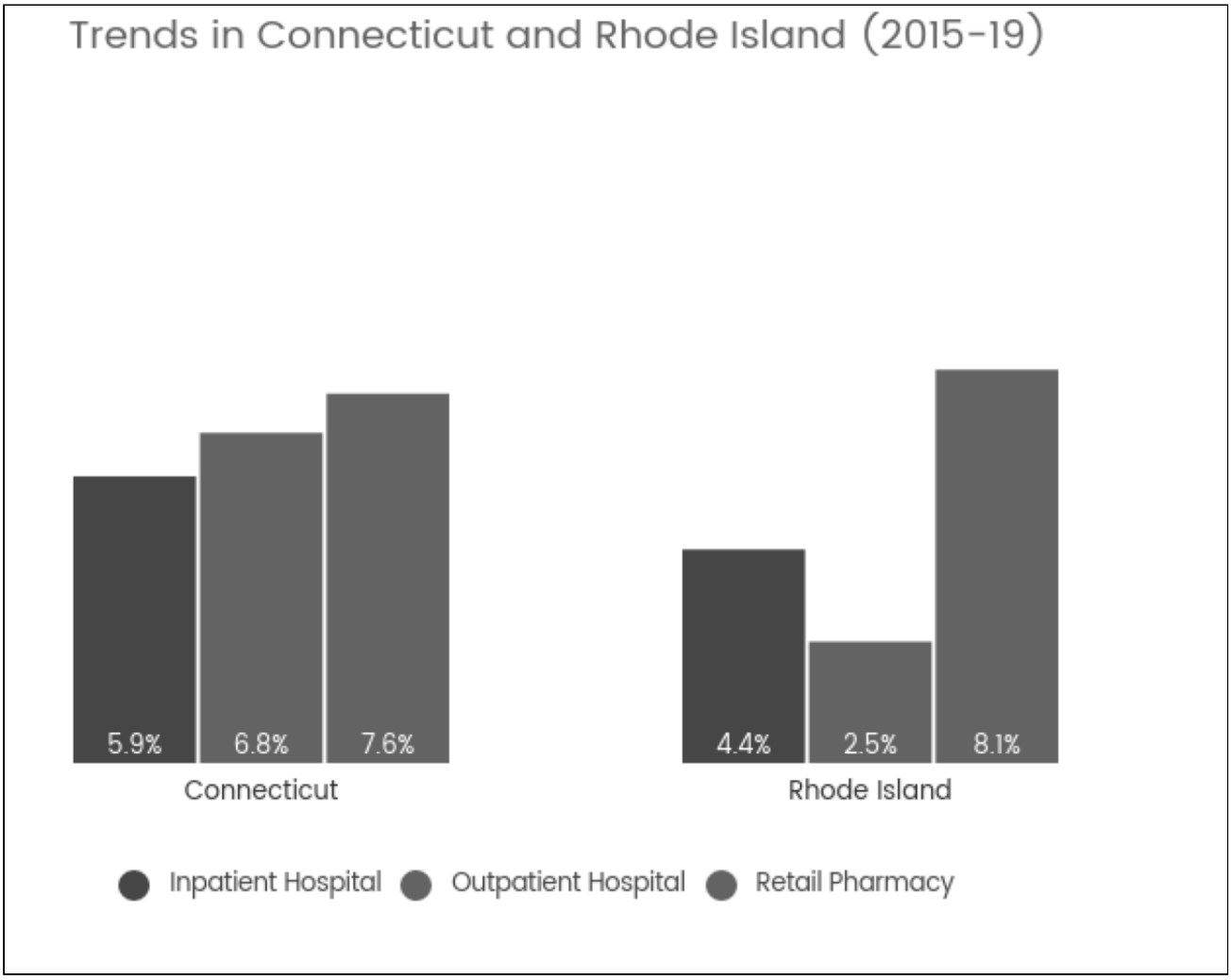
Price Increases—Not Increased Service Use—Have Generally Been The Cause Of High Rates Of Hospital And Pharmacy Spending Growth

Price increases in most years have been highest in the commercial market. While there is some variation across states, a national analysis of commercial claim data by the Health Care Cost Institute <https://healthcostinstitute.org/images/pdfs/HCCI_2019_Health_Care_Cost_and_Utilization_Report.pdf> found that from 2015 to 2019, approximately two-thirds of the increase in spending growth was due to increases in service prices. In addition, a 2022 Congressional Budget Office report <https://www.cbo.gov/publication/57422> stated, "The main reason for the growth of per-person spending by commercial insurers—and for the difference from the growth of per-person spending by Medicare FFS—has been rapid increases in the prices that commercial insurers pay for hospitals' and physicians' services."

Analysis by Connecticut has revealed that commercial prices grew fastest between 2015 and 2019 for those hospitals that primarily serve commercially insured patients. This indicates that hospital market power and associated price discrimination have driven prices upward, rather than hospitals responding to lower levels of payment from public payers ("cost shifting").

Exhibit 5 demonstrates the annual rates of growth in payment per service in Connecticut and Rhode Island for hospital and retail pharmacy services, with inpatient and outpatient payment trends distinguished. Retail pharmacy demonstrated the highest rate of growth in both states. Hospital payments per unit of service were higher in Connecticut than Rhode Island. This difference is likely influenced by Rhode Island's regulatory cap on commercial insurer annual increases to hospital rates.

Exhibit 5. Annual commercial trend in hospital and retail pharmacy payment per unit of service (price) CT (2015-19) and RI (2016-19)



Source: Author's analysis of a public presentation published by Connecticut <https://portal.ct.gov/-/media/OHS/HBI/March-28-2022/Steering-Committee-meeting-5-2022-328.pdf> and an unpublished analysis shared with the author by Rhode Island <https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-04/public%20forum%202022%204-27%20cost%20trends%20results%20for%202020%20%2B%20final.pdf> .

Takeaway message: Any state efforts to mitigate commercial spending growth must directly or indirectly address price growth.

What Does All This Portend For The Future?

While the past two years have demonstrated how unpredictable the future can be, the underlying dynamics that have propelled past health care spending growth, and specifically price growth, remain intact. Market consolidation appears likely to only increase, creating upward pressure on prices, especially in the commercial market. In addition, limited market competition and a lack of regulatory levers should mean

continued high growth in pharmacy prices. Finally, rising labor and supply input costs during 2021 and 2022 are likely to result in elevated trend for at least the next two years.

To navigate these future dynamics, states with cost growth targets can utilize available data in new ways to understand whether the problem (cost growth) is worsening or improving and why. To start, states can consider a range of strategies to address rising prices, although those strategies will differ for hospital <https://www.commonwealthfund.org/publications/issue-briefs/2022/feb/state-strategies-slowing-health-care-cost-growth-commercial-market> and pharmacy <https://www.nashp.org/state-strategies-to-lower-drug-prices-new-legislative-and-medicaid-models/> prices. Only concerted and persistent efforts to address these cost drivers will prevent health care spending growth from being an ever-increasing source of financial challenge for millions of Americans <https://www.kff.org/health-costs/report/kff-health-care-debt-survey/> .

Author's Note

Michael Bailit is the president of Bailit Health, a health policy consulting firm. He and his colleagues currently provide technical assistance to the six states participating in the Peterson-Milbank Program for Sustainable Health Care Costs.

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"What Is Driving Health Care Spending Upward In States With Cost Growth Targets?", Health Affairs Forefront, August 9, 2022.

DOI: 10.1377/forefront.20220805.244579

Washington State Health Care Authority

INDEX: Article – Varied spending growth across US states (UW IHME article)

TAB 10

RESEARCH ARTICLE | COSTS & SPENDING

HEALTH AFFAIRS > VOL. 41, NO. 8: SPENDING, PAYMENT & MORE

Varied Health Spending Growth Across US States Was Associated With Incomes, Price Levels, And Medicaid Expansion, 2000–19

Emily K. Johnson, Matthew A. Wojtesta, Sawyer W. Crosby, Herbert C. Duber, Eunice Jun, Haley Lescinsky, Phong Nguyen, Maitreyi Sahu, Azalea Thomson, … See all authors

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View Article

Abstract

Little is known about health care spending variation across the US for recent years. To estimate health spending by state and payer, we combined data from the government's State Health Expenditure Accounts, which have estimates through 2014, with other primary data on spending. In 2019 state-specific per person spending ranged from $7,250 to $14,500. After adjustment for inflation, annualized per person spending growth for each state ranged from 1.0 percent in Washington, D.C., to 4.2 percent in South Dakota between 2013 and 2019. The factors that explained the most variation across states were incomes (25.3 percent) and consumer prices (21.7 percent). Medicaid expansion was associated with increases in total spending per person, although the median of spending in expansion states showed slower growth in out-of-pocket spending than the median in nonexpansion states. Contemporary estimates of state health spending are valuable for tracking divergent expenditure trajectories in the US and assessing the associated factors.

TOPICS

COSTS AND SPENDING | MEDICAID | STATE HEALTH EXPENDITURE ACCOUNTS | COST GROWTH | ACCESS TO CARE | MEDICARE | MEDICARE ADVANTAGE | POPULATIONS | PRIVATE HEALTH INSURANCE | ACCESS AND USE

Health care spending in the US, which has the highest health spending per person in the world, continues to increase rapidly. After inflation is accounted for, national health spending per person in the US doubled between 2000 and 2020 and increased as a share of the economy from 13.3 percent to 19.7 percent. In 2020 total health spending reached $4.1 trillion, or about $12,530 per person.[1,2] Health spending is expected to continue to grow, with total spending estimated to reach $6.8 trillion by 2030—and more by 2050.[3,4]

In addition to growing quickly over time, health spending per person varies substantially across the US. In 2014 (the last year with comprehensive estimates), spending per person ranged from $5,982 in Utah to $11,064 in Alaska.[5] From 2005 to 2014, annualized growth rates ranged from 2.8 percent in Tennessee to 5.3 percent in North Dakota (before adjustment for inflation).[6] These disparate trajectories are the consequence of state-specific factors that affect the demand for care, including demographics and the

underlying health of the population, as well as differences in how health services are provided, financed, and regulated in each state. Factors such as personal income, the share of the population enrolled in Medicare or Medicaid, and health care provider supply have also been linked to differences in health care spending across the US.[5]

In recent years policy changes have occurred at both the federal and state levels that have affected states differently. Many of the changes mandated by the Affordable Care Act (ACA) in 2010 were phased in over time, with components of the law, including Medicaid expansion, taking effect in 2014 or later.[7,8] Variation in the expansion of Medicaid has affected health spending substantially, with smaller increases in the size of the insured population and the federal transfer payments in states that declined to expand Medicaid.[9] Similarly, state-specific characteristics such as the lifting of individual mandate penalties led to other differences in how the ACA affected consumers' health care behavior.[10]

Beyond the ACA, other changes in health policy are likely to affect health care spending differently across states. Variation in compensation rates, differing approaches to dental health coverage, and varying state legislative approaches to matters of immigrant health care are examples of changes that likely affect health spending in some, but not all, states.[11–15]

Although the Centers for Medicare and Medicaid Services (CMS) provides an official accounting of health spending at the national level through 2020 in the annually updated National Health Expenditure Accounts, the State Health Expenditure Accounts extend to only 2014, which is not current enough to enable analysis of the effects of Medicaid expansion and other recent health policy changes.[6] The Bureau of Economic Analysis produces state-level health expenditure reports through 2020, but they are incompatible with the more-often-relied-upon National Health Expenditure Accounts and State Health Expenditure Accounts and are not disaggregated by payer or type of care.[16] Our work seeks to fill this gap by generating consistent state-specific spending estimates for the period 2015–19 by payer and type of service, and it sheds light on changes in health spending during a period with substantial changes in health policy at the state and federal levels.

Study Data And Methods

State Spending Forecasts

This analysis estimated total health spending and spending by payer and type of service for each US state (and Washington, D.C., hereafter referred to as a state) for the period

2015–19, using, when available, the primary data used in the State Health Expenditure Accounts to construct spending estimates for 1991–2014. Because not all primary data used in the construction of these accounts were available to our team, we used regression methods to predict spending during 2015–19, with the available primary data as our models' covariates. These data sources (described more fully in section 1.1 of the online appendix)[17] include Medicare fee-for-service claims spending reports and Medicaid total spending reported to CMS, total hospital spending reported by the American Hospital Association, and data from the Census Bureau, among others. Instead of choosing a model specification and set of covariates a priori, we tested more than 380,000 unique iterations of the model. These models included all combinations of available input data, a wide range of model specifications, and distinct ways of aggregating the estimates to ensure that they match the reported 2015–19 national estimates. The "best" model was identified by minimizing out-of-sample root-mean-square error, which ensured that model selection was robust to overfitting. Model uncertainty was estimated using bootstrapping methods to fit models with 1,000 random samples of states. The advantage to this method is that it is relatively simple, is based on linear regressions, and builds primarily from the same building blocks used to construct the State Health Expenditure Accounts. Before modeling spending, we adjusted all estimates for economy-wide national inflation rates to 2020 US dollars, using deflators from the Bureau of Labor Statistics, to ensure comparability across time.[18]

Similar to the State Health Expenditure Accounts, this analysis estimated total state spending as well as payer-specific and type of service–specific spending. The State Health Expenditure Accounts report spending by Medicare (including Medicare Advantage), Medicaid, and private insurers. This analysis used the same payer categories, along with a remainder category that accounted for out-of-pocket spending combined with other public insurers, such as Veterans Affairs and the Indian Health Service. For type of service, this analysis matched the hospital, physician/clinic, nursing facility, home health, dental, pharmaceutical, and other professional spending categories defined and reported in the State Health Expenditure Accounts. The remainder of total spending from these types of services, including durable medical equipment spending, is categorized as "other" spending in this analysis.

Spending Variation Analyses

After total, payer-specific, and type of care–specific health spending were estimated for 2015–19, we completed several analyses to validate the estimates and evaluate spending trends.

First, to validate our spending estimates, we compared them against health services supply and utilization measures, which were observed and not used for our projections. Our hypothesis is that the supply and use of health services should be directly correlated with health spending. These results are in appendix table e6.[17]

Second, to assess variation in spending across time and state, we used age standardization, price adjustment, linear regression, and decomposition methods to assess which factors explained the largest amount of spending variation. Age standardization was completed on total and payer-specific spending estimates, using indirect methods and data from the Institute for Health Metrics and Evaluation's Disease Expenditure Project, and National Health Expenditure Accounts; regional economywide price parity indices were extracted from Bureau of Economic Analysis data and combined with year-to-year inflation factors from the Bureau of Labor Statistics.[2,18–20] Linear regression controlled for time, household income, population density, age-standardized smoking prevalence, and age-standardized physical activity. Shapley decomposition was used to assess how much variation could be attributed to each factor (see appendix figure e5).[17] To illustrate the role that these factors played in explaining disparate spending levels, we estimated per person health spending, setting these factors to the national level for all states. The remaining variation in spending levels reflects variation that cannot be explained by these key factors and highlights differences in the way health care is provided and used.

Third, to assess the impacts of expanding Medicaid eligibility on total health spending and out-of-pocket spending, we used linear regression methods to test whether extending Medicaid coverage was associated with health spending changes. Medicaid expansion and changes to income eligibility thresholds for children, parents, and other adults, as well as the proportion of Medicaid enrollees on managed care, were tested separately to identify which parts of Medicaid expansion were most associated with changes in total spending.

Additional detail on the methodology for all steps of the analysis and equations for the spending forecasts and policy analysis regression are in supplemental methods in the appendix.[16]

Limitations

Although these methods are a promising means of estimating state spending on health in the US for 2015–19, there remain some important limitations. First, this analysis uses many, but not all, of the data that were used in the CMS State Health Expenditure Accounts. In particular, data tracking spending on Medicare supplemental insurance

(Medigap) and data tracking Medicare Advantage spending more precisely were not readily available, but inclusion of these sources would likely improve fit for the payer models. Similar to the State Health Expenditure Accounts, this analysis missed some categories of spending that were relevant from a policy perspective, such as federal subsidies to states for Medicaid spending, administrative costs associated with running insurance companies, and public health activities. This analysis also assumed (similar to the State Health Expenditure Accounts) that there was no uncertainty coming from the input data. Instead, our estimates of uncertainty reflected uncertainty from the modeling framework. Importantly, modeled estimates should never replace official estimates of spending. The estimates produced in this research depend on prior official accounts from the State Health Expenditure Accounts for model training and selection and can be used alongside other official accounting data for 2015–19 when State Health Expenditure Accounts data are unavailable. Furthermore, although estimates of state health spending for more recent years would provide useful insight into the effects of the COVID-19 pandemic on health spending, pandemic estimates of spending were out of scope of this analysis, as we believed that the expected shift in spending would not be adequately captured by our models.

Some additional limitations relate to the regression analysis of spending estimates. First, because the regression models on supply, utilization, and Medicaid policy variables were modeled independently to avoid multicollinearity and reduced sample size, assessing how these associations are related to each other was not possible. Second, this project investigated only conditional associations, not causal relationships. Further research into the causality of spending growth would be a valuable extension of this analysis.

Study Results

For this research, 368,640 models predicting total health spending for each state were considered. The best model for total spending estimated year-over-year changes and used primary data from Medicaid CMS-64 administrative reports, Medicare spending estimates, the American Hospital Association, the Bureau of Economic Analysis, and the Medical Expenditure Panel Survey (MEPS). Out-of-sample validation showed that for five years of prediction, mean absolute error of health spending per person (which reflects the average amount that our modeled estimates deviated from observed estimates when applied to historic data) was $73 (see appendix table e4).[17] Key covariates in the best payer-specific models included Medicare fee-for-service spending and data from the MEPS–Insurance Component reporting on premiums. For Medicare, Medicaid, private insurance, and out-of-pocket spending, the mean absolute errors were $53, $70, $126, and $135, respectively. For estimating the fraction of spending for each type of service,

main covariates included data from the Economic Census, the Census of Annual Retail Trade, and the American Hospital Association. The mean absolute error for five-year out-of-sample predictions was less than or equal to $72 for each type of service (see appendix table e4).[17] Validation regressions showed that there was a significant (all p values <0.002) relationship between health care spending and supply and use of hospitals and hospital beds, admission rate per capita, and inpatient days per capita (see appendix table e6).[17] These data were collected independently and highlight the expected relationships between health spending and the health system infrastructure, workforce, and use of services.

In 2019 the state with the lowest modeled spending per person spent half as much per person as the state with the highest spending. Moreover, variation in spending across states was much higher in recent years than in the early 2000s (see appendix figure e10).[17] Estimates show that spending per person ranged from $7,250 (95% uncertainty interval: 7,190–7,320) in Utah to $14,500 (95% UI: $14,300–$14,710) in Alaska (see exhibit 1; 95% uncertainty intervals not shown). Annualized growth rates in total spending per person from 2013 to 2019 ranged from 1.0 percent (95% UI: 0.8–1.2) in Washington, D.C., to 4.2 percent (95% UI: 4.0–4.4) in South Dakota after adjusting for economywide inflation but without controlling for changes in age patterns, prices, or other factors discussed below (see appendix table e9d).[17] Appendix table e9a contains a table of all projected state estimates of total spending, and appendix figure e10 displays change over time of a measure of variation in spending across states.[17]

Exhibit 1 State-level health spending per person in 2019 and annualized rate of change of spending per perso 2019, United States

	2019 spending per person ($)		Annualized rate of change per person, 2013–19 (%)			2019 spending per person ($)		Annuali change 2013–1
State	Spending	Std. spending	Spending	Std. spending	State	Spending	Std. spending	Spendir
AK	14,500	14,820	3.6	3.4	WA	9,900	9,660	2.7
DC	14,080	11,840	1.0	0.1	KY	9,900	11,290	2.7
NY	12,480	11,100	3.1	2.3	CA	9,900	10,410	3.4

	2019 spending per person ($)		Annualized rate of change per person, 2013–19 (%)			2019 spending per person ($)		Annuali change 2013–1
State	Spending	Std. spending	Spending	Std. spending	State	Spending	Std. spending	Spendir
SD	12,360	13,150	4.2	4.5	FL	9,850	10,230	2.4
WV	12,310	12,930	3.5	3.5	LA	9,790	11,100	2.7
ND	12,260	11,900	2.1	1.5	MI	9,740	10,530	2.1
MA	12,220	10,350	1.2	0.3	IA	9,600	10,300	1.6
DE	12,200	12,080	2.0	2.3	AR	9,500	10,940	3.1
VT	11,740	10,270	1.2	0.4	OK	9,360	10,350	2.2
NH	11,700	9,520	2.5	1.8	VA	9,350	9,440	2.4
CT	11,570	9,320	1.5	1.9	KS	9,340	10,440	2.2
ME	11,540	10,700	2.2	1.8	MS	9,190	11,010	1.9
PA	11,300	11,020	2.3	2.0	NC	9,100	9,840	2.6
NJ	11,020	9,930	2.8	2.5	HI	9,100	9,360	2.7
RI	10,930	10,840	1.3	0.6	NM	8,900	11,500	2.7
MN	10,830	10,770	2.3	1.6	SC	8,740	9,640	2.0
WI	10,440	11,320	1.8	1.5	TN	8,710	8,950	1.8
NE	10,440	11,360	2.5	2.3	AL	8,650	9,720	1.9
OH	10,410	11,320	2.1	1.6	TX	8,590	10,300	2.4

	2019 spending per person ($)		Annualized rate of change per person, 2013–19 (%)			2019 spending per person ($)		Annuali change 2013–1
State	Spending	Std. spending	Spending	Std. spending	State	Spending	Std. spending	Spendir
MT	10,350	11,200	2.7	2.2	CO	8,580	9,060	3.0
IN	10,350	11,670	2.6	2.1	ID	8,530	11,190	2.9
MD	10,280	9,690	1.9	1.8	GA	8,340	9,830	3.0
WY	10,220	10,070	2.2	2.2	NV	8,270	10,100	3.0
OR	10,110	11,030	3.2	2.0	AZ	8,220	10,310	3.1
MO	9,990	11,200	2.3	2.3	UT	7,250	11,090	2.4
IL	9,980	10,710	2.1	1.7				

SOURCE Authors' estimates of health spending for 2019, generated from multiple sources, as listed in appendix table e1 (see note 17 in text). NOTES Health spending is shown in dollars per person (in 2020 US dollars). Standardized (std.) health spending per person is spending adjusted to reflect the age and sex profile, economywide prices, mean income, population density, smoking rates, and physical activity rates. Annualized rate of change is calculated using authors' estimates of spending per person from 2013 to 2019. Uncertainty intervals for all estimates are in the appendix. States appear in order from the most 2019 health spending per person to the least.

In 2019, across the states, Medicare spending ranged from 9 percent (95% UI: 6–12) of total health spending in Alaska to 30 percent (95% UI: 26–35) in Florida (see exhibit 2). Medicaid spending ranged from 10 percent (95% UI: 7–15) of total health spending in South Dakota to 26 percent (95% UI: 22–30) in Washington, D.C. Private insurance spending ranged from 25 percent (95% UI: 12–40) of total health spending in West Virginia to 49 percent (95% UI: 42–56) in Washington, D.C. Finally, out-of-pocket spending, along with spending on other public insurance schemes, made up the remainder of spending, with fractions of total spending ranging from 12 percent (95% UI: 6–21) in Washington, D.C., to 42 percent (95% UI: 29–55) in Alaska. In all states, hospital care and physician and clinical services were the largest fractions of spending (per

person). Hospital spending ranged from 35 percent (95% UI: 32–38) of total health spending in New Jersey to 51 percent (95% UI: 49–53) in South Dakota, and physician and clinical services spending ranged from 16 percent (95% UI: 16–17) of total health spending in Vermont to 30 percent (95% UI: 27–32) in Alaska (see appendix tables e9b and e9c for a complete set of estimates by payer and type of service by year).[17]

Exhibit 2 State-level health spending per person by payer as a fraction of total spending, United States, 2019

	Spending by payer (% of total)					Spending by payer (% of total)			
State	Medicare	Medicaid	Private	OOP	State	Medicare	Medicaid	Private	OO
AK	9	18	31	42	RI	22	22	31	26
SD	19	10	33	38	ME	23	18	33	26
MT	19	14	30	37	TX	23	16	36	25
ND	15	15	33	37	NM	21	25	28	25
NH	20	11	37	32	IL	22	14	39	25
WV	25	18	25	32	OR	20	21	33	25
VA	20	12	37	31	WI	20	15	40	25
WY	17	11	40	31	MN	18	20	37	25
NE	20	11	38	31	PA	24	17	34	25
DE	22	16	31	31	CT	22	19	34	25
NV	25	14	31	30	UT	17	12	48	24
ID	21	14	35	30	SC	27	14	34	24
IN	23	17	31	30	MI	27	16	33	24

	Spending by payer (% of total)					Spending by payer (% of total)			
State	Medicare	Medicaid	Private	OOP	State	Medicare	Medicaid	Private	OO
WA	18	17	35	29	LA	26	20	30	24
HI	20	17	36	28	MO	25	17	34	24
OK	24	16	32	28	GA	24	13	40	23
NC	25	16	32	27	TN	26	16	35	23
IA	21	16	36	27	AR	26	22	28	23
FL	30	12	31	27	NJ	24	15	39	22
MD	22	17	34	27	AZ	26	19	35	20
OH	23	18	32	27	CO	19	17	44	20
VT	19	21	34	27	CA	23	21	37	20
MA	20	19	34	27	KY	25	21	34	20
AL	29	14	32	26	NY	22	25	33	20
MS	28	19	27	26	DC	13	26	49	12
KS	22	11	40	26					

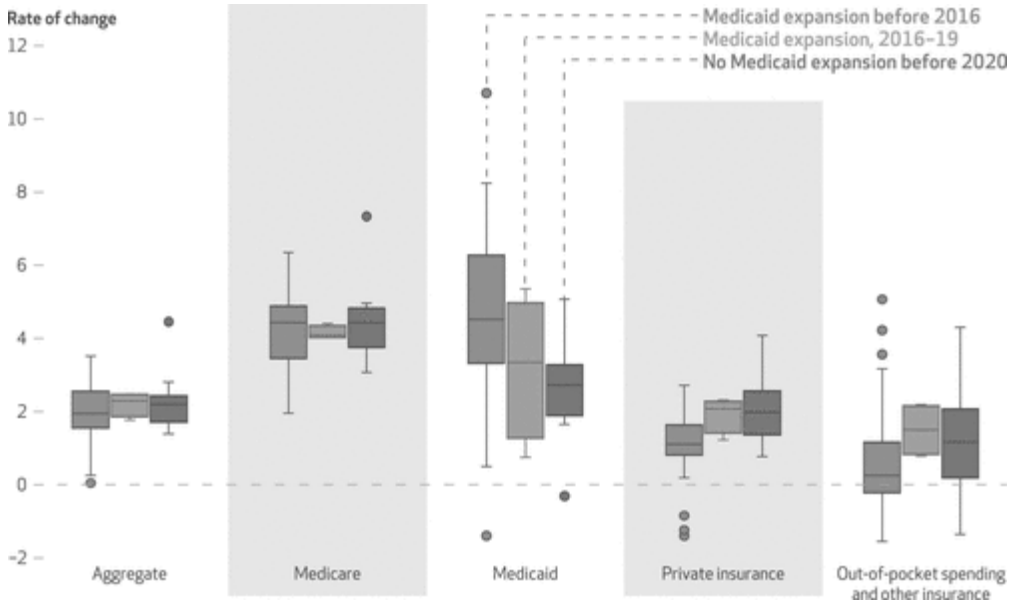
SOURCE Authors' estimates of health spending by payer for 2019, generated from multiple sources, as listed in appendix table e1 (see note 17 in text). NOTES Health spending is shown as percent of total US health spending for that year. Uncertainty intervals for all estimates are in the appendix. States are ordered from those with the largest fraction of health spending from out-of-pocket sources to those with the least.

Six non–health system factors were tested as potential factors explaining variation in health spending per person, both in the State Health Expenditure Accounts estimates for 2000–14 and in the estimated spending for 2015–19 (see appendix figure e5).[17] Income

explained the largest fraction of variation in health spending per person, at 25.3 percent (95% UI: 25.2–25.4). Moreover, a 10 percent increase in mean state income was associated with a 4.8 percent (95% UI: 4.3–5.9) increase in health spending (see appendix table e6).[17] Regional price parity also explained a great deal of spending variation, at 21.7 percent (95% UI: 21.1–22.3). Two main behavioral risk factors were tested (physical activity levels and smoking rates, lagged fifteen years), collectively explaining 8.0 percent (95% UI: 7.7–8.2) of variation in health spending, whereas 12.8 percent (95% UI: 11.8–13.6) of the variation was explained by a time trend, reflecting growth year over year that occurred consistently across all states. Different age and sex profiles explained 4.6 percent (95% UI: 4.4–4.8) of the variation in health spending, with population density explaining 4.8 percent (95% UI: 4.7–5.0). Collectively, these controls explained 77.2 percent (95% UI: 76.7–77.6) of the variation in state health spending per person during the period 2000–19, with 22.8 percent (95% UI: 22.4–23.3) left unexplained (appendix figure e5).[17]Exhibit 1 shows that when states are standardized across these factors, the spread of per person spending across states is smaller, although still sizable, ranging from $8,950 (Tennessee) to $14,820 (Alaska).

The expansion of Medicaid access through income eligibility changes and Medicaid expansion under the ACA had a complex relationship with state spending growth. Exhibit 3 shows that after state spending is standardized by age, sex, price, and other key factors, the annualized growth rates for total health spending per person from 2013 to 2019 (labeled “Aggregate” in exhibit 3) were similar for early Medicaid expansion and nonexpansion states, with the median for the states that expanded before 2016 being slightly lower. In contrast, median Medicaid-specific standardized spending per person growth from 2013 to 2019 was much larger for early Medicaid expansion states (4.2 percent) than for nonexpansion states (2.6 percent). For the same period, standardized Medicare spending growth was comparable for early expansion and nonexpansion states, but standardized private insurance spending growth and out-of-pocket and other insurance spending growth were higher for nonexpansion states, at 3.2 percent and 0.9 percent versus 2.7 percent and 0.1 percent, respectively. Medicaid expansion timelines and categorization for exhibit 3 are described in appendix table e5.[17]

Exhibit 3 State-level per person health spending growth rates, standardized for age, prices, income, urban density, and behavioral risk factors, aggregate and by payer, United States, 2013–19



SOURCE Authors' estimates of standardized health spending and the Centers for Medicare and Medicaid Services' State Health Expenditure Accounts. Authors' estimates generated from multiple sources, as listed in appendix table e1 (see note **17** in text). NOTES This exhibit shows the annualized rate of change for total standardized health spending per person and payer-specific standardized health spending per person. The box-and-whisker plots show the interquartile range (the boundaries of the box), the median (the line within the box), the range of the data (the whiskers), and outlier points (the dots).

Exhibit 4 shows the factors tested for associations with total and out-of-pocket spending, where the reported coefficient represents the percentage increase in spending associated with a 10 percent increase in the percentage of Medicaid beneficiaries in managed care or when Medicaid raised or lowered income eligibility thresholds in a given state year. Medicaid expansion was statistically associated with a 1 percent (95% UI: 1–3) increase in estimated total health spending. In addition, Medicaid income eligibility thresholds for adults were statistically associated with increases in estimated health spending per person, whereas those for children were associated with less spending. The Medicaid income eligibility threshold for pregnant women was associated with less out-of-pocket spending.

Exhibit 4 Factors associated with total and out-of-pocket state-level health spending per person, United States, 2000–19

	Covariates

Factors	Covariates		Urban density	Physical activity	Smoking prevalence	State and time indicators
	Value	Income				
Factors	Value	Income	Urban density	Physical activity	Smoking prevalence	State and time indicators
Age-standardized total health spending						
Medicaid expansion	0.01***	0.32***	−0.04**	0.10	0.09***	Yes
Income eligibility thresholds						
For children	−0.02**	0.32***	−0.06**	0.09	0.09***	Yes
For pregnant women	−0.01	0.33***	−0.02	0.15**	0.08***	Yes
For adults	0.02***	0.30***	−0.01	0.14**	0.07***	Yes
Medicaid enrollees on managed care (%)	−0.00	0.41	0.83	0.25	0.16**	Yes
Age-standardized out-of-pocket spending						
Medicaid expansion	0.02	0.31	−0.29	−0.37	0.67***	Yes
Income eligibility thresholds						
For children	−0.07	0.31	−0.38**	−0.37	0.63***	Yes
For pregnant women	−0.15**	0.31	−0.38**	−0.35	0.58***	Yes
For adults	0.01	0.30	−0.33	−0.35	0.58***	Yes
Medicaid enrollees on managed care (%)	−0.00	0.37	0.74	0.27	0.21	Yes

SOURCE Authors' estimates of the relationship between state health spending estimated by the Centers for Medicaid and Medicaid Services State Health Expenditure Accounts for 2000–14 and the authors'

forecasts of health spending for 2015–19, and state Medicaid characteristics from the Kaiser Family Foundation. NOTES Number of observations for all models is 1,020. Linear regression estimates show estimated coefficient estimates, estimated across 50 states and Washington, D.C., for the period 2000–19. The dependent variable for all regressions is total health spending or out-of-pocket spending per person, age, sex, and price standardized. All regressions include state and year fixed effects to control for unobserved time-invariant heterogeneity and idiosyncratic nationwide time shocks. Coefficients can be interpreted as the fractional increase in spending per person associated with a 10 percent increase in Medicaid enrollment in managed care or with a state adopting Medicaid expansion or lowering income eligibility limits for Medicaid within a given year.

**p<0.05

***p<0.01

Discussion

"The state with the highest estimated spending per person in 2019 had nearly double that of the lowest state."

This study showed that health care spending estimates for the period 1991–2019 varied dramatically across US states and that although spending predictions in all states increased consistently during this period, differences between states increased across time. The ranking of the highest- and lowest-spending states also changed in the same period. Some of this variation can be explained by different demographic patterns between states over time, and age-standardized estimates can account for demographic shifts and allow for a study of potential drivers of the remaining variation. However, even after we performed standardization against main controls, such as income and consumer prices, the state with the highest estimated spending per person in 2019 had nearly double the standardized spending of the lowest state (exhibit 1).

"Income explained the largest fraction of variation in health spending per person, at 25.3 percent."

Many existing studies have connected income, prices, and behavioral risk factors to health spending variation and growth.[21–24] In particular, prior work by Louise Sheiner in 2014 found significant relationships between state-specific spending on Medicare and

population age, insurance rate, prevalence of diabetes, and percentage of the population that is Black, along with Medicare pricing. Sheiner also found that four-fifths of the variation in Medicare spend could be attributed to these variables in 2008.[21] Our analysis produced similar findings for spending across all insurer types. The results of the decomposition of spending estimates the period 2000–19 show that income and consumer prices explained the most variation of all controls tested and that factors generally outside the purview of the health sector explained four-fifths of the variation in predicted health spending per person, a finding similar to that of Sheiner, although her work looked at Medicare spending in 2008.[21]

The fact that income was the factor that explained the most spending variation highlights the known association between wealth and access to health care services throughout the US. Income and regional consumer prices combine in such a way that wealthy states with the highest prices consistently had the highest estimated health spending per person. At the same time, those living in states with lower mean income had lower spending despite having a generally higher need for health care in poor regions because of systematically worse health.[25]

Our study also found strong associations between estimated spending and behavioral risk factors, such as lower levels of physical activity and higher smoking rates, consistent with existing literature and highlighting that prevention of disease through healthier living may be a means to drive down health spending.[21] It is worth noting that smoking and physical activity together explained less than one-tenth of estimated health spending variation, offering some evidence that health care resources are not necessarily targeted to people whose behavior may put them in greater need of intervention.

Prior research has also identified relationships between the supply and the use of services, especially hospital services, and spending growth.[21,23,26,27] Our study also supports this association: Regressions showed significant positive relationships between spending estimates and multiple measures of health system capacity and use (see appendix table e6 and figure e6).[17] As one example, this analysis found that a greater supply of health care workers was associated with increased state-level health care spending per person year over year. Earlier work found similar relationships, but with substantial evidence suggesting that general increases in the supply of the clinical health care workforce improve overall health care efficiency through increases in the effectiveness of medical care service provision.[28]

Although much of the variation in state spending estimates can be explained by demographic and economic characteristics outside the purview of policy makers, this analysis also showed that early Medicaid expansion states had comparable estimated

growth in total health spending than states that have not expanded Medicaid. In the expansion states, predicted Medicaid spending drove the increases, whereas the median growth rate for out-of-pocket spending in these states was lower than in states that expanded Medicaid. This finding is consistent with trends emerging on the overall spending impact of the ACA, which show that increased state and national spending is associated with increased access to care.[8] Increased insurance coverage has been shown to increase access to care at the state level, and Medicaid expansion was associated with gains particularly among the most financially disadvantaged segments of the population.[8,29] Low levels of access to care are associated with higher hospitalization rates and costs; thus, it is plausible that the increased access to care enjoyed by beneficiaries in Medicaid expansion states could lead to a shift in cost away from high-price hospital services in those markets.[29]

It is worth noting that our study found a significant negative association between increases in state spending estimates and increased Medicaid income eligibility thresholds over time for children (exhibit 4). States that have enhanced care access for children (irrespective of the state's participation in specifically ACA-related Medicaid expansion initiatives) do not seem to systematically exhibit significant overall differences in long-term spending because of these policies, yet the benefits of increased child health care access are known to be substantial.[30]

Without asserting causality of health care spending growth, this study helped unpack factors underlying state spending variation by investigating differences in spending estimates across payer types and identifying the impact of system-level variation. After we assessed spending variation associated with the usual and best-understood spending drivers, one-fifth of the variation in health spending remained unexplained. This finding calls for a reexamination of possible factors underlying the often piecemeal, state-specific approach to addressing the rising cost and uneven quality of health care.

Conclusion

Even as health care spending becomes an increasingly dominant portion of the US economy, health outcomes are falling short of national expectations for what this spending should deliver. To reach goals of health spending containment alongside improvement in population health, policy makers must seek data-driven solutions calibrated by accurate assessments of changes in US spending, yet both generating and interpreting credible assessments of spending changes are complex undertakings. Official state-specific spending estimates that date back to 2014 are not recent enough to enable analyses that consider newer policies or changing state characteristics. In

addition, structural, legal, economic, and demographic features vary across US states and types of payers, resulting in substantial variation in health spending across states and payers that is challenging to interpret. Our study offers state-level spending estimates that are compatible with existing State Health Expenditure Accounts estimates through 2014 and report the increasing range of health spending by state for a more recent and actionable period. Moving forward, it seems critical as well as feasible to update comprehensive estimates of state-specific health spending and to continue analysis of why spending levels vary so dramatically across the fifty US states and Washington, D.C.

ACKNOWLEDGMENTS

This work benefited from the contributions of Ian Pollock, Meera Beauchamp, and Theresa McHugh at the Institute for Health Metrics and Evaluation. The authors additionally thank Larry Levitt from the Henry J. Kaiser Family Foundation, Joe Thompson from the Arkansas Center for Health Improvement, and David Radley from the Commonwealth Fund for their review and advisement. Funding for this work was provided by an award from Gates Ventures and by the Peterson Center on Healthcare, Grant No. 21016 (for both, Joseph Dieleman, principal investigator).

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To access the appendix, click on the Details tab of the article online.

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Washington State Health Care Authority

INDEX: Public comment – Providence Swedish Central Service Area

TAB 11

My name is Renee Rassilyer-Bomers, Chief Nursing Officer for the Providence Swedish Central Service Area and the CNO for Cherry Hill Campus. The Central Service area comprises of four Hospital campuses, including First Hill, Ballard, Issaquah and Cherry Hill. Working in a complex hospital network, allows our organization to serve a community of patients with various diagnoses and care needs. Likewise, it allows for specialization of services which improves quality outcomes, operational efficiencies, and maximizes training and recruitment of staff, including nurses. Our two larger hospital facilities reside in Seattle, which includes the First Hill and the Cherry Hill campuses. Both are relatively good-sized hospitals. Cherry Hill has more than 200 beds; First Hill has more than 600. Yet, the patients treated in these two facilities are markedly different. The differences are intentional.

Cherry Hill is a level 1 stroke center with the most advanced technologies for neurosurgery and cardiovascular surgery in addition to interventional care. First Hill has a more typical mix of patients and services, including general surgery, transplant, women's and children's specialties, and general medical acute care services.

One can see the differences in the case mix index CMS calculates for our two hospitals. The case mix for Cherry Hill is twice that of First Hill. CMS recognizes our operating costs and payments for Cherry Hill should be twice that of First Hill because of the population of patients cared for. For example, the services, interventions, and expertise associated with neuro/cardiovascular cases is not comparable to general surgical cases regarding cost, length of stay, and level of care. CMS also recognizes that Seattle is one of the most expensive places in the country for hiring nurses and other hospital employees. This too is extremely important when analyzing our costs compared to other areas of the state which may have a lower salary base.

I request that the Health Care Transparency Board accounts for the many important factors that impact costs so there is not only awareness but understanding of the complexity of care practices within different healthcare organizations and campuses. Data that evaluates case mix index and regional cost of living, provides a more comprehensive review that more transparently depicts comparisons, that would otherwise not be apparent without this information. I am appreciative of the opportunity to highlight the importance of taking these factors into account through the analysis process.

Renee Rassilyer-Bomers, DNP, CMSRN, RN-BC
Chief Nursing Officer
Cherry Hill
Cell 206-228-3100
Renee.Rassilyer@swedish.org

Washington State Health Care Authority

INDEX: Public comment – Washington State Hospital Association

TAB 12

August 17, 2022

To: Health Care Cost Transparency Board

From: Albert Froling, Technical Product Manager, Data Analytics

I want to thank the Board for granting WSHA the opportunity to present information at the last Board meeting. Unfortunately, we did not have time to cover all our material or address questions. We have asked staff if there is an additional chance to do so in the future.

Since we made our presentation, Michael Baillit has published an article in Health Affairs noting that hospital cost increases are driving overall spending increases. We hope to comment when we can see the results of the HCCTB analysis on cost drivers. However, I would also note the recent article in Health Affairs by the UW Institute for Health Metrics and Evaluation. It shows WA is among the lowest states in per capita health care spending, when rates are standardized for incomes, age, sex, health, and other relevant factors. WA is only $9,600 per capita, which puts it in the bottom ten states and its standardized rate of increase is also relatively low.

We look forward to being able to have a continued discussion on these issues, but in the meantime, I want to emphasize parts of our presentation we did not get a chance to discuss – the importance of both input prices and intensity of service or case mix relative to hospital costs and payments. Both need to be factored into any analysis that compares either individual hospital or aggregate hospital state performance.

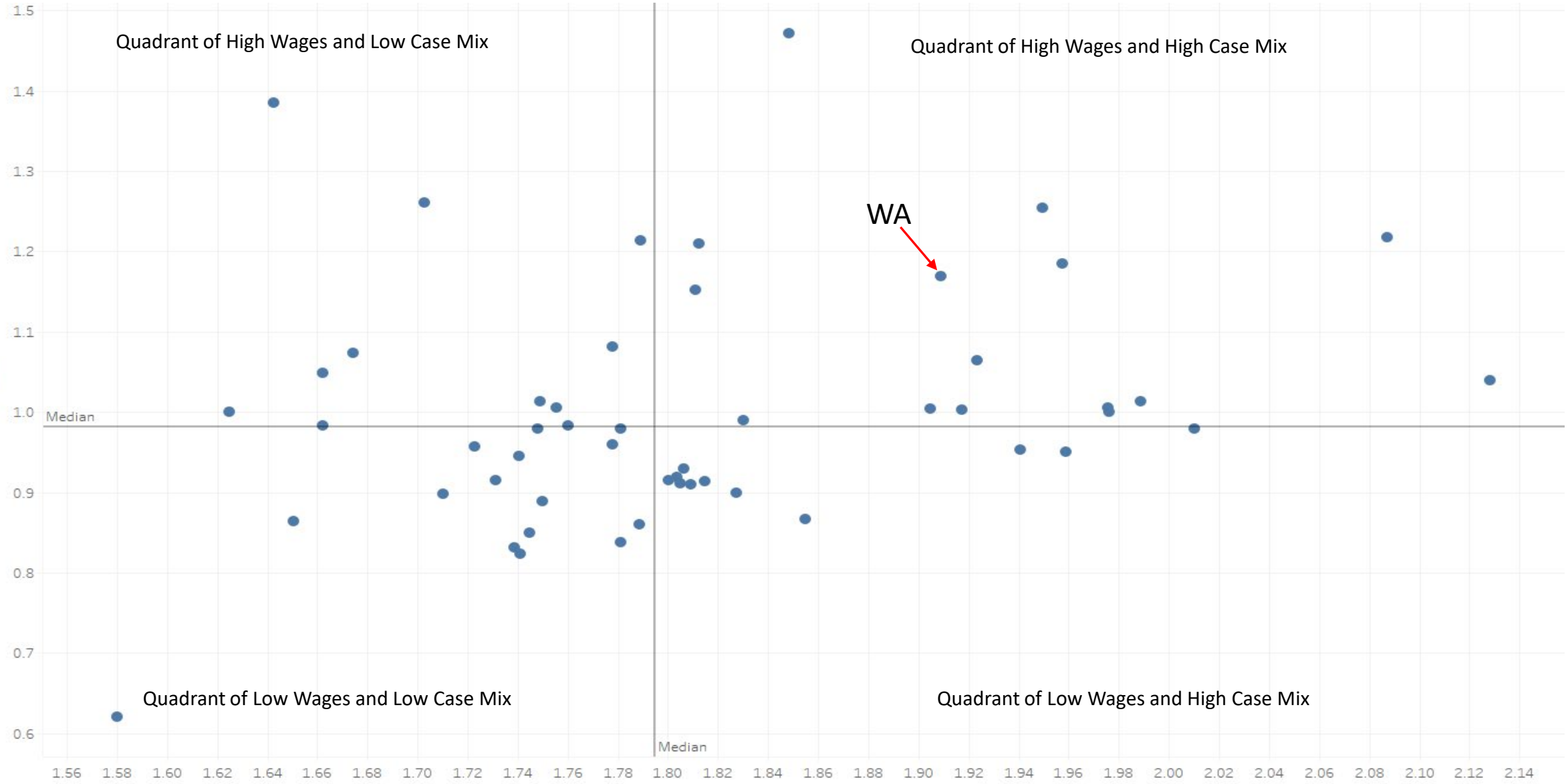
It makes no sense to compare hospitals on a per discharge basis without considering the types of cases that the hospital treats or the economic environment in which it hires staff. The importance of these variables is explicitly recognized in the Board's underlying legislation. Specifically, Section 5 subsection 2(c)(ii) says the Board must take into account both intensity of services provided to the patients and regional differences in input prices in any hospital specific accounting for the benchmark. Both intensity of services and input prices such as variations in area wages make a marked difference that needs to be recognized.

At its last meeting, the Board heard from the Colorado consultants that WA is a relatively high cost and high payment state. Based an initial data analysis we performed, we believe the reasons are straight forward. It is not due to hospital performance in our state. It is due simply to the fact that Washington has relatively high wages for hospital type personnel as well as a marked case mix difference in the types of patients seen. I have provided a scatterplot analysis that illustrates these findings.

These factors are important in statewide comparisons and equally important when looking at the performance of individual hospitals in the state. We urge the Board to make sure any analysis done is reflective of the environment within WA hospitals must operate and the patients they see.

Attachment: WSHA Analysis

US State Scatterplot Showing Relative Hospital Wage Index and Case Mix Rankings*



Relative Wages for Hospital Personnel as Calculated by CMS

Case Mix Index for Medicare (for Prospective Payment Hospitals)

Froling, WSHA,
August 2022

Washington State Health Care Authority

INDEX: Advisory Committee on Primary Care nominations

- List of nominees
- CVs and resumes in list order

TAB 13

Advisory Committee on Primary Care Proposed Members

Washington State Health Care Authority

Name	Title	Place of Business
Chandra Hicks	Assistant Director – Delivery System Analytics	Regence
David DiGiuseppe	Vice President of Healthcare Economics	Community Health Plan of Washington
DC Dugdale	Medical Director, Value-Based Care	University of Washington Medicine
Eileen Ravella	Urgent Care Physician Assistant	Kaiser Urgent Care
Ginny Weir	Chief Executive Officer	Foundation for Health Care Quality, Bree Collaborative
Jonathan Staloff	Family Medicine Doctor, Fellow	University of Washington Medicine
Katina Rue	Family Medicine Doctor, President-Elect	Washington State Medical Association
Kevin Phelan	Vice President, Network Management	Molina Healthcare
Kristal Albrecht	Senior Vice President of Finance	Community Health Association of Spokane
Lan H. Nguyen	Medical Director	Premera
Linda Van Hoff	Primary Care Nurse Practitioner, President ARNP United	Advanced Registered Nurse Practitioner United, Overlake Clinic
Maddy Wiley	Family Nurse Practitioner	Family Care of Kent
Mandy Stahre	Managing Director, Forecasting and Research	Office of Financial Management
Meg Jones	Director of Government Relations	PacificSource Health Plans
Michele Causley	Vice President of Health Plan Operations	United Healthcare
Nancy Connolly	Internal Medicine Doctor	University of Washington Medicine
Sarah Stokes	Associate Director of Network Operations	Kaiser Permanente
Sharon Brown	Executive Director	Greater Columbia Accountable Community of Health
Sharon Eloranta	Medical Director	Washington Health Alliance
Shawn West	Chief Medical Officer	Embright
Sheryl Morelli	Chief Medical Officer	Seattle Children's Hospital
Staici West	Vice President	Coordinated Care
Tony Butruille	Family Medicine Doctor	Cascade Medical Center
Tracy Corgiat	Vice President Primary Care	Confluence Health

Chandra Hicks, FSA, MAAA

Seattle, WA | ChandraHicks@gmail.com

PROFILE

- 17 years of diverse health actuarial experience with increasing leadership responsibilities that includes areas of accountable care, value based care, forecasting and financial planning, provider performance measurement, provider network development, provider reimbursement analysis, and risk mitigation.
- Passionate advocate for change and innovation with an energy for situations that require creative problem solving.
- Current role managing two teams with diverse levels of experience while also working with consultants, vendors, external health plans, provider groups, external departments (DTS, Finance, provider network executives), other actuarial teams and external companies/associations to support the company's innovative provider partnership initiatives.
- Repeatedly recognized as an organized people and project manager who can work effectively across teams and departments based on abilities that include a high drive for results, perseverance in the face of obstacles and setbacks and novel approaches to finding solutions through working with stakeholders.

Professional Background

CAMBIA HEALTH SOLUTIONS (REGENCE BLUECROSS BLUESHIELD) | FEBRUARY 2005-PRESENT

Assistant Director of Delivery System Analytics | 2020-Present, Manager 2013-2020

- Actuarial leadership developing strategic provider partnerships for commercial lines of business.
- Manage two teams of 7 Actuaries and actuarial analysts whose key accountabilities are providing network analytics & network pricing, pre-contracting analytics for value based arrangements, target setting for provider incentives, forecasting savings of value based programs and system development.

Delivery System Analytics, Senior Actuary | 2011-2013

- Actuarial support in developing the company's strategic Accountable Healthcare Initiative. Provided recommendations on program methodology and contract design.
- Coordinated with several DTS and informatics areas to implement data processes, including implementation of cross-Blue plan data transfers.
- Provided actuarial expertise during operational build to support Accountable Healthcare Initiative.
- Represented Actuarial during initial provider education meetings and regularly scheduled post-contract support meetings. Responsible for presenting contracting results and explaining areas of opportunity.
- Coordinated with network executives to design Exchange networks based on target performance. Led team internally to develop factors used for Health Insurance Exchange product pricing.

Provider Network, Contract & Reimbursement | 2005-2006; 2009-2011

- Developed several methodologies to support value-based and pay-for-performance contracts.
- Contributed to development of a methodology for long-range network reimbursement management, which used underwriting principles to recommend ideal reimbursement levels and calibrate payments.
- Key contributor to development of a performance based network of healthcare providers.
- Modeled the impact of proposed hospital and professional contracts while working closely with the provider contracting department.

Corporate Forecasting | 2006-2009

- Responsible for coordinating and developing the company's budget for senior management review, as well as regular forecasting of company product lines.
- Responsible for forecasting and developing assumptions for healthcare reform impacts (Affordable Care Act), including development and modeling of company strategies to mitigate risks.
- Performed scenario modeling and sensitivity testing, including elasticity of membership impacts, RBC impacts and value-at-risk calculations for "worst-case" outcomes.
- Overhauled the projection methodology for large group forecasting through coordination with the Underwriting and Pricing departments.

Organizations And Activities

Member of the American Academy of Actuaries | 2008

Fellow of the Society of Actuaries | 2010

Member of Toastmasters International | 2009-2012

Grader, Society of Actuaries | 2011

Cambia Actuarial Internship Coordinator | 2011-2013

Formal & Continuing Education

B.S. MATHEMATICS, B.S. PHYSICS | 2003 | UNIVERSITY OF WASHINGTON

ACTUARIAL LEADERSHIP DEVELOPMENT PROGRAM | 2012 | CAMBIA

DATA SCIENCE SPECIALIZATION, COURSES 1-7, | 2017 | COURSERA, JOHNS HOPKINS UNIVERSITY

LEADERSHIP JOURNEY | 2018 | CAMBIA

SAS, SQL, R, TABLEAU, GITHUB, VBA LANGUAGES AND MS OFFICE

David DiGiuseppe

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PROFESSIONAL PROFILE

Healthcare executive with 20+ years of experience in consulting and organizational leadership roles. Deep understanding of all dimensions of the healthcare marketplace. Expertise in population health, healthcare economics, analytics and data science, risk adjustment, value-based contracting, and performance evaluation. Experience spans Medicaid managed care, Medicare Advantage and commercial insurance products. Employed for past 18 years with Community Health Plan of Washington (a not-for-profit regional managed care organization serving 260,000 members in Washington state) and Community Health Network of Washington (an affiliation of Washington-based federally qualified health centers).

EXPERIENCE & ACHIEVEMENTS

Community Health Plan of Washington – Seattle, Washington – Feb 2004 to Present

Vice President, Healthcare Economics reporting to Chief Finance & Strategy Officer — May 2017 – Present

Provide strategic and operational leadership in finance and analytics. Lead four highly capable analytic teams. Responsible for broad scope including actuarial, Medicaid and Medicare Advantage premium development, risk adjustment, HEDIS/Stars quality measurement, program design and evaluation. Foster relationships with external partners to design and support complex value-based care and total cost of care arrangements. Recent achievements:

- Directed Cascade Select rate filing for Washington's pioneering public option coverage
- Supported clinic partners to improve performance in multimillion-dollar value-based care arrangements
- Designed payment models and negotiated provider contracts to support behavioral health integration
- Developed predictive model to identify future high-needs members, incorporating SDoH
- Service and representation:
    - King County's Accountable Communities of Health (Healthier Here), Finance Committee
    - Washington's Health Benefit Exchange, Advisory Council
    - Washington Health Alliance, Healthcare Economics Committee

Vice President, Population Health Management & — Nov 2015 – Apr 2017
Director, Medical Management Program Development reporting to Chief Medical Officer — Apr 2015 – Oct 2015

Responsible for quality improvement and care management, including Washington Medicaid's transition to integrated behavioral health (i.e., Apple Health Fully Integrated Managed Care).

- Led successful NCQA re-accreditation effort
- Launched new behavioral health team for IMC early adoption
- Developed and implemented population risk stratification model
- Implemented innovative Model of Care pilot projects with clinic partners to close gaps in care

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Director, Medicare Strategy reporting to Chief Executive Officer Mar 2013 – Mar 2015

Responsible for stabilizing Medicare Advantage product line.

- Instrumental in restoring product line profitability via improvements in product strategy and risk adjustment
- Designed innovative in-clinic care gap closure program and implemented new vendor partnerships

Director, Healthcare Economics & Aug 2012 – Feb 2013

Director, Strategy & Analytics reporting to Chief Financial Officer Jan 2010 – Jul 2012

Responsible for pricing products, managing analysts, strategic planning, managing chronic condition gap closure programs, and Medicare Advantage bid development.

- Directed Exchange product pricing
- Chaired multi-department workgroup, securing $9M in cost savings opportunities
- Conducted site visits with leadership teams of clinic partners to identify improvement opportunities
- Established and led corporate strategic planning process

Product Development Director / Manager reporting to various executives Feb 2004 – Dec 2009

Responsible for evaluating and implementing new business opportunities.

- Designed new product development process
- Implemented Mental Health Integration Project with clinic, government and academic partners
- Implemented Medicare Advantage benefit designs and pricing

Select Examples of Prior Employment

Research Consultant – Child Health Institute, University of Washington, Seattle, WA 2001 – 2004

Responsible for supporting outcomes research projects with study design, statistical analyses and manuscript writing.

Senior Scientist – Vector Research, Ann Arbor, MI 1991 – 1994

Consultant on Department of Defense healthcare purchasing and HRSA physician marketplace projects.

EDUCATION

Case Western Reserve University, Cleveland, OH	**M.Sc., Health Services Research**
University of Michigan, Ann Arbor, MI	**B.A., Economics**

PUBLICATIONS

Published as primary or secondary author on 15 papers appearing in peer-reviewed journals such as *JAMA*, *Pediatrics*, and *Health Services Research*.

UNIVERSITY OF WASHINGTON **October, 2021**
SCHOOL OF MEDICINE/DOM

David C. Dugdale, III. M.D.
Curriculum Vitae

I. Personal Data

Date of birth:	March 25, 1955
Place of birth:	Bryn Mawr, PA
Citizenship:	United States
Address:	Box 358220 University of Washington Seattle, WA 98195-6350
Phone:	206-543-6310
Fax:	206-685-6052
Email:	dugdaled@uw.edu

II. Education

1976	B.A., magna cum laude with Honors in Physics, Williams College, Williamstown, MA
1978	M.S. in Physics, Cornell University, Ithaca, NY
1982	M.D., University of Pennsylvania, Philadelphia, PA

III. Postgraduate Training

1982-1985	Intern and resident in internal medicine, Primary Care Internist Program-Boise, University of Washington, Seattle, WA
1985-1986	Chief Resident in Internal Medicine, Primary Care Internist Program-Boise, University of Washington, Seattle, WA
1986-1987	Acting Instructor in Medicine, Division of General Medicine (Medical Consult Service), Department of Medicine, University of Washington, Seattle, WA
1997-1998	Certificate Program in Medical Management, University of Washington, Seattle, WA

IV. Faculty Positions Held

1985-1987	Acting Instructor in Medicine, Division of General Medicine, Department of Medicine, University of Washington
1991-1996	Assistant Professor of Medicine, Division of General Medicine, Department of Medicine, University of Washington
1994-1996	Acting Head, Section of General Medicine, University of Washington Medical Center, Division of General Medicine, Department of Medicine University of Washington
1996-2006	Associate Professor of Medicine, Division of General Medicine, Department of Medicine, University of Washington
2006-present	Professor of Medicine, Division of General Medicine, Department of Medicine, University of Washington
2014-2015	Vice Dean for Clinical Affairs

V. Hospital and Health System Positions Held

1987-1988	Staff Physician, McNeil Island Corrections Center, Steilacoom, WA
1988-1991	Chief Medical Officer, McNeil Island Corrections Center, Steilacoom, WA
1991-present	Active Medical Staff, University of Washington Medical Center
1991-2004	Director, General Internal Medicine Center, University of Washington Medical Center
1997-1999	Associate Medical Director for University of Washington Medical Center-Roosevelt
1997-1999	Chair, Roosevelt Management Board, University of Washington Medical Center-Roosevelt
2004-2006	Associate Medical Director for Ambulatory Care, University of Washington Medical Center
2004-2006	Medical Director, Eastside Specialty Center, University of Washington Medical Center
2006-2013	Director, Hall Health Primary Care Center, University of Washington
2013-Dec 2017	Medical Director for Care Management and Population Health, UW Medicine
Jul 2017-Jun 2018	Hypertension Control Champion, UW Medicine
Jul 2018-Jun 2019	Medical Director, Hypertension Population Health, UW Medicine
Feb 2019-Jun 2019	Medical Director, Accountable Care, UW Medicine
July 2019-present	Medical Director, Value Based Care, UW Medicine
October 2019-April 2020	Interim Executive Director, Hall Health Center, University of Washington

VI. Honors

1975	Phi Beta Kappa
1976	Sigma Xi

VII. Board Certification

1979	National Board of Medical Examiners, part I
1980	National Board of Medical Examiners, part II
1983	National Board of Medical Examiners, part III
1986	American Board of Internal Medicine, enrolled in MOC

VIII. Current License to Practice Medicine

1982-present	Washington #21037

IX. Professional Organizations

1986-present	American College of Physicians
1986-present	Society of General Internal Medicine
1999-2002	Regional Council, NW region, Society of General Internal Medicine
2001-2002	Meeting Chair, NW region, Society of General Internal Medicine
2004-2007	National Council, Society of General Internal Medicine
2005-present	Fellow, American College of Physicians
2006-2014	American College Health Association
2007-2014	Washington State Executive Committee, American College of Physicians
2015-2018	National Council, Society of General Internal Medicine
2015-2018	Treasurer, Society of General Internal Medicine

X. Teaching Responsibilities

1991-2006	Medicine 665, inpatient student preceptor
1991-2008	Medicine 665, outpatient student preceptor
1992-2002	Vertical Advisor, School of Medicine
1993-2007	Medicine 691 and 602, outpatient student preceptor (at UWMC)
1999-2006	Introduction to Clinical Medicine-II, examination preceptor
2001	MSRTP-RUOP student preceptor for student Wendy McGoodwin
2007-2014	Introduction to Clinical Medicine-I, examination preceptor
2007-2020	MED ECK 602, outpatient student preceptor (at Hall Health Center)
2010-2019	Endocrinology 4th year elective outpatient student preceptor (At UW Medicine Diabetes Institute)

2010-2019	Endocrinology elective outpatient resident preceptor (At UW Medicine Diabetes Institute)

XI. Editorial Responsibilities

None

XII. Special National Responsibilities

1995-2000	Member, Managed Care Task Force, Society of General Internal Medicine (SGIM)
1997-2017	Member, Society of General Internal Medicine Medical Resident Clinic Director's Interest Group
1999-2002	Member, Blue Ribbon Panel, The Coding Institute, Naples, FL
2001-2006	Member, Finance Committee of SGIM
2001-2002	Member, SGIM national meeting workshop committee
2002	Member, Nominations Committee of SGIM
2002-2006	Member, SGIM national meeting Innovations in Practice Management selection committee
2003-2004	Member, SGIM national meeting program committee and Chair, Innovations in Practice Management selection committee
2003-2004	Member, SGIM Horn Scholars Nominating Committee
2004-2007	Member, SGIM National Council
2005-2006	Member, SGIM Blue Ribbon Panel on Clinical Practice
2005-2013	Member, SGIM clinical practice committee
2007-2011	Chair, SGIM membership committee
2007-2008	Member, Planning Committee, Primary Care Ambulatory Health Information Technology and Patient Safety Conference, Primary Care Organizations Consortium
2008	Member, Nominations Committee of SGIM
2010	Member, SGIM national meeting Scientific Abstracts selection committee
2010	Member, SGIM ad hoc financial review committee
2011	Member, SGIM national meeting Clinical Vignettes selection committee
2011-2012	Chair, American Board of Internal Medicine’s committee to develop Practice Improvement Module on Care Coordination
2012-2015	Member, SGIM Maintenance of Certification Task Force
2012-2013	Member, SGIM national meeting Innovation in Practice Management selection committee

2013-2014	Co-chair, Clinical Practice Innovations selection committee, SGIM National Meeting

XIII. Special Local Responsibilities

University of Washington Medical Center Committees

1991-2001	Managed Health Care Utilization Review Committee
1992-1994	Medical Records Committee
1994-1996	Clinical Care Committee of the UWMC-Roosevelt Management Board (chair 1995-6)
1994-2006	UWMC-Roosevelt Management Board (chair 1997-1999)
1994-2004	Primary Care Committee of UWMC-Roosevelt Management Board; renamed best practice committee 2001
1994-2004	Finance Committee of the UWMC-Roosevelt Management Board (chair 1999-2004)
1999-2001	UWMC Workplace violence committee
1999-2001	UWMC-Roosevelt Chartless medical record task force
2004-2006	Chair, Ambulatory Care Advisory Committee
2004-2013	Medical Staff Administrative Committee
2005-2006	Chair, Roosevelt Management Board

University of Washington Physicians Committees

1994	University of Washington Physicians Subcommittee on Practice Policies and Managed Care
1996-1998	Remote Charge Entry Steering Committee
1998-2001	University of Washington Physicians Board of Trustees, at large trustee
2002	University of Washington Physicians Clinic Cancellation Policy Committee
2002-2005	University of Washington Physicians, Contracting Committee
2003-2006	University of Washington Physicians, Communications Committee
2007-2013	University of Washington Physicians IT Advisory Committee
2019-present	University of Washington Physicians Board of Trustees, at large trustee
2019-present	University of Washington Physicians Clinical Practice Committee

UW Medicine Committees

2004-2006	UW Medicine Access Working Group
2006-2010	UW Medicine Service Excellence Committee
2007-2013	Office of Medical Staff Appointments Board
2008-2013	UW Medicine Consolidated Quality Improvement Plan, Outpatient Committee; renamed to Quality and Patient Safety Primary Care Committee in 2010
2010-2011	UW Medicine Diabetes Care Strategic Planning Committee
2013-2017	UW Medicine Care Management and Population Health Committee (chair)
2013-2015	UW Medicine Operations and Finance Committee
2018-present	UW Medicine Value Based Care Committee
2019-present	UW Medicine Value Based Care Coordination Committee (chair)

University of Washington School of Medicine Committees

1994-2001	University of Washington Health Plans Board
1994-1998	Chair, Medical Advisory Committee to University of Washington Health Plans Board
1997-2001	Billing compliance officer, Department of Medicine
1999-2000	UWMC-Roosevelt Family Medical Center review committee (constituted by Dean)
2000-2001	Chair, faculty search committee, UWMC section, resulted in successful search for clinician teacher faculty member
1999-2003	UW Faculty senate
2001-2008	Continuing Medical Education Advisory Committee
2001-2004	UW Faculty Council on Retirement, Insurance, and Benefits
2002	Department of Medicine Documentation Template Development Committee
2003-2007	CME course committee, "Laboratory Testing Update for Primary Care"
2004-2007	Department of Medicine Appointment and Promotions Committee
2007-2008	Search committee for Chair, Department of Family Medicine
2009	Radiology Chairman Review Committee
2009-2010	UW Faculty senate
2009-2017	University of Washington Medical Retirement Review Board
2010-2011	Search committee for Director, Health Sciences Library

2013-2015 Clinical Chairs Committee

State of Washington

2021-present Member, Bree Collaborative

XIV. Research Funding

2001-2004 5% salary funding for grant, Expert pharmacotherapy and cognitive behavioral therapy vs. usual care for panic disorder, PI Peter Roy-Byrne, Department of Psychiatry. Increased to 10% May 16, 2003 through June 30, 2004.

2005-2006 5% salary funding for grant, CALM: usual care vs. collaborative care for anxiety disorders, PI Peter Roy-Byrne, Department of Psychiatry.

2015-2017 co-PI and 30% salary funding for Transforming Clinical Practice Initiative, Centers for Medicare and Medicaid Innovation

XV. Bibliography

A. Refereed journals

1. Wasserheit JN, Dugdale DC, Agosti JM: Rhabdomyolysis and acute renal failure: a new presentation of acute brucellosis. Jour Inf Dis 1984;150:782-783.

2. Dugdale DC, Salness TA, Knight L, Charan NB: Endobronchial granulocytic sarcoma causing acute respiratory failure in acute myelogenous leukemia. Am Rev Resp Dis 1987;136:1248-1250.

3. Dugdale DC, Stevens DL, Knight LL: Mycotic aneurysm and disseminated *Mycobacterium avium-intracellulare* infection in a patient with hairy cell leukemia. West Jour Med 1989;150:207-208.

4. Dugdale DC, Peterson K: The prevalence of HIV seropositivity and HIV-related illness in Washington State prisoners. The Prison Journal, Summer, 1989.

5. Dugdale DC, Ritter KJ, Wilhyde DE: Lung abscess causing Horner's syndrome. West J Med 1990;153:196-197.

6. Dugdale DC, Ramsey PG: *Staphylococcus aureus* bacteremia in patients with Hickman catheters. Am J Med 1990;89:137-141.

7. Dugdale DC, Epstein R, Pantilat SZ. Time, the Patient-Physician Relationship, and Managed Care. J Gen Intern Med, 1999,14:S34-S40.

8. Wong JG, Fagan M, Pinsker J, Society of General Internal Medicine Medical Resident Clinic Director's Interest Group Consortium. Expectations of and for the medical director of the resident's ambulatory clinic. Am J Med 2001;111:84-87.

9. Roy-Byrne P, Russo J, Dugdale DC, Lessler D, Cowley D, Katon W. Undertreatment of panic disorder in primary care: role of patient and physician characteristics. J Am Board Fam Pract. 2002;15:443-50.

10. Dugdale DC. Ambulatory Internal Medicine Training: Challenges and Opportunities (editorial). J Gen Intern Med 2003;18:313-314.

11. DeWitt DE, Dugdale DC. Clinical Correlations: Using New Insulin Strategies in the Outpatient Treatment of Diabetes. JAMA 2003;289:2265-2269.

12. DeWitt DE, Dugdale DC. Common Problems in Outpatient Management of Patients with Diabetes in the Age of Insulin Analogues. Primary Care Clinics 2003;30(3):543-556.

13. Dugdale DC. Post-Marketing Drug Safety: Keep Patients your Priority (editorial). DOC News 2005;2:3.

14. Means-Christensen AJ, Sherbourne CD, Roy-Byrne PP, Schulman MC, Wu J, Dugdale DC, Lessler D, Stein MB. In Search of Mixed Anxiety-depressive Disorder: A Primary Care Study. Depress Anxiety 2006;23:183-189.

15. Dunham DP, Dugdale DC. Methods of Compensation in Ambulatory Care for Academic General Internal Medicine Practices. Medical Group Management Association Academic Practice Assembly Matrix. 2006;20(1):4-7.

16. Blue Ribbon Panel of the Society of General Internal Medicine. Redesigning the Practice Model for General Internal Medicine. A Proposal for Coordinated Care. A Policy Monograph of the Society of General Internal Medicine. J Gen Intern Med 2007;22(3):400-409.

17. Dugdale DC. Evidence-based Medicine and College Health: Opportunities and Challenges (editorial). Student Health Spectrum. 2007(June):2-3.

18. McBride D, Dugdale DC. New leadership and changes in student health services. Student Health Spectrum 2008(February):27-35.

19. **Mauksch LB, Dugdale DC, Epstein RE. Relationships, communication, and efficiency in the medical encounter: Creating a clinical model from a literature review. Archives of Internal Medicine 2008;168(13):1387-1395.

20. Staiger TO, Chew LD, Helenius I, and the practice management subcommittee of the Society of General Internal Medicine's clinical practice committee. A case-based approach to outpatient evaluation and management service coding. Postgrad Med 2008;120(4):101-106.

21. **Sinsky CA, Dugdale DC. 2013. Medicare Payment for Cognitive vs Procedural Care: Minding the Gap. JAMA Internal Medicine 2013;173(18):1733-1737.

22. Wong CJ, Gaster B, Dugdale DC. Choosing wisely: in defense of the preventive health visit. Am J Prev Med 2014; 47(5):653-655; doi.org/10.1016/j.amepre.2014.06.019

23. **DeWitt D, Dugdale DC, Adam WR. Nonglycemic targets in diabetes. Med Clin N Am 2015;99(1):187-200; doi.org/10.1016/j.mcna.2014.08.014

24. McGough PM, Bauer AM, Collins L, Dugdale DC. Integrating behavioral health into primary care. Population Health Management. 2016;19(2):81-87. doi:10.1089/pop.2015.0039.

25. **Smetana GW, Nathan DM, Dugdale DC, Burns RB. To what target hemoglobin A1c level would you treat this patient with type 2 diabetes? Ann Intern Med 2019;171:505-513. doi:10.7326/M19-0946.

26. Kuo T, Chen S, Oh S-M, and the American Heart Association Western States Chronic Disease Prevention and Management Committee. Comprehensive medication management as a standard of practice for managing uncontrolled blood pressure. Front Med (Lausanne). 2021; 8: 693171. Published online 2021 Aug 3. doi:10.3389/fmed.2021.693171.

27. **Dugdale DC, Khor S, Liao JM, Flum DR. Association between a population health intervention and hypertension control. J Gen Intern Med. Published online 2022 Apr 14. DOI: 10.1007/s11606-022-07522-4.

B. Book Chapters

1. Dugdale DC, Ramsey PG, Larson EB: General medical care. In Larson EB and Ramsey PG, eds., Medical Therapeutics. Philadelphia: W.B. Saunders, 1989.

2. Dugdale DC: Fluid and electrolyte therapy. In Larson EB and Ramsey PG, eds., Medical Therapeutics. Philadelphia: W.B. Saunders, 1989.

3. Dugdale DC, Ramsey PG, Larson EB: General medical care. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 2nd ed. Philadelphia: W.B. Saunders, 1992.

4. Dugdale DC: Fluid and electrolyte therapy. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 2nd ed. Philadelphia: W.B. Saunders, 1992.

5. Thornton M, Dugdale DC: Hypertension. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 2nd ed. Philadelphia: W.B. Saunders, 1992.

6. Dugdale DC: Infectious mononucleosis. In Copass M, Eisenberg M, and Mengert T, eds., Emergency Medical Therapeutics, 4th ed. Philadelphia: W.B. Saunders, 1994.

7. Dugdale DC: Low Back Pain. In Copass M, Eisenberg M, and Mengert T, eds., Emergency Medical Therapeutics, 4th ed. Philadelphia: W.B. Saunders, 1994.

8. Dugdale DC, Ramsey PG: Intravascular catheter-related infections. In Schlossberg D, ed. Current Therapy of Infectious Disease. Mosby-Year Book, 1995.

9. Dugdale DC: Sigmoidoscopy and colonoscopy. In Fihn SD, DeWitt DL, eds., Outpatient Medicine, 2nd ed. Philadelphia: W.B. Saunders, 1996, pp. 342-345.

10. Dugdale DC: Dyspepsia. In Fihn SD, DeWitt DL, eds., Outpatient Medicine, 2nd ed. Philadelphia: W.B. Saunders, 1996, pp. 311-313.

11. Dugdale DC, Reilly DL. General medical care. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 3rd ed. Philadelphia: W.B. Saunders, 1997.

12. Dugdale DC. Fluid and electrolyte therapy. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 3rd ed. Philadelphia: W.B. Saunders, 1997.

13. Dugdale DC. Hypertension. In Larson EB and Ramsey PG, eds., Medical Therapeutics, 3rd ed. Philadelphia: W.B. Saunders, 1997.

14. **Marcotte LM, Dugdale DC. Prevention as a population health strategy. In Sangvai DG and Viera AJ, eds. Population Health. Primary Care: Clinics in Office Practice. December 2019:46(4):493-503.

Books and software

1. **Dugdale DC, Eisenberg MS (eds.). Medical Diagnostics. Philadelphia: W.B. Saunders, 1992.

2. **Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's Medical Drug Reference. St. Louis: Mosby, 1997.

3. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's Medical Drug Reference, 2nd ed. St. Louis: Mosby, 1998.

4. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's Medical Drug Reference, 3rd ed. St. Louis: Mosby, 1999.

5. Surawicz CM, Sinanan M, Dugdale DC, Medwell S. Anorectal disease. In Kimmey MB, Lee SP eds. Gastroenterology and hepatology for the primary care provider: principles, practice, and guidelines for referral. University of Washington CD-ROM, 2000.

6. Dugdale DC. Male osteoporosis. In Laya M, Migeon M, eds. OsteoEd web site (http://osteoed.org/), 2000.

7. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's 2001-2002 Medical Drug Reference. St. Louis: Mosby, 2001.

8. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's 2003 Medical Drug Reference. St. Louis: Mosby, 2002.

9. Dugdale DC. Male osteoporosis. In Laya M, Migeon M, eds. OsteoEd web site (http://osteoed.org/), 2002.

10. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's 2004 Medical Drug Reference. St. Louis: Mosby, 2003.

11. Dugdale DC. Male osteoporosis. In Laya M, Migeon M, eds. OsteoEd web site (http://osteoed.org/), 2003.

12. **Dugdale DC, Nadkarni M for the SGIM Medical Residents Clinic Directors Interest Group. Clinic Directors Orientation Manual. http://www.sgim.org/MRCDIG.cfm, 2003.

13. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's 2005 Medical Drug Reference. St. Louis: Mosby, 2004.

14. Dugdale DC, Staiger TS, Watkins C. An academic general internist's primer for the CPT coding system for outpatient visits. SGIM Academic Physician Administrators and Leaders Interest Group. http://www.sgim.org/APAIGCPT.pdf, 2004.

15. Ellsworth AJ, Dugdale DC, Oliver LM, Witt DL. Mosby's 2006 Medical Drug Reference. St. Louis: Mosby, 2005.

16. Dugdale DC, Staiger TS, Watkins C. An general internist's primer for the CPT coding system for outpatient visits. American College of Physicians Practice Management Center. http://www.acponline.org/pmc/cpt_code.ppt, 2005.

17. Dugdale DC. Male osteoporosis. In Laya M, Powell, H, eds. OsteoEd web site (http://osteoed.org/), 2006.

18. Dugdale DC. Male osteoporosis. In Laya M, Powell, H, eds. OsteoEd web site (http://osteoed.org/), 2008.

D. Other

1. Dugdale DC, Larson EB: Fever of unknown origin: a pragmatic approach. Hospital Medicine 1990; Jan:72-92 and Feb:87-103.

2. Dugdale DC: The difficult patient. In Smith CS, Paauw DS: Ambulatory Medicine Syllabus, University of Washington, 1990.

3. Dugdale DC: Neurology. In Paauw DS, ed., Medicine 665 Syllabus, University of Washington School of Medicine, 1996.

4. Dugdale DC. Introduction to flexible sigmoidoscopy and selected colorectal problems, syllabus for internal medicine resident elective, 1996.

5. Dugdale DC. Introduction to flexible sigmoidoscopy and selected colorectal problems, syllabus for internal medicine resident elective, 2nd ed., 1998.

6. Dugdale DC. Introduction to flexible sigmoidoscopy and selected colorectal problems, syllabus for internal medicine resident elective, 3rd ed., 2000.

7. Eisenberg MS, Ellsworth A, Dugdale DC. Beyond MOFA: what every mountaineer should carry in a first aid kit. Mountaineer 2001;95(3):1-2.

8. Eisenberg MS, Ellsworth A, Dugdale DC. Acute mountain sickness: prevention and treatment. Mountaineer 2002;96(4):1-4.

9. Dugdale DC. Introduction to flexible sigmoidoscopy and selected colorectal problems, syllabus for internal medicine resident elective, 4th revision, 2002.

10. Dugdale DC. Introduction to flexible sigmoidoscopy and selected colorectal problems, syllabus for internal medicine resident elective, 5th revision, 2004.

11. Dugdale DC. Type 1 diabetes and anaphylactic shock. Diabetes Self-Management 2010(Jan-Feb):53-4.

12. Dugdale DC. The 2012 SGIM member survey results: part 1. SGIM Forum 2012;35(10):4-5.

13. Dugdale DC, Lopez L, Palacio, Price E. The 2012 SGIM member survey results: part 2. SGIM Forum 2013;36(5):6, 11.

14. Dugdale DC. College health: part 1. SGIM Forum 2013;36(8):2, 12.

15. Dugdale DC. College health: part 2. SGIM Forum 2013;36(9):6, 14.

16. Dugdale DC, Dunne L. SGIM Finance 101. SGIM Forum 2017;40(12):9, 12, 15.

17. Dugdale DC. My European Sabbatical - How You Can Do One, Too! SGIM Forum 2018;41(12):12-13.

E. Manuscripts Submitted

1. None

F. Abstracts

1. McGoodwin W, Dugdale DC. Gaps in Rural Delivery of Preventive Health Services. J of Investigative Med; 2002;50(1).

2. Dugdale DC, Carle M. Dissemination and Impact of an Evidence-based Care Guideline for Patients with Sore Throat. Research abstract presentation at Northwest Region meeting, SGIM, February, 2010.

3. Dugdale DC, Carle M. Dissemination and Impact of an Evidence-based Care Guideline for Patients with Sore Throat. Research poster presentation at National SGIM Meeting, May, 2011.

4. Dugdale DC, Watts M. "Modification of Opioid Prescribing Patterns by use of Electronic Health Record (EHR) Tools", Research poster, Northwest Region SGIM meeting, February, 2012.

5. Theodore BR, Read-Williams P, Taylor MR, McGough P, Dugdale DC, Cahana A. Chronic pain care in the medical home: developing a model for best practices in pain management and care coordination in the primary care setting. American Academy of Pain Medicine, April, 2013.

6. Perez KM, Mao A, Nourbakhsh N, et al. Managing the pressure: staff reflections on an intervention to improve hypertension control. Poster presentation, Washington American College of Physicians meeting, November 2019.

G. National Presentations

May, 1997	Workshop Presentation to National SGIM meeting, "Time Management and the doctor-patient relationship in Managed Care", part of precourse on managed care.
April, 1998	Workshop Facilitator at National SGIM meeting, "Role Conflict and Professionalism: The Balancing Act"
April, 1999	Workshop Presentation to National SGIM meeting, "The Future of Managed Care: What to Expect and How to Thrive"; Session on managed care and the patient-physician relationship: Continuity of care issues.
May, 2002	Workshop Presentation to National SGIM meeting, "A Case-based Approach to Using New Diabetes Treatments"
May, 2002	Coordinator for Precourse Presentation to National SGIM meeting, "Resident Teaching Clinics: Recent Innovations and Meeting Challenges of the Next 25 Years"
May, 2003	Workshop Presentation to National SGIM meeting, "A Case-based Approach to Using New Diabetes Treatments"
May, 2003	Workshop Presentation to National SGIM meeting, "Managing chronic pain in academic primary care clinics"
May, 2004	Workshop Presentation to National SGIM meeting, "A Case-based Approach to Using New Diabetes Treatments"

May, 2004	Workshop Presentation to National SGIM meeting, “Measuring And Rewarding Productivity In An Academic General Internal Medicine Ambulatory Care Practice”
May, 2004	Workshop Presentation to National SGIM meeting, “How Academic General Internists Can Obtain Higher Reimbursement Without Doing Any More Work: Understanding And Applying The CPT Coding System”
April, 2005	Rammelkamp Visiting Professor, Metro Health System, Cleveland, OH
May, 2005	Workshop Presentation to National SGIM meeting, "A Case-based Approach to Using New Diabetes Treatments"
May, 2005	Workshop Presentation to National SGIM meeting, “Charting Smarter Not Longer: How academic general internists can obtain higher reimbursement without doing any more work”
April, 2006	Workshop Presentation to National SGIM meeting, "A Case-based Approach to Using New Diabetes Treatments"
April, 2006	Workshop Presentation to National SGIM meeting, “Charting Smarter Not Longer: Basic Concepts in Outpatient Coding to Improve Reimbursement Without Doing Any More Work”
April, 2006	Workshop Presentation to National SGIM meeting, "Practice Innovations for Resident Primary Care Clinics”
April, 2006	Workshop Presentation to National SGIM meeting, “Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding to Improve Reimbursement Without Doing Any More Work”
April, 2007	Workshop Presentation to Association of Chiefs of General Internal Medicine Leadership and Management Training Institute, “Improving Academic Ambulatory Practices: Improving Quality and Efficiencies”
April, 2007	Workshop Presentation to National SGIM meeting, “See One, Do One, Teach One: How Academic General Internists Can See, Do, and Teach Effective Documentation for Optimal Coding Choices to Peers and Residents”
April, 2007	Workshop Presentation to National SGIM meeting, "Developing Leadership Skills: Change Management”
April, 2007	Workshop Presentation to National SGIM meeting, “Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding to Improve Reimbursement Without Doing Any More Work”
Jan, 2008	Invited Workshop Presentation to Student Health Services at Academic Medical Centers National Meeting, “Diabetes Care at a Student Health Center: Case by Case and in Groups”
April, 2008	Invited Workshop Presentation to National SGIM meeting, “A Case-based Approach to Starting and Changing Insulin Therapy for Generalist Faculty and Trainees: From RCTs to Real World”
April, 2008	Workshop Presentation to National SGIM meeting, "Principled Negotiation Skills”

April, 2008 Workshop Presentation to National SGIM meeting, "Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding to Improve Reimbursement Without Doing Any More Work"

Jan, 2009 Invited Workshop Presentation to Student Health Services at Academic Medical Centers National Meeting, "Depression Among University Students: Diagnosis, Treatment, and New Models of Care"

May, 2009 Workshop Presentation to National SGIM meeting, "Leading and Managing Change"

Jan, 2010 Invited Workshop Presentation to Student Health Services at Academic Medical Centers National Meeting, "Pharyngitis: Clinical Update & Quality Improvement Project"

April, 2010 Workshop Presentation to National SGIM meeting, "Charting Smarter Not Longer: Advanced Concepts in Outpatient Coding to Improve Reimbursement Without Doing Any More Work"

January, 2012 Invited Workshop Presentation to Student Health Services at Academic Medical Centers National Meeting, "Opioid Analgesic Use, Overuse, and Abuse among patients at University Health Centers"

May, 2012 Invited Workshop Presentation to American College Health Association National Meeting, "Opioid Analgesic Use, Overuse, and Abuse among patients at University Health Centers"

January, 2013 Invited Workshop Presentation to Student Health Services at Academic Medical Centers National Meeting, "Urinary Tract Infections: Clinical Update and Guideline Development"

April, 2014 Peer-reviewed Presentation, SGIM National Meeting, "Update in Diabetes", part of Clinical Updates section

February, 2016 American College of Cardiology 2016 Cardiology Summit, Las Vegas, NV, "Accountable Care and Commercial Insurance in Washington State"

May, 2016 National Society of General Internal Medicine Annual Meeting, Fort Lauderdale, FL, Invited Symposium, "Achieving Population Health by Clinical Integration in Accountable Care Organizations"

April, 2017 National Society of General Internal Medicine Annual Meeting, Washington DC, Invited Clinical Update, "Technology and Diabetes Care"

April, 2019 "To what target hemoglobin A1c level would you treat this patient with type 2 diabetes?", ACP National Meeting.

May, 2019 Hypertension Interest Group, SGIM National Meeting.

EILEEN RAVELLA PA-C

422 4th Ave SW Tumwater, Washington | Cell: (405) 834-5148 | Email: eileenrr@hotmail.com

PROFESSIONAL SUMMARY

I am a well respected and highly motivated Physician Assistant with over 30 years of experience focused on clinic management and patient care. I have practiced medicine in a wide range of settings including primary care, interventional radiology, urgent care, and emergency medicine.
NCCPA certified since 1987

LEADERSHIP

WAPA Board President Elect 2018, President 2019, Immediate Past President 2020
Successfully passed HB 2378 to modernize PA practice law in the state of Washington through collaboration with stakeholders including the state medical association, medical commission and board of directors.

Clinic Owner, Family Medicine, Newkirk, OK 1989-2006
Served in leadership position as rural family medicine clinic owner from start up to marketing to developing protocols and sustaining 30 plus staff at three locations. Established financial key indicators for success of practice, developed skills criteria for all staff and maintained core staff for 17 years.

Assistant Administrator, Blackwell Regional Hospital, Blackwell, OK 1990-1993
Served a small rural hospital as CQI director for all clinical departments. Collaborated with department heads and physicians in reducing LOS and improving reimbursement through DRG review.

Mayor, Blackwell, OK 1990-1993
Managed 6 million dollar budget through rural electric cooperative in collaboration with city council and city manager.

WORK HISTORY

Urgent Care PA
Kaiser Urgent Care **-** Olympia, WA 2019-Present

- Work in collaboration with physicians, nurses, and PAs managing complex patients
- Worked per diem for four years, full time since April
- Serve on Through put and APP Guidelines committee to develop practice guidelines for all urgent care APPs

Site Clinical Lead
Providence Medical Group Immediate Care **-** Olympia, WA 2016-2019

- Opened first Providence urgent care in Olympia as sole provider until a medical director was hired. I worked in collaboration with the Medical Director to develop management, care guidelines, hired support staff and developed staffing templates for expansion of 2 additional clinics in Lacy and Hawkes Prairie, Washington.
- Developed CQI tools through chart review, developed protocols for high acuity low frequency events, collaborated with local ER for seamless transfer from urgent care to the ER.

Emergency Medicine PA
Olympia Emergency Medicine Services
St. Peter Hospital **-** Olympia, WA 2011-2016

- Ordered and executed diagnostic tests and analyzed diagnostic images to further investigate patient conditions.
- Treated pediatric patients with minor illnesses and geriatric patients with complex illnesses.
- Served on the Throughput Committee to develop surge protocols.
- Level II trauma center

Physician Assistant
Interventional Radiology Clinic**-** Providence St. Peter Hospital – Olympia, WA 2011-2013

- Responsible for outpatient and inpatient consults, post procedure follow up.
- Established Kyphoplasty registry for outcomes management, marketed practice to primary care and other specialists.

Emergency Medicine PA
Emergency Medicine Associates
Southwest Medical Center Vancouver, Washington 2008-2011

- Ordered and executed diagnostic tests and analyzed diagnostic images to further investigate patient conditions.
- Treated pediatric patients with minor illnesses and geriatric patients with complex illnesses.
- Level II trauma center

EDUCATION

Master of Science: End of Life Care George Washington University - Washington, DC 2004
Bachelor of Science: Physician Associate University of Oklahoma Health Sciences - Oklahoma City, OK 1984
Bachelor of Science: Biology East Central University - Ada, Oklahoma 1980

CERTIFICATIONS

- Active PA license in the State of Washington ACLS BLS PALS Certified 2019
- Current NCCPA Board Certified
- Member AAPA, WAPA and SEMPA

AWARDS

- **Preceptor of the Year**, University of Oklahoma, 1997
- **Physician Assistant of Year,** Oklahoma Academy of Physician Assistants, 1993

SKILLS

- Competent in suturing and minor surgical procedures
- Excellent time management skills and prioritizing multiple complex patients
- Medical staff management
- Conflict resolution ability
- Calm under pressure

Virginia "Ginny" Weir, MPH

gweir@qualityhealth.org | (206) 204-7377

PROFESSIONAL EXPERIENCE

Foundation for Health Care Quality, Seattle WA
Chief Executive Officer October 2020 – Present

- Lead organizational mission to catalyze health system-wide improvement in quality and equity.
- Recruitment and retention of staff, diverse board, and of program members.

Director, Bree Collaborative November 2013 – September 2020

- Develop and implement strategies to improve visibility, credibility, and population health impact.
- Facilitate Bree Collaborative meetings and subgroup meetings to develop evidence-based recommendations collaboratively. Recommendations used for contracting by Health Care Authority and as a community standard.
    - Manage thirty subgroups focused on developing best practices for diverse topics from surgical bundled payment models, integrating behavioral and physical health, to opioid prescribing.
    - Develop clinical guidelines, majority of which successfully integrated into contracts.
- Manage program budget and work of Bree Collaborative staff. Negotiate contract with Health Care Authority.
- Direct or conduct research into clinical best practice, existing evidence, and expert option on health care topics.
- Present to diverse stakeholder groups including Washington State Senators and Representatives, in-person and virtual conferences, boards, hospital and medical group leadership, lobbyist organizations, and consumers.

Qualis Health, Seattle, WA July 2012 – October 2013
Program Analyst

- Managed development and deployment of health care quality improvement framework with 60+ contributors.
- Developed medical home webinar curriculum for physicians and staff from 65 primary care practices.
- Designed Lean and NCQA quality improvement tools to enhance patient and provider outcomes.
- Authored and edited quarterly program financial reports, online publications, and monthly visual systems.

Department of Rehabilitation Medicine, University of Washington, Seattle, WA January 2011 – July 2012
Graduate Research Assistant

- Presented research findings at national conferences and to Multiple Sclerosis Society board, staff, and clients.
- Authored telephone-administered survey based on validated measures and input from multiple stakeholders.
- Trained research assistants on standardized survey protocol resulting in successful administration.
- Wrote focus group facilitator scripts and analyzed qualitative focus group data for survey development.

EDUCATION

School of Public Health, University of Washington, Seattle, WA June 2012
Master of Public Health, Health Services
Thesis: Predictors of Help-Seeking Behavior in Adults with Multiple Sclerosis

University of California at Berkeley, Berkeley, CA May 2008
Bachelor of Arts, Psychology
Honors Thesis: The Pursuit of Happiness: A Multidisciplinary Approach to Antidepressant Use
Semester Abroad Program, Freie Universitat, Berlin, Germany 2005

COMMUNITY LEADERSHIP

- Clinical Instructor, Department of Health Services, University of Washington School of Public Health, 2019 – Present.
- Member, Performance Measures Coordinating Committee, 2022 – Present.
- Group Facilitator, Program for Early Parent Support (PEPS), 2021-2022.
- Board Member, Washington State Public Health Association, 2016 – 2019.
- Program Development Committee Member, Out In Front: Seattle's LGBTQ Leadership Program, 2016 – 2018.

JONATHAN STALOFF, MD, MSC **SEPTEMBER 2022**

1. PERSONAL DATA

Place of Birth: Freehold, NJ
Current Address: 6900 East Green Lake Way North, Apt 249, Seattle, WA, 98115
Email: Jon.Staloff@gmail.com

2. EDUCATION

8/2010-5/2014 BA, Community Health, *with honors,* Brown University, Providence, RI
8/2015-5/2019 MD, Warren Alpert Medical School of Brown University, Providence, RI
8/2015-5/2019 MSc, Population Medicine, Primary Care Population Medicine Program, Warren Alpert Medical School of Brown University, Providence, RI

3. POSTGRADUATE TRAINING

6/2019-6/2022 Resident in Family Medicine, *Area of Concentration in Health Policy & Scholarship*, University of Washington, Seattle, WA
9/2019-present Fellow, Value and Systems Science Lab, University of Washington, Seattle, WA
7/2022-present Physician Fellow, Advanced Fellowship in Health Services Research & Development, VA Puget Sound, US Department of Veterans Affairs, Seattle, WA

4. FACULTY POSITIONS HELD

7/2022-present Acting Instructor, Department of Family Medicine, University of Washington School of Medicine, Seattle, WA

5. HOSPITAL POSITIONS HELD

8/2022-present Attending Physician, Family Medicine Inpatient Service, University of Washington Medical Center-Northwest, Seattle, WA

6. CURRENT NON-UW EMPLOYMENT

Start 7/2022 Primary Care Physician, VA Puget Sound Health Care System

7. HONORS

2013 First Prize Presentation, Vitality Institute Conference
2014 EMT of the Year, Brown University Emergency Medical Services, Providence, RI
2018 Gold Humanism Honor Society, Warren Alpert Medical School of Brown University, Providence, RI
2019 Amos Throop Prize, Warren Alpert Medical School of Brown University, Providence, RI
2019 Student Graduation Speaker, Warren Alpert Medical School of Brown University, Providence, RI
2021 Alpha Omega Alpha Honor Medical Society, University of Washington School of Medicine, Seattle, WA
2021 Scholarship Award for Best Abstract, University of Washington Department of Family Medicine 50th Anniversary Scholarship Forum, Seattle, WA
2021 Larry A. Green Visiting Scholarship, The Robert Graham Center: Policy Studies in Family Medicine, Washington, D.C.
2021 Patient Safety Nut Award, University of Washington School of Medicine Housestaff Quality and Safety Committee, Seattle, WA
2022 Scholarship Award for Best Overall Presentation, University of Washington Department Fair and Scholarship Forum, Seattle, WA

2022 Family Medicine Resident Award for Scholarship, Association of Family Medicine Residency Directors and North American Primary Care Research Group

8. BOARD CERTIFICATION

7/1/2022 Diplomate in Family Medicine, American Board of Family Medicine

9. CURRENT LICENSE TO PRACTICE

7/2022-10/2023 Washington State Medical License
1/2022-2/2025 DEA License
Exp 2022 Buprenorphine Waiver
6/2021-6/2023 Advance Cardiac Life Support
Exp 2025 Advanced Life Support in Obstetrics
7/2021-7/2023 Neonatal Resuscitation Program

10. DIVERSITY EQUITY AND INCLUSION INITIATIVES

2/2021-4/2021 **"**Picture a Scientist" Women's History Month Planning Committee: Served on planning committee for a UW Graduate Medical Education (GME) community wide screening of the documentary "Picture a Scientist" about women in STEM fields, and helped coordinate a subsequent panel discussion of cis and transgender women in medicine and basic sciences fields.

11. PROFESSIONAL ORGANIZATIONS

2019-present. Member, American Academy of Family Physicians
Offices Held: Resident Commissioner, Commission on Quality and Practice (2020-2021)
2019-present Member, Washington Academy of Family Physicians
Offices Held: Member, Primary Care Investment Task Force (2020-2021), WAFP Representative to the AAFP Primary Care Policy and Investment Learning Community

12. TEACHING RESPONSIBILITIES

2016-2017 Course Director, Healthcare in America, Warren Alpert Medical School of Brown University
2018-2019 Course Director, Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University

13. EDITORIAL RESPONSIBILITIES

2020- Associate Editor, *Healthcare: The Journal of Delivery Science & Innovation*

14. SPECIAL NATIONAL RESPONSIBILITIES

2014-2017 Jed and Clinton Health Matters Campus Program, Board of Advisors
2018 American Medical Association Accelerating Medical Education Consortium, Conference Planning Committee

15. SPECIAL LOCAL RESPONSIBILITIES

2019-2022 Curriculum Committee, University of Washington Family Medicine Residency
2019-2021 Chief Resident Selection Committee, University of Washington Family Medicine Residency
2020-2022 Residency Application Reviewer and Interviewer, University of Washington Family Medicine Residency
2021 Research Track Admissions Committee, University of Washington Family Medicine Residency
2021-2022 Reviewer, University of Washington Department of Family Medicine Scholarship Fair

2022 Primary Care Certification Workgroup for Primary Care Transformation Model, Washington Health Care Authority
2022 Brown University Emergency Medical Services Continuity Board

16. RESEARCH FUNDING

A. Past

2016 Primary Care Population Medicine Program, Warren Alpert Medical School of Brown University
Physician Engagement in Accountable Care Organizations
Total Costs: $5,000
Role: Principal Investigator, Master's Research

2021 Robert Graham Center: Policy Studies in Family Medicine, American Academy of Family Physicians
Family Medicine Resident Contributions during COVID-19 Pandemic
Total Costs: $600 + DC housing costs
Role: Larry Green Visiting Scholar

17. BIBLIOGRAPHY

A. Publications in Referenced Journals

1. **J Staloff,** M Diop, R Matuk, A Riese, J White. "Caring for Caregivers: Burnout and Resources for Caregivers in Rhode Island." *Rhode Island Medical Journal.* November 1, 2018. PMID 30384512
2. **J Staloff,** K Monteiro, M Mello, I Wilson. "Knowledge, Attitude, and Confidence in Accountable Care Organization-Based Payment Models Among RI Physicians." *Rhode Island Medical Journal.* March 1, 2019. PMID 30823694
3. Zmijewski PV, **Staloff JA,** Wozniak MJ, Mazzaglia PJ, Subtotal Parathyroidectomy vs Total Parathyroidectomy with Autotransplantation for Secondary Hyperparathyroidism in Dialysis Patients: Short- and Long-Term Outcomes*, Journal of the American College of Surgeons* (2019). PMID 30776511
4. **J Staloff**. "What Does it Mean to Heal?" *Rhode Island Medical Journal*. June 4, 2019. PMID 31167521
5. Marcotte LM, Navathe AS, **Staloff JA**, Liao JM. "Medicare's Reliance on Acute Hospitalization Rates Could Undercut the Impact of its Primary Care First Program," Health Affairs Blog, May 13, 2020. 10.1377/hblog20200511.241173
6. **Staloff JA**, Navathe AS, Liao JM. "It's Time to Advance Payment Reform Using the Principle of Policy Equipoise." JAMA Health Forum. November 2, 2020. doi:10.1001/jamahealthforum.2020.1323
7. **Staloff J**; Davenport-Welter C; Stands-Over-Bull G; Wilson M. "Is cognitive behavioral therapy more effective than other psychotherapies in patients with schizophrenia" Evidence-Based Practice, August 12, 2021. doi: 10.1097/EBP.0000000000001398

B. Published Videos

1. **J Staloff.** "President Biden's Quest for a Public Option," *The Podcast by KevinMD*. April 15, 2021.

C. Other Publications

1. **J Staloff.** "Campus View: JFK's Inspiring Role In ObamaCare." *USA Today.* September 29, 2013.
2. **J Staloff.** "Opinion: It's Time Our Primary Thought Is Primary Care." *CNN Health*. January 22, 2014.

3. J Seidman, **J Staloff,** M Coppage, D Jagun, A Valladares. "The Forest Through the Trees: Maximizing Value in an Evolving Healthcare System." *Robert Wood Johnson Foundation & Avalere Health*. May 12, 2015.
4. **J Staloff.** "The Most Loving Thing: End of Life and Saying Goodbye" *KevinMD.com*. March 6, 2019.
5. **Staloff JA,** Liao JM, Reddy A, Marcotte LM. Primary Care First. *VSSL Briefs.* 2020; 1:2.
6. **Staloff JA**, Liao JM, Clodfelter R, Marcotte LM. Direct Contracting. *VSSL Briefs*. 2020; 1:3.
7. **J Staloff.** "How President Biden's Quest for a Public Option Mirrors LBJ's Passage of Medicare and Medicaid." *KevinMD.com.* Jan 25, 2021.
8. Clodfelter R, Liao JM, **Staloff JA,** Marcotte LM. Pathways to Success Medicare Shared Savings Program. *VSSL Briefs.* 2021; 1:8.
9. **J Staloff** and C Simon. "The Pandemic's Epidemic: Opioid Use Disorder and Subpar Suboxone Access." KevinMD.com. March 26, 2021.
10. Marcotte LM, **Staloff JA**, Reddy A, Liao JM. The Primary Care Reform Intervention Stakeholder Matrix: A Framework For Advancing Primary Care. *Value and Systems Science Lab*. March 2021.
11. **Jonathan Staloff. "**Engaging Washington State Primary Care Workforce in Primary Care Transformation." Policy Brief for *Washington Health Care Authority*. May 2022.

D. In Press

1. **Staloff J**, Jabbarpour Y. "Reflections from Family Medicine Residents on Training During the COVID-19 Pandemic." *Family Medicine*. *In press.*

18. INVITED TALKS, SPEECHES, AND PRESENTATIONS

A. National

1. "Subtotal Parathyroidectomy Versus Total Parathyroidectomy with Autotransplantation for Secondary Hyperparathyroidism in Dialysis Patients: Short and Long Term Outcomes" *New England Surgical Society 99th Annual Meeting*. Co-Author on Podium Presentation (Presentation given by lead author Dr. Polina Zmijewski), 2018.
2. "Optimizing HIV PrEP at University of Washington Family Medicine Residency Clinics." Co-presenter. *Society for Teachers of Family Medicine* 2022 *Annual Spring Conference*.
3. "Family Medicine Resident Contributions to Care of the American Public During COVID-19." Lead presenter. *Society for Teachers of Family Medicine* 2022 *Annual Spring Conference*.

B. Regional

1. "The #HealthySelfie," *Vitality Institute Public Health Intern Innovation Challenge*. Lead Presenter, 2013.
2. "Brown Medical Students for the Affordable Care Act." Speech given at Rhode Island Congressional Delegation Save Healthcare Day of Action Rally. Invited by the office of US Senator Jack Reed. Feb 2017. https://www.facebook.com/SenJackReed/videos/1278249148932358

C. Local

1. Value Based Payment Reforms: ACOs and PCMH." Lecture delivered in Health Systems Sciences I,II, and III and Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2016-2019.
2. "History of Healthcare Reform in the United States" Lecture delivered at Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2019.

3. "Knowledge, Attitudes, and Confidence in Accountable Care Organization-Based Payment Models Among RI Physicians," Poster presentation at *Warren Alpert Medical School of Brown University Scholarship Forum,* March 2019.
4. "ABC(D)s of Medicare and Medicaid."
    a. Lecture delivered at Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2019
    b. Lecture delivered at Noon Conference, University of Washington Family Medicine Residency, 2021.
5. "Hospital and Physician Payment and Developing Payment Reforms."
    a. Lecture delivered at Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2019.
    b. Lecture delivered at Noon Conference, University of Washington Family Medicine Residency, 2021.
6. "Pharmaceutical Development and Drug Policy Challenges." Lecture delivered at Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2019.
7. "Affordable Care Act: A Policy Overview"
    a. Lecture delivered at Fundamentals of Health Policy and Management, Warren Alpert Medical School of Brown University, 2019.
    b. Lecture delivered at Noon Conference, University of Washington Family Medicine Residency, 2021.
8. "What Does it Mean to Heal?" Student Commencement Speech. Warren Alpert Medical School of Brown University. May 2019. https://www.youtube.com/watch?v=7jenZmYukAg
9. "First Things First: Using Prior Insights to Succeed in Medicare's Primary Care First Program." Poster presentation at *University of Washington Department of Family Medicine Scholarship Fair*, April 14, 2021.
10. "Family Medicine Resident Contributions and Experiences During the COVID-19 Pandemic" Long form presentation at *University of Washington Department of Family Medicine Scholarship Forum*. Long Presentation. April 20, 2022.
11. **"**Engaging Washington State Primary Care Workforce in Primary Care Transformation." Presentation delivered to the Office of the Chief Medical Officer of the *Washington Health Care Authority*, May 4, 2022.
12. "COVID-19 Policy in the White House," Coordinated and moderated discussion with Vidur Sharma, Policy Advisor for Testing on White House Coronavirus Task Force, *R3 Practice Management Curriculum*, University of Washington Family Medicine Residency, May 4, 2022.
13. "Physician Leadership in Medicare and Medicaid Policy," Coordinated and moderated discussion with Dr. Nancy Fisher, Chief Medical Officer for Region 10 of Centers for Medicare and Medicaid Services, and Dr. Charissa Fotinos, Acting Medicaid Director for State of Washington, *R3 Practice Management Curriculum,* University of Washington Family Medicine Residency, May 4, 2022.

19. OTHER EMPLOYMENT

2012	Research Assistant, Hospital of the University of Pennsylvania, Philadelphia, PA
2013	Health Matters Initiative Intern, Clinton Foundation, New York, NY
2014-2015	Associate, Center for Payment & Delivery Innovation, Avalere Health, Washington, D.C.
2017	Medicaid Policy Intern, Rhode Island Executive Office of Health and Human Services

Katina Rue, DO, FAAFP, FACOFP

Personal Data

411 Wickersham Road
Yakima, WA 98908

509.480.1603 (cell)
doctorkatwoman@gmail.com

Place of Birth: Pueblo, CO

Citizenship: USA

Education

6/2000-6/2004 Doctor of Osteopathy
University of Health Sciences College of Osteopathic Medicine, Kansas City, MO
(currently named Kansas City University)

9/1995-6/1999 Bachelors of Science (Biology 1999, Exercise Science 1998)
Montana State University, Bozeman, MT

9/1993-6/1995 Undergraduate Coursework
Western Washington University, Bellingham, WA

Post-Graduate Training

10/22-3/23 National Institute for Program Director Development Fellowship

1/21 -5/21 Institute for Healthcare Improvement Open School Basic Certificate, Virtual

1-3/20 WSMA Physician Leadership Course, Seattle, WA

7/19-6/20 PNWU Master Preceptor Fellowship, Yakima, WA

2019-2020 AOGME CME Leadership Development Fellowship, Online and San Diego, CA

9/17-6/18 UW/Madigan Faculty Development Certificate Program

7/05-6/07 Medical Center of Independence Family Medicine Residency, Independence, MO
2006-2007 Chief Resident

7/04-6/05 Medical Center of Independence Osteopathic Rotating Internship, Independence, MO Chief Intern

Faculty Positions

1/22- present **Program Director**

Trios Family Medicine Residency Program

Kennewick, WA

6/19-present **Clinical Assistant Professor**

WSU, EFSCOM Department of Medical Education and Clinical Sciences

Pullman, WA

6/2019-pres **Adjunct Clinical Faculty**

Des Moines University, Department of Family Medicine

Des Moines, IA

1/16-present **Clinical Instructor**

UW Department of Family Medicine

Seattle, WA

12/07-present **Adjunct Clinical Faculty**

Pacific Northwest University College of Osteopathic Medicine- Department of Family Medicine and Osteopathic Principles and Practices

Yakima, WA

10/15-2/21 **Core Faculty**

Central Washington Family Medicine Residency

Yakima, WA

1/20 – 6/21 **Clinical Instructor in Family Medicine**

Idaho College of Osteopathic Medicine

Meridian, ID

1/09-6/18 **Clinical Instructor in Family Medicine**

Gonzaga University

Spokane, WA

9/07-1/20 **Adjunct Clinical Faculty**

Kentucky College of Osteopathic Medicine

Pikeville, KY

1/08-6/10 **Clinical Instructor in Family Medicine**

UW Med-Ex PA Program

Seattle, WA

7/04-6/07 **Clinical Instructor in Family Medicine**

University of Health Sciences

Kansas City, MO

6/16-12/19 **Adjunct Clinical Faculty**

Physician Assistant Training Program at Heritage University

Toppenish, WA

Hospital/Clinical Positions

1/22-Present **Trios Health Family Medicine Residency Clinic**

10/15-5/21 **Community Health of Central Washington**

Contracted Inpatient Family Medicine Attending Physician 2/2021-5/2021

Inpatient and Outpatient Family Medicine Attending Physician (2015-2021)

Highland Clinic Site Director 2016-2019

Graduate Medical Education Committee Member 2017-2020

resPIP Committee Member

Clinical Competency Committee Member 2016-2020

Centralized Access Center Task Force Co-Chair 2020

Program Evaluation Committee Committee Member 2016-2020

CARED committee Member 2017-2020

Ignite Leader 2016-2020

7/07-5/21 **Virginia Mason Memorial, Yakima, WA**

Inpatient and Outpatient Family Physician (2007-2015)

Antibiotic Stewardship Committee 2019-2021

CME Committee Chair 2011-2015

Physician Pillar Member 2013-2014

Credentials Committee Member 2009-2012

Bylaws Committee Member 2010-2011

Backup Committee Member 2008-2010

10/15-3/19 Astria Regional Medical and Cardiac Center, Yakima, WA

Inpatient Family Medicine Physician

Medicine Department Chair 2016-2019

6/15-12/16 **Westside MediCenter, Yakima, WA**

Urgent Care Physician

6/12-6/16 **MiCare Clinics, Yakima, WA**

Outpatient Family Physician

7/08-6/15 **Yakima Valley Memorial Hospital, Yakima, WA**

Lead Medical Consultant to Inpatient Psychiatric Medicine Service

8/07-6/15 **Family Medicine of Yakima, Yakima, WA**

Outpatient Family Medicine

Executive Leadership Team 2011-2015

6/11-6/13 **Memorial Physicians After Hours Clinic, Yakima, WA**

Medical Director

7/05-6/07 **Urgent Care of Kansas City, Independence, MO**

Urgent Care Physician

7/04-6/07 **Medical Center of Independence, Independence, MO**

Resident Physician

Graduate Medical Education Committee Member 2006-2007

Non-Surgical RPAC Resident Member 2005-2007

Consulting Positions

10/21-1/22	Graduate Medical Education Consulting, Trios Family Medicine Residency. Tri-Cities, WA.

Honors

2021	Washington State Medical Association Grassroots Advocate Award
2020	Society of Teachers of Family Medicine, Master Preceptor
2020	Fellow, American College of Osteopathic Family Physicians
2018	Fellow, American Academy of Family Physicians
2007	Resident of the Year, Medical Center of Independence
2006	Resident Research Forum Award, Missouri Association of Osteopathic Physicians and Surgeons (MAOPS)
2006	Wetzel Convention Scholarship Recipient, MAOPS
2005	Judge Donald J Manford Scholarship Recipient
2004	Outstanding Primary Care Resident Scholarship Recipient, Medical Center of Independence
2004	Clinical Science Research Awardee, University of Health Sciences
2003	Scholarship Recipient, Northwest Osteopathic Medical Foundation
2002	Clinical Research Fellowship Recipient, University of Health Sciences
2002	American Medical Association UHS-COM Chapter Scholarship Recipient, Spring
2002	Sigma Sigma Phi, National Osteopathic Service Fraternity Inductee
2000	Clallam County Community Physicians Benefit Fund Scholarship Recipient
1999	Who's Who Among Students in American Universities and Colleges
1999	Harrison Award for Unrecognized but Vital Service to Montana State University
1998	Mortar Board and Golden Key National Honor Societies Inductee
1992	Helen Radke Youth Achievement Award; Clallam County, WA

Board Certification

AOBFP Board Certified Family Medicine/Osteopathic Manipulative Treatment 2007, 2015

Current Licenses to Practice

Washington State Department of Health, DO OOP002241, expires 2023

DEA License, expires 2023. Details available upon request.

Buprenorphine Waiver, granted 2018

Professional Organizations

Washington State Medical Association

2022-2023	President
2022-2024	Latinx Advisory Council Member
2021-2022	President-Elect
2021-2023	Co-Chair, Diversity, Equity, and Inclusion Committee
2021-2022	Chair, Corporate Practice of Medicine Task Force
2020-2021	1st Vice President
2019-2020	2nd Vice President
2018-2019	Secretary-Treasurer
2017-2018	Assistant Secretary-Treasurer
2016-present	Board of Trustees
2013-2015	Nominating Committee
2014-2015	Young Physicians Section Delegate to House of Delegates
2013-2014	Young Physicians Section County Society Liaison
2010-2013	Young Physicians Task Force Founding Member
2007-present	Member

Washington Academy of Family Physicians

2022-2024	Alternate Delegate to AAFP Congress of Delegates
2023	Nominating Committee Chair

2022	Reference Committee Chair at Annual House of Delegates
2020-2022	Nominating Committee
2019-2021	Primary Care Investment Task Force Member
2019-2020	Nominating Committee Chair
2016-2021	South Central Chapter President
2014-present	Bylaws Committee Member
2019-present	South Central Chapter Delegate to Annual House of Delegates
2008-present	Member
2018	Reference Committee Chair at Annual House of Delegates
2010	Reference Committee Chair at Annual House of Delegates
2009	Reference Committee Member at Large at Annual House of Delegates

Washington Medical Political Action Committee

2022-2023	Chair
2020-2022	Vice-Chair
2019-2020	Secretary-Treasurer
2016-present	Board of Trustees
2015-present	Diamond Club Member

Northwest Osteopathic Medical Foundation

2022-2024	Immediate Past-President
2020-2022	President
2019-2020	President Elect
2018-present	Lifetime Member
2014-present	Board of Trustees

Washington Osteopathic Medical Association

2016-present	Bylaws Committee Member

2014-present Professional Affairs Committee Member

2007-present Member

Yakima County Medical Society

2022-Present Immediate Past-President

2020-2022 President

2010-present Board of Trustees

2016-2017 Immediate Past-President

2014-2016 President

2013-2014 President-Elect

2012-2013 Treasurer

2010-2014 Delegate to WSMA HOD

2009 Alternate Delegate to WSMA HOD

2007-present Member

Society of Teachers of Family Medicine

2015-present Member

American Academy of Family Physicians

2020-2021 Member, Wellness Fellowship Advisory Group

2004-present Member

American College of Osteopathic Family Physicians

2000-present Member

2013 Washington State Delegate, Congress of Delegates

Association of Family Medicine Residency Directors

2017-present Member

2020-1/2021 Board of Trustees Member

2020-1/2021 Membership Committee Member

Assembly of Osteopathic Graduate Medical Educators

2017- present Member

American Osteopathic Association

2000-present Member

Osteopathic Foundation of Central Washington

2010-2012 Golf Classic Committee Chair

2009-2012 Board Member

Jackson County, Missouri Osteopathic Association

2005-2007 Resident Board Member

Missouri Association of Physicians and Surgeons

2004-2007 Resident Liaison to Missouri State Medical Association

2000-2007 Member

Missouri State Medical Association

2003 Reference Committee Member

2000-2007 Member

American College of Clinical Pharmacy

2005-2006 Associate Member

Student National Medical Association

2000-2004 Member

2001-2002 Chair, Youth Science Enrichment Project

Teaching Responsibilities

Medical Student Education

2021-present PNWU Osteopathic Principles and Practices Instructor

2015-2/2021 Clerkship Site Director at CWFM-R for UW and PNWU clerkship students (about 15 students/year)

2015-2/2021 Sub-Intern Student Director at CWFM-R (about 25 students/year)

2015-12/2020 Community Clinical Case Conferences (C4s) – Yakima Valley Interprofessional Education Consortium

2015-2019 Clinical Skills Instructor, Pacific Northwest University

2007-present Family Medicine Preceptor, Pacific Northwest University

Resident Education

2021-present Curricular Lead: Inpatient Medicine, Gynecology, Obstetrics, Health Systems Management/Advocacy, procedure; Co-Lead: Quality Improvement

2021-2022 Resident Didactics (Intro to Advocacy, Residents as Educators, Clinical Reasoning, OMT, Implicit Bias, Leadership)

2019-2020 Wellness Curricular Co-Lead

2018-2020 Transition to Post-Residency Curricular Lead

2018-2020 Family Medicine Inpatient Medicine Curricular Co-Lead

2017-2020 Resident Orientation Curricular Lead

2017-2020 General Surgery Curricular Lead

2017-2020 Surgical Subspecialties Curricular Lead

2016-2020 Occupational Medicine/Quality Curricular Lead

2016-2020 Ambulatory Family Medicine Curricular Lead

2017-2020 Musculoskeletal Medicine Curricular Lead

2015-2020 Osteopathic Medicine Curricular Lead

2015-2020 Resident Didactics (OMT workshops, leadership, advocacy, infertility evaluation, diarrhea and constipation, suicide prevention, fatigue mitigation, introduction to patient safety, professionalism, evaluation and treatment options for hip pain, suturing workshops, intrauterine device insertion workshop)

Regional Presentations/Faculty Development

6/2022 Intro to GME to TeamHealth Clinical Faculty

10/2020 Telehealth and the Physician Community; Presentation to Washington State Legislature Joint Select Committee on Health Care Oversight.

2019 Acute Opioid Prescribing – WOMA Primary Care Update with Jeb Shepard

Faculty Development

2015-present Family Medicine Residency Network Faculty development monthly webinars

2022 American College of Osteopathic Family Physicians Program Director/Faculty Development Workshop Attendee

2019-2020 Pacific Northwest University Master Preceptor Fellowship

2019-2020 American Association of Colleges of Osteopathic Medicine/Assembly of Osteopathic Graduate Medical Educators Faculty Development Program for GME Leaders

2015-2021 University of Washington Family Medicine Clerkship End of Quarter meetings

2019 Success with Interprofessional Practice and Education Program 101

2019 Family Medicine Program Directors Workshop Attendee

2018 Family Medicine Program Directors Workshop Attendee

Leadership Development

2020 Washington State Medical Association Physician Leadership Course (40 hrs)

2010-present Washington State Medical Association Annual Leadership Development Conference

Advising

2022	Advisor for Family Medicine Residents
2015-2020	Advisor for Family Medicine Residents (3-4/year)

Editorial Responsibilities

None

Special National Responsibilities

None

Special Local/Regional Responsibilities

2022-present	Primary Care Certification Workgroup Member, Washington State Health Care Authority
2022-present	Yakima Valley Interprofessional Education Consortium Faculty Development Committee Member
2021-2023	Community Health Worker (CHW) Leadership Committee including Operations and Education subcommittees, Washington State Department of Health
2021-2022	Yakima Valley Interprofessional Education Consortium External Advisory Committee Member
2019-2020	Washington Osteopathic Medical Association Planning Primary Care Update Committee Co-Chair
2019	Washington State Department of Health Community Health Workers Task Force Member
2019	Washington State Medical Association/Washington State Radiological Association CME Planning Committee Member
2018-2019	Washington Osteopathic Medical Association Planning Primary Care Update Committee Co-Chair
2018-2019	Washington Osteopathic Medical Association Annual Fall Seminar Planning Committee Co-Chair
2017-2018	Washington Osteopathic Medical Association Annual Fall Seminar Planning Committee Co-Chair
2001-2007	Kansas City Free Health Clinic Volunteer Physician

Research Funding

None

Bibliography

Peer-Reviewed Manuscripts

THE VALUE OF OSTEOPATHIC RECOGNITION. Katina Rue, Kim Stutzman, Michelle Chadek. The Annals of Family Medicine Jan 2021, 19 (1) 86-87; DOI: 10.1370/afm.2663. PMID: 33431402

Other Peer-Reviewed Scholarly Work

None

Book Chapters

None

Media Presence

1. Family Physician comments on telehealth during the COVID-19 pandemic. KAPP/KVEW TV aired Sept 19, 2020.
2. Perspectives on how Osteopathic Recognition enhances patient care. Katina Rue. Posted April 1, 2020. https://ormatters.org/perspectives-on-how-osteopathic-recognition-enhances-patient-care-from-katina-rue-do/
3. Interview: La Zeta 104.9 Spanish Radio. How to find a family physician in Yakima. August 29, 2018.

Lay Press

1. Flu combined with COVID-19 could mean double trouble for many patients. Guest opinion .Yakima Herald-Republic. Sept 20, 2020
2. State can remedy primary care gap. Guest Opinion. Yakima Herald-Republic. Feb 2, 2014. Updated May 28, 2015
3. Unhappy Holidays? Advice for managing a child's behavior during this busy season. Busybee magazine. October 22, 2012.

Manuscripts submitted

None

Scholarly Works-in-Progress

2020 Effect of dedicated newborn clinic on rate of newborn visits in a teaching health center.

2019 Spinal Cryptococcal infection in a multiple sclerosis patient on fingolimod. **Katina Rue**, DO 1 ; Gina Many, PhD 1 ; Charles Kotulski, MD 1 ; Peter Grunert, MD

Abstracts

1. *Bioassay for Direct Antimicrobial Activity of Lansoprazole Against Vaginal Lactobacilli* – JAPHA Mar 2004.
2. *Effect of Lansoprazole on PMN Activity and Chemokines in Healthy Women* – JAPHA Mar 2004.
3. *Effect of Lansoprazole on IL-6 in Healthy Women* – JAPHA Mar 2004.

Presentations

International

None

National

None

Regional

1. The Feminine Touch: Women in Osteopathic Medicine Documentary guest panelist discussion. Northwest Osteopathic Medical Foundation. March 2021
2. A Virtual Chat with a Virtual Site Visitor and a review of the ACGME Osteopathic Recognition Focused Revisions effective July 1, 2021. University of Washington Family Medicine Residency Network Osteopathic Lead Webinar. February 2021.
3. Telehealth Revolution. Association of Washington Businesses Rural Vitality Summit. November 2020.
4. Select Joint Committee on Health Care Oversight, Washington State Legislature. Testimony Provided on Telehealth. October 2020
5. Pacific Northwest University Regional Site Administrator Residency Interview Roundtable Discussion panelist. October 2020

6. Washington State Opiate Reporting Tool presented with Jeb Shepard at Washington Osteopathic Medical Association 2019 Annual Meeting
7. Diabetic Group Visits mentored Resident presenter at Washington Osteopathic Medical Association 2019 Annual Meeting
8. OMT Billing and Coding for Washington State Coders Association. March 2019
9. OMT Basics for MD's presented at Washington Academy of Family Physicians Annual Scientific Assembly. Spokane, WA. April 2018
10. OMT Billing and Coding for Washington State Coders Association. Sept 2013
11. Osteopathic treatment of common low back ailments. WAFP Resident and Student Retreat. January 2011
12. *Preference of Adults for an Herbal or Natural Product over Prescription Medication to Treat Chronic Illness* – abstract oral presentation 2006 MAOPS Convention; abstract poster presentation 2005 ACCP Annual Meeting, 2006 KCUMB Research Symposium
13. *Effect of Lansoprazole on Vaginal Lactobacillus* – abstract oral presentation 2003 UHS-COM Research Symposium; abstract poster presentation 2003 ACOG Annual Conference, Clinical Pharmacy 2003 Annual Research Day, KC Area Life Sciences Research Day, Missouri Life Sciences Week
14. *Effect of Lansoprazole on Vaginal Ecosystem* – abstract poster presentation 2003 UHS-COM Research Symposium, 2003 Clinical Pharmacy Annual Research Conference, 2003 KC Area Life Sciences Research Day, 2003 Missouri Life Sciences Week .

Local

1. Women in Medicine Panelist for Pacific Northwest University WIM and FMIG. February 2022.
2. Giving Feedback. Trios Family Medicine Residency Faculty. November 2021
3. Women in Medicine Panelist for Pacific Northwest University WIM and FMIG. December 2020.
4. Residency Application Personal Statement. Presenter. Pacific Northwest University Yakima Rotation Cohort. May 2020
5. Physician and Student Suicide Prevention Panelist, Pacific Northwest University, November 2019.
6. OMT Basics for MD's. Central Washington Family Medicine Faculty Development Workshop May 2019.
7. Grand Rounds Lecture 49 year old Type 1 DM with complications from gastroenteritis, Pacific Northwest University, March 2019
8. Grand Rounds Lecture Complications from poorly controlled Type 1 diabetes, Pacific Northwest University, October 2018
9. Resident Advising Best Practices, Central Washington Family Medicine Residency Faculty Retreat, August 2018

10. MD's Precepting DO Residents, Central Washington Family Medicine Residency Faculty Retreat, August 2018
11. Billing and Coding for Undergraduate Medical Students, Pacific Northwest University, Jan 2018
12. Yakima Valley Interprofessional Education Panelist for PNWU Academic Day, April 2017

Educational Innovations

1. Evaluated and implemented wellness curriculum in Family Medicine Residency Program.
2.

KEVIN PHELAN | PROVEN INNOVATIVE & STRATEGIC BUSINESS LEADER | SUCCESSFUL HEALTHCARE NETWORK DEVELOPER

PORTLAND, OR • 602.882.0490 • LINKEDIN.COM/IN/KEVIN-PHELAN1• PHELANKJ@GMAIL.COM

SUMMARY

Dedicated network development leader with a strong drive to excel in any given task. Proven accountable for the strategic direction and oversight of operations in network development in new and existing markets. Demonstrated ability to maintain balance in agile work environments for creating sustainable business partnerships, increasing employee engagement plus retention, and successfully leveraging win-win partnerships. Experienced in collaboration with senior leaders, developing cross-functional partnerships, and communicating with key providers and stakeholders. Intrinsically passionate about improving healthcare operations, meeting community need, and ensuring company's future growth potential.

KEY PROFICIENCIES AND SKILLS

STRATEGIC PLANNING | BUSINESS DEVELOPMENT | NETWORK STRATEGY | COMPLEX CONTRACT NEGOTIATIONS | POPULATION HEALTH | VALUE - BASED PAYMENT
MEDICAID | MEDICARE | DUALS | LTSS | PROVIDER PARTNERSHIPS | COMMUNITY STAKEHOLDERS | VENDOR MANAGEMENT | HEALTH PLAN OPERATIONS

PROFESSIONAL EXPERIENCE

VICE PRESIDENT, NETWORK MANAGEMENT | MOLINA HEALTHCARE | BOTHELL, WA **2022-PRESENT**

Plans, organizes, staffs, and leads all activities of the Provider Network Management and Operations Department. Works with staff and senior management to develop and implement provider contracting and service strategies to contain unit cost, improve member access and enhance provider satisfaction with the Plan. Also oversees provider credentialing, delegation oversight and provider network administration activities.

- Develop and implement provider network and contract strategies, identifying specialties and geographic locations in which to concentrate resources for purposes of establishing an adequate network of providers to serve the health care needs of the membership.
- Develop and maintain a market-specific provider reimbursement strategy consistent with Reimbursement Tolerance Parameters (across multiple specialties/geographies). Oversees the development of new reimbursement models.
- Directs the preparation and negotiations of provider contracts and oversees negotiation of contracts in concert with established company templates and guidelines with physicians, hospitals, and other health care providers.
- Contribute as a key member of the Senior Leadership Team and other committees addressing the strategic goals of the department and organization.
- Negotiate and implement VBP programs with provider partners including Behavioral Health and SDOH initiatives to incentivize quality performance.

VICE PRESIDENT, NATIONAL PROVIDER NETWORKS | CARESOURCE | DAYTON, OH **2021-2021**

Developed and executed the national network strategic plan. Accountable for the development and execution of VBP plans for Pharmacy, Retail, and Behavioral Health initiatives for CareSource's 2.1+ million members. *Position eliminated due to company reorganization.*

- Proactively monitored projected member access for several markets including OH, IN, GA, KY and West VA. Continually identified areas of opportunity in provider services for Medicare, Medicaid, and Commercial products towards optimal utilization of services in both urban and rural areas per individual state guidelines and policy; ensured implementation of budgeted parameters and reimbursement standards while leveraging traditional, virtual, and delegated provider partners with timeliness.
- Collaborated, designed, and implemented VBP programs with Path to Value along the continuum of care including Behavioral Health and SDOH initiatives for ensured quality performance with consideration of states' outcome goals.
- Led provider partnership development for new markets in AK and RI; collaborated with key stakeholders to develop market entry approach for new procurements plus secured collaborative provider partnership opportunities in new and existing markets to promote accessibility of member access, assurance of quality outcomes performance, and methodically identified potential barriers for successful contract negotiation outcomes.
- Consulted with legal counsel and appropriate regulatory agencies to clarify, negotiate, and resolve contractual issues across all markets; proactively streamlined processes for claim payments, eligibility, and prior authorizations resulting in the prevention of contract terminations.

STRATEGY ADVANCEMENT PRINCIPAL | MEDICAID & DUALS BUSINESS DEVELOPMENT | HUMANA | LOUISVILLE, KY 2018-2021

Led provider network development within Business Development team and drove strategic provider initiatives to grow Medicaid, Duals, and LTSS lines of business with the focus on building new markets for Humana's already 20+ million members. Proactively researched and presented key information via leading presentations for provider landscape in prospective markets.

- Led collaboratively with Medicaid leadership and business partners towards aligned approaches for new network builds, shared researched provider strategies, program development initiatives, and drafted lengthy proposal response narratives for network-related items.
- Responsible for the development of VBP programs, SDOH initiatives, and telemedicine opportunities; designed provider programs such as HIV CHW programs for underserved populations in LA.
- Led new network development initiatives and implementation activities, including VBP program development for new market opportunities, adequately assessed in areas of program requirements, benefits, reimbursement models, population, health, anticipated membership, and utilization of services.
- Drove timely completion of deliverables, oversaw project plans and cross-functional resources via reverse engineered strategic processes for state release of procurements; collaborated with relevant teams towards risk mitigation.
- Led cross-functional teams to ensure efficient and timely provider load in applicable systems, creation of directories compliant with state requirements; streamlined processes in operations (i.e., contract flow process, PCP/member attribution, and financial approval process).

SENIOR DIRECTOR, NATIONAL NETWORK DEVELOPMENT I AETNA | PHOENIX, AZ 2012-2017

Promoted to direct network development activities and VBP contracting for new Medicaid/Duals/LTSS markets, which included managing network Directors at the market plan level with accountability to market leadership. Assisted the Executive Director of Business Development and Regional Vice Presidents in developing strategy and provider relationships in new opportunities.

- Led development of the provider network strategy for contracting, reimbursement, reviewed state procurement opportunities with RFPs towards state alignment and utilization of services, VBP, and cultivated provider relationships for new markets via successfully built trust-based relationships with on-time management skills; further assisted in community health centers, public health departments, and in rural centers that served low-

income populations aimed at the underinsured and non-insured.

- Managed new build initiatives and day-to-day operations of multiple network management teams consisting of up to 40+ people, included staff development via coaching/training, handling direct reports, keeping legal finance teams on-task, and increased employee engagement via innovative strategic leadership methods via directed cooperative employee learning opportunities.

DIRECTOR, NATIONAL NETWORK DEVELOPMENT | AETNA | PHOENIX, AZ **2008-2012**

Directed new Medicaid market network builds and contracting efforts with hospital systems, physicians, ancillary providers, and vendors. Responsible for securing defined network within prescribed timeline and budgeted financial parameters for healthcare operations in 10+ markets.

- Negotiated competitive and complex managed care contractual relationships with providers according to guidelines with emphasis placed on efficiency via detailed contracts to serve in multiple states; successfully negotiated within reimbursement parameters and volume for optimal rates as part of a national and regional network strategy.
- Managed resources assigned to network development activities while provided training and guidance for benefit design, covered services, reimbursement methodologies, regulatory requirements, and oversaw operations teams to build environments for each market; included identification of program requirements, benefits, reimbursement structures, claims payments, Medicaid/Duals fee schedules, and specifically aligned state expectations in current market.

EDUCATION

Bachelor of Science | University of Phoenix | Phoenix, AZ **1999**
Associates in Applied Science | Phoenix College | Phoenix, AZ **1992**

Additional experience includes:

- *Principal, Network Development Consultant - 2007-2008*
- *Senior Contracting Manager, Schaller Anderson - 2004-2007*
- *Provider Network Manager, Blue Cross Blue Shield of Arizona - 1999-2003*

**References available upon request*

Kristal L. Albrecht MBA, CPA

kalbrecht@chas.org (509) 979-9563

Experienced executive with more than 20 years of progressive experience in financial leadership. Highly motivated by the concepts of Quadruple Aim and improving the quality of life for community members. Proven history of adapting to new environments, including a unique ability to pick up new software systems and professional skills. Open and honest communication, curiosity and a drive to learn new skills make me a unique addition to any team.

PROFESSIONAL SKILLS

- Financial & Strategic Planning. Budget Development. Business Expansion & Startup
- Capital Planning; including bond and traditional financing
- Accounting & Financial Operations. Informatics & Patient Accounts Operations
- Liaison with software teams to optimize patient management and electronic health record systems
- Prepare and present financial materials to the operations directors and board of directors
- Project Management with experience in implementations of large, critical projects
- Management consulting, accounting and reporting for clinics in WA, AK, ID, OR, NM, VA, HI, PA, MT, CA.
- State and Federal grant applications and related compliance reports such as FSR and UDS
- Interim CFO for clients during recruitment periods. Mentor for new CFOs; including business coaching.
- A133 Audits. Medicare and Medicaid Cost Report (VA, ID, CA, WA, PA)
- Payer Contracting, including maximizing results

PROFESSIONAL EXPERIENCE

Senior Vice President of Finance 2016 – present, Community Health Association of Spokane, WA.

Chief Financial Officer 2010 – 2016, Columbia Valley Community Health, Wenatchee, WA.

Health Care Management Consultant 2003 – 2010, Community Link Consulting, Inc., Spokane, WA.

Controller / Chief Financial Officer 2001 – 2004, Community Health Association of Spokane, WA.

PROFESSIONAL LICENSES

Washington State Certified Public Accountant, License # 24064

EDUCATION

Carlson School of Management - University of Minnesota, Twin Cities. BS in Business, Accounting. 1999.

Western Governors University. MBA with an emphasis on Healthcare Management. 2010.

Harvard School of Business Online Certificate program 2022 - 2023

OTHER PROFESSIONAL SKILLS/COMMITTEES

- Excel, Lotus, Word, Access, Outlook, Paradox, Approach, Power Point, Schedule, Extended Report Writer, HyperTerminal, PC Anywhere, UltraVNC, Remote Desktop, EFTPS, GroupWise, Adobe Acrobat, Crystal Reports, Health pro, Altapoint, NextGen, MD Serve, Centricity, eClinical Works, Halogen Evaluation Software, Ultimate Software, Cognos Report Studio, Cognos Query Studio, Athena, Workday
- Accounting Software: Open Systems Acctg Software, SAP (MIP), Grants Mgmt Software, American Fundware, Quicken, MIP Pro, QuickBooks Pro, QuickBooks Premier, PeachTree, Bivio
- Conference Trainer for Northwest Regional Primary Care Association's Primary Care Conferences on Board Training and new Finance Manager Training sessions. (2007-2012). StuderGroup Leadership Training.
- Statewide Federally Qualified Health Center Committee (2011-current); 1 of 3 Technical advisors to the Committee

Lan H. Nguyen MD, MHA

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Mountlake Terrace, WA 98043
Work: 425-381-8388 | Cell: 360-463-3200
Lan.Nguyen@Premera.com

CLINICAL EXPERIENCES

Family Medicine Physician, Bellevue, WA — 8/2016-4/2022
Washington Permanente Medical Group, Kaiser Permanente

Family Medicine Physician, Olympia, WA — 7/2013-7/2016
Multicare Capital Medical Center

Family Medicine Resident, Augusta, GA — 7/2010-6/2013
Medical College of Georgia

LEADERSHIP ROLES

Medical Director, HMO, Premera Blue Cross, Washington — 4/2022-present

Associate Medical Director, WA Permanente Medical Group, Kaiser Permanente — 2019-2022

Quality Champion, Bellevue Medical Center, WA Permanente Medical Group — 2017-2022

Care Management Subcommittee, UW ACO, Multicare Capital Medical Center — 2015-2016

Medical Director, Multicare Capital Medical Center — 2015-2016

Physician Leadership Group, Multicare Capital Medical Center — 2015

Quality Improvement Committee, Multicare Capital Medical Center — 2013-2015

Pharmacy and Therapeutics Committee, Multicare Capital Medical Center — 2013-2015

Athena/Meditech Physician Advisor, Multicare Capital Medical Center — 2013-2015

ICD-10 Physician Champion, Multicare Capital Medical Center — 2015

Synchronicity Super User, MCG, Augusta, GA — 2012

Graduate Medical Education Committee, MCG, Augusta, GA — 2012-2013

Resident Quality Assurance Committee, MCG, Augusta, GA — 2010-2012

Lan H. Nguyen MD, MHA

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7001 220th St SW
Mountlake Terrace, WA 98043
Work: 425-381-8388 | Cell: 360-463-3200
Lan.Nguyen@Premera.com

EDUCATION

University of Washington, Seattle, WA — 2014-2016
Master of Health Administration

Medical College of Georgia, Augusta, GA — 2010-2013
Family Medicine Internship and Residency

Ross University School of Medicine, Dominica, West Indies — 2006- 2010
Medical Doctor Degree

Spalding University, Louisville, Kentucky — 2002-2006
Bachelor of Science

RESEARCH AND PUBLICATIONS

The Olympian, Op-Ed, An Open Letter to Trump — 12/2016

The Olympian, Op-Ed, The Chronic Opioid Crisis — 11/2016

The Olympian, Op-Ed, Challenging Critical Thinkers During the Political Season — 8/2016

The Olympian, Op-Ed, Virus or Bacteria: That is The Question — 6/2016

The Olympian, Op-Ed, The Challenges of Mental Health in Primary Care — 5/2016

The Olympian, Op-Ed, Telemedicine in Primary Care — 3/2016

The Olympian, Op-Ed: FDA Menu –Labeling Rule — 3/2016

The Olympian, Op-Ed: Obamacare and the Community — 1/2016

Curtis G. Hames Foundation Grant Award, Augusta, GA — 2012
"The Use of a Patient Registry to Improve Quality Management of Patients with Diabetes Mellitus Type 2 in a Level 3 Patient-Centered Medical Home"

NAPCRG Poster Presentation, New Orleans, LA — 2012
"Prevalence of Helicobacter Pylori in a Primary Care Setting in the Southeastern United States: A Case Series Study

Linda A. van Hoff, ARNP

11329 163rd CT NE (425) 736-5089

Redmond, WA 98052 lindavh@outlook.com

Professional Employment

Overlake Medical Clinics – Redmond Primary Care Clinic	Redmond, WA	1/2017-present
Primary Care Redmond, PLLC Owner and Manager of Independent ARNP owned Family Practice Clinic		9/11 – 12/2016

Family Nurse Practitioner Employment:

Inglewood Family Health	Bothell, WA	1/04 – 6/2011
Evergreen Medical Group at Canyon Park	Bothell, WA	2/00 – 10/2003
Medical Arts Associates, PS	Bellevue, WA	3/98 – 2/2000
University Health Service, Binghamton University	Binghamton, NY	10/97 – 12/1997

Staff Nursing Employment:

Robert Packer Hospital Medical/Coronary Care ICU	Sayre, PA	6/92 – 3/1995
Hackensack Medical Center Medical floor with Telemetry	Hackensack, NJ	9/91 – 6/1992

Education

Masters of Family Nursing with role as Nurse Practitioner	8/93 – 5/1996
Bachelors of Science with a major in Nursing	8/87 – 5/1991

Decker School of Nursing

Binghamton University

Binghamton, NY

Licensure & Certification

RN License	RN00128764	WA State	Renewal: 3/28/23
AP License	AP30004449	WA State	Renewal: 3/28/24
DEA	MV0335770		Renewal: 5/31/25
ANCC Certification	30070659		Renewal: 8/31/26
BLS-C			Renewal: 11/23
CCRN			2/94 – 2/1997
ACLS			3/93 – 3/1997

Professional Activities & Memberships

Preceptor	Nurse Practitioner Students	1999 – present
Board Member	ARNPs United of WA State	1/2016 – present
	President of ARNPs United of Washington State	1/2019- present

Committee Chair: Family Practice Track 9/2015 – 2019

University of Washington – School of Nursing

Pacific Northwest Annual National Conference: Advanced Practice in Primary and Acute Care

Quality and Patient Experience Committee	Eastside Health Network	1/2017 - present
Quality Committee	Evergreen Health Partners	1/2015 – 2017
Continuing Education Co-Chair	AENP	1/03 – 12/2004

ARNPs United of WA State		1998 - present
AANP	American Association of Nurse Practitioners	1996 - present

Madeline D. Wiley, MSN, ARNP, FAANP

FamilyCare of Kent, 10024 SE 240th ST. #201, Kent, WA 98031 ◆ 253/859-2273
mwiley@familycareofkent.com

EDUCATION

M.S.N.

University of Pennsylvania, School of Nursing
Philadelphia PA December, 1980
Major: Family Nurse Practitioner

B.S.N.

State University of New York at Buffalo, School of Nursing
Buffalo NY May, 1977
Summa Cum Laude

EXPERIENCE

FAMILY NURSE PRACITIONER

FamilyCare of Kent
Kent WA July 2022 to Present
Former owner now part time to assist transition of practice to Pacific Lutheran University School of Nursing ownership and continue to provide primary family-oriented care to a caseload of patients.

MANAGING PARTNER AND FNP

FamilyCare of Kent
Kent WA September 2005 to July 2022.
Shareholder in FNP owned Family Practice. Manage the business and provide primary family-oriented care to a caseload of patients as a family nurse practitioner.

GROUP DIRECTOR AND FNP

Stryker Corporation: FamilyCare of Kent
Kent WA March 2000 to August 2005
Full time position providing primary family-oriented care to a caseload of patients as a family nurse practitioner and responsible for clinic operations at 3 FamilyCare Clinics.

FAMILY NURSE PRACTITIONER

Valley Medical Center Kent Primary Care
Kent WA April 1996 to March, 2000.
Full time position providing primary family-oriented care to a caseload of patients as a family nurse practitioner.

PRESIDENT

Health & Medical Care, PS
Kent WA January 1985 to December, 1996
Co-founder and developer of three business entities:

- Health Connections - a comprehensive health and medical practice using Family Nurse Practitioners to provide a full spectrum of primary care to clients of all ages, January 1985 to April 1996. (Sold to Valley Medical Center)
- Nurse Practitioner Support Services - a company providing information for and about nurse practitioners including a statewide newsletter, January 1994 to December 2003. (Rolled over into NP Central a non-profit January 2004)

• Internet Wizards - a company providing Internet services for businesses, nurse practitioners and the general consumer including direct dial-up access, May 1995 to December 1996. (Rolled over into NPSS.)

FAMILY NURSE PRACTITIONER

Health Connections
Kent WA January 1985 to April,1996.
Part time position January 1985 to May 1988. Full time thereafter. Provide primary family-oriented care to a caseload of patients as a family nurse practitioner. Administratively responsible for all aspects of center operations.

CLINICAL FACULTY

University of Washington
Seattle Washington, January 1987 to Present
Clinical preceptor for Family Nurse Practitioner master's & doctoral degree candidates

CLINICAL PRECEPTOR

Seattle Midwifery School
Seattle Washington, September 1990 to September 1991.
Clinical preceptor for Direct Entry Midwifery students.

FAMILY NURSE PRACTITIONER

Virginia Mason Clinic.
Seattle Washington, June 1987 to May 1988.
Provided general health care in the Section of Allergy/General Medicine for a diversified group of adult patients including allergy evaluations and research patients.

COORDINATOR, GERIATRIC NURSING SERVICE

Group Health Cooperative of Puget Sound.
Seattle Washington, January 1985 to June 1987.
Administratively responsible for the development of a new program using nurse practitioners as the primary care providers for GHC enrollees in Nursing Homes, including quality assurance, orientation and training of staff, budgeting, etc. And as a nurse practitioner provided direct care to established caseload of nursing home patients.

FAMILY NURSE PRACTITIONER

Visiting Nurse and Health Association of Camden County, Inc.
Camden, New Jersey. February 1981 to December 1984 in the following positions:
COORDINATOR of Employee's Health Program at the VNHA and Family Nurse Practitioner (July 1984 to December 1984). Responsibilities included the development and management of the Employee's Health Program, as well as the provision of these services. Provision of pediatric primary care to an inner-city population on a half time basis.
FAMILY NURSE PRACTITIONER and CENTER ADMINISTRATOR Full time (VNHA) contracted position in the Camden County Health Department's Family Practice Center at Bergen-Lanning (February 1981 to July 1984). Responsibilities included clinical, administrative, and educational components in a multi-organizational center.

ADJUNCT CLINICAL FACULTY

Rutgers State University
Camden, New Jersey, Spring 1982 to Spring 1983.
Clinical preceptor for RN and Generic students in a BSN program.

FAMILY NURSE PRACTITIONER

Planned Parenthood of Southeastern Pennsylvania
Philadelphia, Pennsylvania. July 1981 to October 1983, part time.
Provision of women's health care with a focus on family planning.

ADJUNCT CLINICAL FACULTY

Thomas Jefferson University
Philadelphia, Pennsylvania, Spring 1982, and Spring 1983.
Clinical preceptor for RN and Generic students in a BSN program.

FAMILY NURSE PRACTITIONER STUDENT

Development of clinical skills in various settings while at the University of Pennsylvania from September 1979 to December 1980:
Penn Urban HMO; Adults, Sept. to Dec. 1980.
Spring Garden Clinic; Adults, Oct. to Dec. 1980.
Germantown Hospital; Women's Health, Jan. to May 1980.
Pediatric Associates; Pediatrics, Sept. to Dec. 1979.
Chester Co. Children's Clinic; Oct. to Dec. 1979.

STAFF NURSE

Germantown Hospital and Dispensary
Philadelphia, Pennsylvania, May 1980 to May 1982, part time.
Emergency Department. Triaged clients and provided emergency nursing care, including charge responsibilities.

ASSISTANT HEAD NURSE AND STAFF NURSE

Buffalo General Hospital
Buffalo, New York, May 1977 to May 1979.
Assistant Head Nurse responsibilities on a Surgical Unit; Staff nursing in ICU and ER settings.

CERTIFICATION & LICENSURE

Washington ARNP Licensure #AP30001318
ANA Certification as a Family Nurse Practitioner 1981 to present
American Red Cross Cardio-Pulmonary Resuscitation Instructor 1977 to 1996

HOSPITAL AFFILIATIONS

CHI St. Anne's Hospital 2021 to Present
Valley Medical Center, Allied Health Professional Staff, 1996-2000
Virginia Mason Medical Center, Allied Health Professional Staff, active status, October 1987 to February 1997.
Highline Community Hospital, Allied Health Professional Staff, active status, February 1990 to February 1997.
Bylaws Committee Member, 1993 to 1996
Ad Hoc Committee Chair Allied Health Professionals, 1993.
Family Practice Department member, 1990 to 1996.

PUBLICATIONS

ARNP Care

Publisher and founder of monthly newsletter to Washington State ARNPs, July 1990 to 2020
Co-Editor, July 1989 to 2015

Adult Primary Care

Edited by Meredith and Horan, Co-author of chapter: *Policy, Issues, and Trends Affecting Practice,* 2000

Nursing 2000 Drug Handbook
Clinical Consultant, 20th Anniversary Edition, 2000
Nurse Practitioner's Drug Handbook
Clinical Reviewer, 2nd Edition, 1998
Advance for Nurse Practitioners:
Workplace Question and Answer Guest Columnist, September 1997, Volume 5, Number 9.
Nurse Practitioner News:
Co-Author of "Net Walker" a computer column published every other month, Sept. 1995 to December 1996
The Nurse Practitioner:
Editorial Board, July 1992 to July 2012
Contributing Editor, April 1992 to December 1996
Co-Editor of "Nurse Practitioner Abstracts," a monthly column, July 1991 to December 1996
Co-Author of "Practice Issues," a bi-monthly column, February 1996 to December 1996
Journal of the American Academy of Nurse Practitioners
Marketing and Management Columnist in quarterly journal, January 1989 to March 1990:
"Marketing: An Issue of Particular Relevance to Nurse Practitioners." 1(1), 1989.
"Quality Assurance for Office Laboratories." 1(2), 1989.
"Marketing Techniques: In Print." 1(3), 1989.
"Hospital Privileges: Who Needs Them?" 1(4), 1989.
"Marketing Techniques: In Person." 2(1), 1990.
Clinical Abstracts for Nurse Practitioners
Associate Editor of bimonthly publication, September 1989 to August 1990.

MEMBERSHIPS

University of Washington Continuing Nursing Education Planning Committee for NP Conferences, 1988 to present; Pacific Northwest Annual Conference for Primary Care Practitioners, 1989 to 2020, Co-Chair of conference hosting up to 1000 Advanced Practice Nurses yearly.
ARNPs United of WA State member 1987 to present
Treasurer 2012 thru 2014
American Association of Nurse Practitioners, member 1984 to present
Washington State Representative, 1988 to 1991;
Region 10 Board Member, 1986 to 1988;
Recording Secretary 1985 to 1986;
Steering Committee 1984 to 1985;
Chairperson, Bylaws Committee.
American College of Nurse Practitioners, member 1997 to 2013
American Nurses Association, member 1977 to present.
Washington State Nurses Association, member 1985 to present.
Healthy Kids WA State WSNA Representative, 1994 to 1995
ARNPs United Silent Auction Committee Chair, 1992 & 93.
Ad Hoc Committee on Medicaid Reimbursement for ARNPs, Chair, 1988 to 1991.
WSNA Ad Hoc Committee on Home Care, member, 1985 to 1986.
King County Nurses Association, member 1985 to present.
Legislative Committee member 1985 to 1987;
Nurse Practitioner Special Interest Group member 1985 to 1992;
Nurse Practitioner Special Interest Group Legislative Committee; member 1985 to 1990, Chairperson 1987 to 1990.
Pennsylvania Nurses' Association member 1979 to 1984
Nurse Practitioner Third Party Reimbursement Task Force Member 1981 to 1984

Primary Care Clinicians and Practitioners of Philadelphia; member 1980 to 1984
Vice-Chairperson 1981 to 1982;
Chair, 1982 to 1983.
New York State Nurses Association member 1977 to 1979.
Bellevue Community College, NP Conference Planning Committee, 1986 to 1987.
Sigma Theta Tau, Xi Chapter
American National Red Cross

HONORS & AWARDS

Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2020
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2019
Best of Kent Family Practice Provider Winner 2019
Professional Nursing & Health Care Council Best Practice Award, WSNA 2019
WA Health Alliance Patient Experience Award 2018 (awarded to top 4 clinics out of 351 clinics across the state of WA) WA Leaders in Health Care Awards published in the Seattle Business Magazine.
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2018
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2017
Best of Kent Family Practice Provider Winner 2017
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2016
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2015
Best of Kent Family Practice Provider Winner 2014
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2014
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2013
Fellow in the American Academy of Nurse Practitioners 2012
Best of Seattle Family Practice Nurse Practitioner Seattle Met 8/2012
Best of Kent Family Practice Provider Finalist 2012
University at Buffalo Distinguished Alumni of the Year Award 2011
Best of Kent Family Practice Provider 2011
Best of Kent Family Practice Provider 2010
Who's Who of American Women, 2000-2006
University of Washington Outstanding Preceptor Award 2004
Who's Who in Medicine and Healthcare 2002
American Academy of Nurse Practitioners WA State Award for Excellence, 1999
International Who's Who of Professionals, 1996
National Directory of Who's Who in Executives and Professionals, 1996-97
Who's Who Among Outstanding Business Executives, 1996
2000 Notable American Women, 1995
University of Washington Outstanding Preceptor Award, 1993
Who's Who in American Nursing 1993-94
ARNPs United Leadership Award, 1992
Who's Who in America in the West, 1992-2000
Who's Who in American Colleges and Universities
Outstanding Young Women of America
Professional Nurse Traineeship, 1979 to 1980
Anne Walker Sengbusch Leadership Award, 1977
Sigma Theta Tau, 1977 to present
Nursing '76 "Innovations in Nursing" Scholarship

COMMUNITY ACTIVITIES

Golden Bond Rescue of OR and WA Volunteer Coordinator 2019 to present

Golden Bond Rescue of OR and WA Member 2019 to present
Evergreen Golden Retriever Rescue Board Member 2017 to /2019
Evergreen Golden Retriever Rescue Board Member 2017 to /2019
Evergreen Golden Retriever Rescue Board Member 2017 to /2019
Evergreen Golden Retriever Rescue Volunteer Coordinator 2012 to 2019
Evergreen Golden Bond Rescue Member 2019 to 2019
Rotacare Medical Clinic, Volunteer Nurse Practitioner Renton, WA 2003-2018
NP Central Board of Trustees Secretary-Treasurer 2004 to Present.
American Lung Association, Asthma Camp Volunteer Nurse Practitioner, June 1998, 2000-2005
Puget Sound Blood Donor over 100 units 1985 to present
Children's Therapy Center, Kent, WA, Board member, 1992-1999;
Vice President, 1997-98.
Secretary, 1994-97; 1998-99.
Kentwood High School PTA member, 2001 to 2004
Meridian Junior High PTA member, 1998 to 2001
Panther Lake PTA member 1991 to 1998
Legislative Chair 1996-97
DSHS Healthy Kids Committee, 1994 to 1995.
Aloha Medical Mission, Volunteer Nurse Practitioner to Kalibo, Aklan, Philippines for a 10-day mission, Nov. 1993.
Washington State Children's Access to Health Care Committee, 1991 to 1993
Neighborhood Crime Watch Captain, 1986 to 2004.
American Red Cross CPR courses taught annually in the community 1977 to 1996.
Kent School District Health Vocational Advisory Committee, member 1988 to 1991;
Chairperson 1989 to 1991.
Kent Chamber of Commerce, member 1986 to 1996.
East Hill Business Council of the Kent Chamber of Commerce; member 1988 to 1990.

PRESENTATIONS

University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "Endometrial Biopsy and IUD Insertion Seattle WA November Annually 2015-2020.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "When, How & Why Biopsy Which Lesions Seattle WA October 2014.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "Endometrial Biopsy and IUD Insertion Seattle WA October 2014
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "What Knot to Do Seattle WA November 2013.
AANP Annual Conference: "When, How & Why Biopsy Which Lesions Las Vegas NV June 2013.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "When, How & Why Biopsy Which Lesions Seattle WA October 2012.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners: "When, How & Why Biopsy Which Lesions Seattle WA October 2011.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA October 2011.
University of Washington Family Nurse Practitioner Program. "Intro to Suturing: What Knot to Do?" Seattle WA May 2011.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques" Seattle WA. October 2010.
Kent Soroptomist's. "Screening for Cancer." Kent WA September 2010.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA August 2010.

University of Washington Family Nurse Practitioner Program. "Intro to Suturing: What Knot to Do?" Seattle WA May 2010.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "When, How & Why Biopsy Which Lesions Seattle WA November 2009.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA August 2009.
University of Washington Family Nurse Practitioner Program. "Introduction to Surgical Procedures Office Based." Seattle WA May 2009.
Auburn Riverside High School: Asthma Overview 12th Grade Health Class May 2009
Soroptomists of Kent. "Heart Health for Women." Kent WA February 2009
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "When, How & Why Biopsy Which Lesions Seattle WA. November 2009.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA. August 2009.
University of Washington Family Nurse Practitioner Program. "Introduction to Surgical Procedures Office Based." Seattle WA. May 2009.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA. February 2009.
University of Washington Family Nurse Practitioner Graduate Program. "Suturing: What Knot to Do." Seattle WA December 2008.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA January 2009.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners. "Punch Biopsies & Other Surgical Procedures." Seattle WA October 2008.
American Society of Hypertension: Hypertension for the Primary Care Clinician. "Beta Blockers." New Orleans, LA May 2008
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners. "Punch Biopsies & Other Surgical Procedures." Seattle WA October 2007.
University of Washington Pacific Northwest Annual Conference for Primary Care Practitioners. "Punch Biopsies & Other Surgical Procedures." Seattle WA October 2006.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA November 2005
NCNP National Conference. "Basic Suturing." Orlando FL May 2005
NCNP National Conference. "Punch Biopsies & Other Surgical Procedures." Orlando FL May 2005
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA October 2004.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA October 2003.
ACNP National Conference. "Basic Suturing." Cincinnati OH October 2003
ACNP National Conference. "Genital Biopsies." Cincinnati OH October 2003
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA January 2003.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA October 2002.
University of Washington Family Nurse Practitioner Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA January 2002.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA September 2001.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA March 2001.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA January 2001.

University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA September 19, 2000.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA March 2000.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA February 2000.
University of Washington Family Nurse Practitioner Graduate Program. "Dermatology Update: Evaluating Rashes." Seattle WA December 1999.
ACNP National Clinical Symposium, Suturing, What Knot To Do? Nashville, TN, October 7, 1999
ACNP National Clinical Symposium, Cut Punch and Scrape, Sharpen Your Biopsy Technique, Nashville, TN, October 9, 1999
ACNP Clinical Symposium, IUD Insertion Workshop, Nashville, TN, October 8, 1999
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Basic Suturing." Seattle WA September 25, 1999.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA April 1999.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA February 1999.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA September 19, 1998.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA February 1998.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA February 1998.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Basic Suturing Techniques." Seattle WA October 25, 1997.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA February 1997.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA March 1997.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA October 26, 1996.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA September 1996.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA March 1996.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA March 1996.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Basic Suturing Techniques." Seattle WA November 3, 1995.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA May 1995.
University of Washington Family Nurse Practitioner Graduate Program. "Punch Biopsies & Other Surgical Procedures." Seattle WA May 1995.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Advanced Suturing Techniques." Seattle WA October 15, 1994.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Basic Suturing Techniques." Seattle WA November 6, 1993.
University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA May 1993.
University of Washington. Pacific Northwest Annual Conference for Primary Care Practitioners: "Beyond the Basics or What Knot to Do." Seattle WA October 31, 1992.

University of Washington / Seattle King County Jail. "Dermatology Update: Evaluating Rashes." Seattle WA July 1992.
American Academy of Nurse Practitioners Annual Conference. "Suturing and Wound Management." Co-instructor. Washington, DC. June 1992.
University of Washington Graduate Nursing Faculties. "Dermatology Update: Evaluating Rashes." Seattle WA September 1991.
American Academy of Nurse Practitioners Annual Conference. "Suturing and Wound Management." Co-instructor. Portland, OR. May 1991.
University of Washington Family Nurse Practitioner Program. "Private Practice as a Nurse Practitioner." Seattle WA January 31, 1991.
Highline Hospital Senior Wellness Conference. "Physiologic Changes in the Elderly." Seattle WA November 1990.
Contemporary Forums. Nursing Challenges in Family Healthcare. "Dermatology Update: Evaluating Rashes." Anaheim, CA. October 11, 1990.
Contemporary Forums. Nursing Challenges in Family Healthcare. "Chronic Rhinitis: So You Have a Congested Nose." Anaheim, CA. October 12, 1990.
University of Washington. Pacific Northwest Annual Conference for Nurse Practitioners: Primary Care in the 1990's. "Chronic Rhinitis: So You Have a Congested Nose." Seattle WA November 16-18, 1989.
YMCA's Women's Wellness Weekend. "Health Care Through the Decades," September 22, 1989.
American Association of Retired Persons. "Care of the Underinsured." Seattle WA July 18, 1989.
American Academy of Nurse Practitioners. Different Roles: Common Goals. "Chronic Rhinitis: So You Have a Congested Nose!" Philadelphia, Pennsylvania. June 3, 1989.
University of Washington's Clinical Topics for Nurse Practitioners: 1988 Review and Update, Bellevue, WA "Chronic Rhinitis: So, You Have A Congested Nose!" November 4, 1988.
Kent Meridian High School. "Cholesterol and You," September 1988.
YMCA's Women's Wellness Weekend. "Health Care Through the Decades," September 16, 1988.
Uniformed Nurse Practitioner Association National Conference, Norfolk, VA. "So You Have A Congested Nose!," June, 1988.
King County Nurse's Association NP Special Interest Group, Seattle WA "Chronic Rhinitis," May 1988.
Group Health Cooperative, Geriatric Nursing Service, Seattle WA Update to Area Nursing Homes on the GNS, June 1986.
Group Health Cooperative, Geriatric Nursing Service. "Making Visits Count in Nursing Homes," October 1985.
Camden Area health Education Center Continuing Education Course (24 CEU's). "Physical Assessment for Nurses," October 1984.
Coalition of Nurse Practitioners of Pennsylvania, Nurse Practitioners: Power Potential Conference. "Third Party Reimbursement for Nurse Practitioners," September 1984.
Neighborhood Nannies, Haddonfield, New Jersey. "Parenting: Nutrition and Health; Safety and Development," July 1984.
Delaware Valley NAPNAP Association, Philadelphia. "Third Party Reimbursement for Nurse Practitioners," June 1984.
Camden Area Health Education Center, Pathways to Success Conference. "The Role of the Nurse Practitioner in Ambulatory Care," May 1984.
Nurse Practitioner Special Interest Group of Pittsburgh. "Third Party Reimbursement for Nurse Practitioners," May 1984.
Legislative Day, Pennsylvania Nurses Association, Philadelphia. "Third Party Reimbursement for Nurses," April 1984.
Camden Area Health Education Center, Pathways to Success Conference. "The Role of the Nurse Practitioner in Ambulatory Care," November 1983.
Visiting Nurse and Health Association of Camden, Inc. "Trouble Shooting Adult Physical Assessment," December 1982.

Lincoln School for Pregnant Teens, Camden, New Jersey. "Taking Care of Sick Baby," November 1982.

Camden County Extension Services. "Parenting: Social-Emotional Development of Children," September 1982.

Emergency Nurse Training Program, Southeastern Pennsylvania. "Obstetrical and Gynecological Emergencies," February 1981.

University of Washington Pacific Northwest 36th Annual Conference for Primary Care Practitioners Seattle WA November 2013. (16 contact hours)

Mandy Stahre

PROFESSIONAL PROFILE

Mid-career epidemiologist with extensive public service at the federal and state level related to public health and health care topics. Advanced statistical knowledge and experience leading teams, managing projects, and programs.

EDUCATION

Doctor of Philosophy in Epidemiology **April 2012**
University of Minnesota, School of Public Health**,** Minneapolis, MN

- Dissertation Title: *"Examining the Association of Tobacco Use and Binge Drinking and the Effects of Tobacco Interventions on Binge Drinking Behaviors"*

Extracurricular Activities and Affiliations:

- President – Council of Graduate Students
- Graduate Student Rep – University Senate Finance and Planning Committee
- Western Region Rep – National Association of Graduate-Professional Students

Master of Public Health in Epidemiology **April 2003**
University of Michigan, School of Public Health, Ann Arbor, MI

Bachelor of Science in Psychology (Magna Cum Laude) **December 1999**
University of North Texas, Denton, TX

EMPLOYMENT HISTORY

Director – Health Care Research Center **December 2021-present**
Washington State Office of Financial Management, Forecasting and Research Division, Olympia, WA

- Lead the Medicaid Expenditures Forecast group
- Supervise Senior Research Scientists and Senior Data Scientists on health care services research using health care claims data, vital statistics, and other heath care related datasets.
- Identify and coordinate cross-division projects on a variety of health topics.
- Manage and respond to legislative and Governor requests related to health and health care and complete legislatively mandated reports.
- Participate on the WA-APCD Data Policy Committee
- Member of the Health Care Cost Transparency Committee – Data Committee

Senior Research Analyst **July 2016 – December 2021**
Washington State Office of Financial Management, Forecasting and Research Division, Olympia, WA

- Managed and provided oversight to the Washington All-Payer Health Care Claims Database (WA-APCD) and website *www.wahealthcarecompare.com* implementation.
- Developed and gathered stakeholder feedback to draft rules for the WA-APCD.

- Completed federal grant reporting requirements including budget and deliverable tracking.
- Identify and research health care related topics producing reports highlighting demographic differences when applicable.
- Participate on the Data Release Advisory Committee for the WA-APCD and review data requests for legal, ethical, and data quality compliance.
- Complete legislatively mandated reports about WA-APCD implementation, program, and operations; and primary care expenditures in Washington.
- Participate on advisory committees including the State Epidemiology Outcomes Workgroup, Centers for Disease Control and Prevention Alcohol Team, Behavioral Risk Factor Surveillance System Technical Advisory Committee
- Co-chair Council of State and Epidemiologists (CSTE) Public Health and Health Care Analytics workgroup to increase knowledge and access to health care data.
- Review grant proposals for national public health programs at the Centers for Disease Control and Prevention (CDC).
- Peer review submitted journal articles for a variety of health and public health journals.

Chronic Disease Epidemiology Unit Supervisor **May 2014-July 2016**

Washington State Department of Health, Office of Healthy Communities, Surveillance and Evaluation Section, Olympia, WA

- Recruit, hire, and train epidemiologists and research investigators on study design, data collection, and analysis of chronic disease topics including asthma, diabetes, heart disease, stroke, and risk factors such as tobacco, marijuana use, and social determinants of health.
- Manage budget of $1 million for surveillance and evaluation activities.
- Assist with development of evaluation plans for performance measures and program activities as part of a multi-million dollar chronic disease grant from the Centers for Disease Control and Prevention (CDC).
- Partner with CDC Alcohol Team on research projects related to excessive alcohol use and consequences.
- Assist with grant writing for chronic disease (heart disease, diabetes, and stroke) and risk factor (tobacco) topics.

Epidemic Intelligence Service (EIS) Officer **Aug 2012-May 2014**

Centers for Disease Control and Prevention (CDC), Atlanta, GA

- Stationed at the Washington State Department of Health in the Non-Infectious Conditions Epidemiology Section under the State Epidemiologist.
- Assessed the association between housing insecurity and health outcomes among Washingtonians.
- Lead national investigation in central Washington of a cluster of neural tube defects leading a team that collected and reviewed medical records, collected sources of possible exposures, and prepared reports to CDC and department of health.

- Evaluated the Washington State Prescription Monitoring Program (PMP) and presented results to CDC audience.
- Analyzed the effect of school-level poverty on substance use among 8th, 10th, and 12th graders in Washington.
- Partnered with the WA Department of Transportation Safe Routes to School to survey parents of children in kindergarten through 8th grade about bike riding and walking to school and produced report for DOT.

Scientific Advisor **2012-present**
Independent Contractor **2007-2011**
Oak Ridge Institute for Science and Education Fellow **2005-2007**
Association of Schools of Public Health Fellow **2003-2005**

Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Alcohol and Public Health Team, Atlanta, GA

- Lead the development of the Alcohol Related Disease Impact (ARDI) online system (www.cdc.gov/alcohol) that estimates alcohol-attributable deaths and years of potential life lost.
- Provided technical assistance to states and end-users of the ARDI software
- Researched the prevalence and consequences of binge drinking among active duty military personnel.
- Provide technical advice and expertise for updates to the Alcohol Related Disease Impact (ARDI) system.

Editorial Team **Jan 2012 – Dec 2018**

HealthNewsReview.org

- Reviewer for online news articles about health topics including breast cancer (www.healthnewsreview.org).
- Contributor for blog posts and podcasts about health journalism and coverage of health topics in the media.

Graduate Research Assistant **Sept 2007- June 2012**

University of Minnesota, Department of Epidemiology, Department of Medicine, Department of Family Medicine, Minneapolis, MN

- Assessed the impact of state-wide smoking bans in bars and restaurants on alcohol licensing before and after implementation of the ban.
- Examined the relationship between smoking quit attempts and menthol cigarettes by race and ethnicity.
- Managed smoking cessation project targeting low-income smokers including recruiting participants for focus groups, survey development, data cleaning, and data analysis.
- Developed survey for veterans with colorectal cancer and provided data entry.
- Analyzed association between binge drinking and smoking among military veterans.
- Recruited veterans for a smoking cessation intervention from Veterans Affairs Hospitals.

Intern **Summer 2009**
National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, Rockville, MD

Investigated role of reduced blood alcohol limits for repeat DUI offenders on mortality from motor-vehicle traffic crashes

Consultant **Nov 2008-Dec 2010**
Alcohol Justice (formerly Marin Institute), San Rafael, CA

Conducted research project estimating alcohol-attributable deaths and nonfatal injuries and illnesses by race and ethnicity for California.

Consultant **2004-2007, 2010**
The College Board, Reston, VA

Reviewed and judged entries for the Young Epidemiology Scholars (YES) competition

Graduate Research Assistant **2001-2003**
University of Michigan, School of Public Health, Ann Arbor

Research Projects (PI - Dr Kathleen Ford):
- Knowledge of STDs and HIV/AIDS among Detroit middle school students
- Behaviors associate with HIV/AIDS among injection drug users in Bali, Indonesia

ADDITIONAL EXPERIENCE

Grant Reviewer for the following organizations*:*
Department of Defense, Congressionally Directed Medical Research Programs, Breast Cancer Research Program **2010-present**
American Institute of Biological Sciences, Peter T Rowley Breast Cancer Research Program **2018-present**
Centers for Disease Control and Prevention **2014-present**

SKILLS

Computer Software: SAS, SQL, R, SPSS, MS Office Suite, G-Suite
Data collection: survey and interview development, medical record abstraction, focus groups (online and in-person), performance measure development
Data analysis: multivariate modeling, longitudinal analyses, econometric analyses, qualitative analyses
Writing skills: grant writing, data sharing agreements, scientific writing, legal and policy writing
Foreign languages: Spanish, Russian

PUBLICATIONS

Legislative Reports:

"Statewide All-Payer Health Care Claims Database Report." (Evaluation of database and HCA's oversight). Biennial report to the Washington Legislature as required by RCW 43.371.090(2). Washington State Office of Financial Management, Forecasting and Research Division. February, 2021. https://ofm.wa.gov/sites/default/files/public/publications/OFM%20Statewide%20All-Payer%20Health%20Care%20Claims%20Database%20Report%202021.pdf

"Primary Care Expenditures: Summary of current primary care expenditures and investment in Washington." Report to the Washington Legislature as required by Chapter 415, Laws of 2019. Washington State Office of Financial Management, Forecasting and Research Division. December 2019. https://ofm.wa.gov/sites/default/files/public/publications/PrimaryCareExpendituresReport.pdf

"Washington State Statewide All-Payer Health Care Claims Database." (Documentation of launch of database and website). Report to the Legislature as required by RCW 43.371.080. Washington State Office of Financial Management, Forecasting and Research Division. December 2017. https://ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/APCD/AllPayerHCClaimsDatabaseReportToLegDec2017.pdf

"Washington State Statewide All-Payer Health Care Claims Database." (Documentation procurement of vendor and creation of rules). Report to the Legislature as required by RCW 43.371.080. Washington State Office of Financial Management, Forecasting and Research Division. December 2016. https://ofm.wa.gov/sites/default/files/public/legacy/reports/AllPayerHCClaimsDatabaseReportToLegDec2016.pdf

Peer-Reviewed Publications:

Uong S, Tomedi LE, Gloppen KM, Stahre M, Hindman P, Goodson VN, Crandall C, Sklar D, Brewer RD. Screening for excessive alcohol consumption in emergency departments: A nationwide assessment of emergency department physicians. *J Pub Health Man Prac* 2021 Mar 12 [ePub ahead of print] doi: 10.1097/PHH.0000000000001286.

Esser MB, Sherk A, Liu Y, Naimi TS, Stockwell T, Stahre M, Kanny D, Landen M, Saitz R, Brewer RD. Deaths and years of potential life lost from excessive alcohol use – United States, 2011-2015. *Morb Mortal Wkly Rep. Jul 31, 2020;69(30)981-7*. doi:10.15585/mmwr.mm6930a.1.

McDermot D, Igoe B, Stahre M. Assessment of healthy food availability in Washington State – Questioning the food desert paradigm. *J Nutr Educ Behav*, 2017 Feb;49(2):130-136e1. doi: 10.1016/j.jneb.2016.10.1012.

Shar A, Stahre M. Marijuana use among 10th grade students – Washington, 2014. *Morb Mortal Wkly Rep* December 30, 2016; 65(5051);1421-1424 doi:10.15585/mmwr.mm655051a1.

Igoe B, McDermot D, Stahre M. Strengthening the connection between the supplemental nutrition assistance program and farmer's markets. *Prev Chronic Dis* 2016;13;160186. doi:10.5888.pcd13.160186.

Pittman J, Stahre M, Tomedi L, Wurster J. Barriers and facilitators to scientific writing among applied epidemiologists. *J Pub Health Man Prac,* May/Jun 2017;23(3):291-291. doi: 10.1097/PHH.0000000000000433.

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Nelson TF, Stahre M. Alcohol is a Women's Health Issue. Women and Health, Second Edition. Elsevier, Inc, R. Troisi (ed.), Philadelphia, PA,2012.

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Phelan S, Griffin J, Jackson G, Zafar S, Hellerstedt W, Stahre M, Nelson D, Zullig L, Burgess DJ, and van Ryn M. Stigma, perceived blame, self-blame, and depressive symptoms in men with colorectal cancer. *Psycho-oncology*. 2013 Jan ;22(1) :65-73. doi : 10.1002/pon.2048.

Stahre M, Okuyemi K, Joseph A, Fu S. Racial/ethnic differences in menthol cigarette smoking, population quit ratios, and utilization of evidence-based tobacco cessation treatments. *Addiction*. 2010;S1:75-83. doi: 10.1111/j.1360-0443.2010.03200.x.

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HONORS & AWARDS

NAHDO Innovation in Data Dissemination award for www.wahealthcarecompare.com **2018**
Northwest Public Health Leadership Institute Cohort **2013-2014**
President's Student Leadership and Service Award **2010**
Harold B and Helen N Shapira Scholarship **2009-2010**
School of Public Health Dean's Scholarship **2008**
Pre-doctoral Clinical and Translational Research program Summer Fellowship **2007**
Outstanding Unit Commendation for the Centers for Disease Control and Prevention Alcohol and Public Health Team **2006**
Carl W Tyler Award for Excellence in Public Health Practice **2005**
University of Michigan SPH Scholarship **2001-2003**
University of North Texas Regent's Scholarship **1996-1999**

PROFESSIONAL AFFILIATIONS

Council of State and Territorial Epidemiologists
American Statistical Association
Washington State Public Health Association

COMMUNITY AFFILIATIONS

Olympia Genealogical Society (2021-present)
- Publicity Chair

Veterans' Ecological Trades Collective (2020-2022)
- Board member – Secretary

Young Survival Coalition (2010 – present)
- Respected Influencers Through Science and Education (RISE) Advocate (2018-present)

REFERENCES

Thea Mounts Director, Research and Data Analytics, WA Department of Corrections: 360-515-8301; thea.mounts@doc.wa.gov

Marc Baldwin Assistant Director, Forecasting and Research Division, Office of Financial Management: 360-902-0590; marc.baldwin@ofm.wa.gov

Jessica Marcinkevage Section Manager, Office of Immunizations, WA Department of Health: 360-236-3740; jessica.marcinkevage@doh.wa.gov

Dennis McDermot Senior Forecast and Research Analyst, Forecasting and Research Division, Office of Financial Management: 360-902-0621; dennis.mcdermot@ofm.wa.gov

Trevor Christensen Epidemiologist, Office of Immunizations, WA Department of Health: 360-515-6598; trevor.christensen@doh.wa.gov

Jim Jansen Senior Epidemiologist, Community Health Systems, WA Department of Health: 360-236-2821; jim.jansen@doh.wa.gov

Meg L. Jones
meg.jones@pacificsource.com 360-970-3497
1301 A Street, Suite 200 Tacoma WA 98401

Education

Georgetown University, history major – B.A. with honors, with distinction;

Seattle University, J.D., Associate Editor – Law Review, Order of Barristers, Jessup Moot Court team.

Experience

PacificSource Health Plans 2019-present Policy analysis and counsel to the Health Plan as a member of the company's senior executive leadership for commercial fully insured individual and group business, group self-insured lines, Medicare Advantage, dental and emerging lines of business; use expertise in legislative and regulatory affairs to advocate on behalf of PacificSource in Washington state and at federal level.

Leadership, counsel and advocacy experience specifically related to health plan managed care includes work for:

- *the Association of Washington Healthcare Plans as Executive Director*
- *Associate General Counsel, United Healthcare's Northwest Region (Washington, Oregon, Montana, Alaska & Hawaii)*
- *Special Assistant to the Commissioner, Office of the Insurance Commissioner on Affordable Care Act implementation – legislation & rulemaking*
- *Assistant General Counsel, Providence Health Plans for fully insured and Medicaid managed care.*

Experienced leader for over 20 years, providing regulatory and legislative analysis, counsel and support to multiple state agencies, including the Washington Office of the Insurance Commissioner, the Washington State Attorney General's office and the Governor's Office on all lines of health coverage.

Michele Causley

michele.causley@uhc.com

EXECUTIVE PROFILE

Accomplished executive who excels at building relationships and leading teams to achieve corporate and operational goals. A creative thinker able to look forward at the impact of future trends and implement strategies at an operational level. Skilled at empowering employees; critical thinking; data analytics; and financial analysis.

Professional Experience

UnitedHealthcare
Vice President, Medical Plan Operations **Jul. 2022 to present**

- Analyze data to identify opportunities with provider groups to collaborate in value-based performance contracts. Assist with the design, negotiation and implementation of risk-based models such as shared savings, downside risk, and full risk including quality gates or minimum quality performance requirements.
- Analyze paid claims data and market trends to identify opportunities to manage total cost of care. Work across various departments and lines of business including Medicaid, Medicare and Commercial to implement new initiatives and collaborate with providers.
- Directly support the CEO and plan operations for the Commercial line of business in the Pacific Northwest region.
- Represent the company on workgroups to provide perspective related to provider contracting and reimbursement, payment models and value-based design.

Genesys PHO Inc., Burton, MI
Vice President, Population Health Analytics **Sep. 2017 to Jul. 2022**

- Led a diverse team that provides population health analytics to help support over 100 primary care physicians and an Ascension hospital partner. Integrated various data sources such as paid claims and EHR quality metrics to provide actionable reporting for multiple stakeholders.
- Advised the CEO and assisted with the negotiation of value-based risk contracts with various payers.
- Monitored total cost of care and performance in several value-based contracts where over 60% of attributed patients were in downside risk models. One of the models was the Genesys ACO participating in the Medicare Shared Savings Program where a shared savings payment was earned every year since 2015.
- Collaborate with Medical Management department on various initiatives and pilot programs to manage chronic conditions and hospital utilization by providing baseline metrics and tracking performance outcomes.
- Led the design and implementation of various analytic tools including an innovative physician incentive program based on risk adjusted cost and quality performance; risk adjusted physician utilization reports; and a population risk stratification tool utilized by care managers to help patients manage chronic conditions.

Health Alliance Plan, Detroit, MI
Director, Provider Reimbursement **Apr. 2016 to Sep. 2017**

- Managed a team of analysts responsible for all analytics and financial modeling to support provider contract negotiations.
- Responsible for monitoring industry trends and making recommendations to corporate executives regarding reimbursement strategy for both Medicare and Commercial lines of business. Within 2 months of assuming new position identified a $6 million annual savings opportunity by aligning with Medicare reimbursement standards.
- Collaborated with various departments to support corporate initiatives including medical cost containment; provider reporting to support value-based risk contracts; and implementation of a new Business Intelligence reporting tool.

Healthplus of Michigan, Flint, MI (merged with Health Alliance Plan in 2016)
Director, Business Intelligence Unit **Jul. 2015 to Apr. 2016**

- Managed several diverse teams providing support throughout the organization including provider reimbursement and contract negotiation support; financial analysis; population health analytics; provider medical record audit functions; data warehouse maintenance and corporate reporting.
- Member of the senior management team assisting with the development, implementation and tracking of corporate strategic goals.
- Heavily involved in change management activities during the merger with Health Alliance Plan (HAP). Successfully transitioned over 30 direct and indirect employees into new positions with HAP.

Manager, Network Reimbursement Analytics **Apr. 2014 to Jul. 2015**

- Managed a multi-functional team within the Business Intelligence Department providing analytics and corporate reporting for numerous departments within the organization.
- Provided analysis and contract rate modeling to support Provider contract negotiations. Developed new reimbursement models and rates to support corporate objectives.

Project Manager, Network Compensation and Reimbursement **Apr. 2012 to Apr. 2014**

- Project lead for Accountable Care Organization (ACO) services working directly with a Medicare Pioneer ACO.
- Developed all analytical reports used to monitor ACO initiatives including financial analysis, population health metrics and PCP risk adjusted utilization reports based on the John Hopkins ACG system.
- Led weekly conference calls with ACO executives to review performance and identify opportunities to manage appropriate utilization of healthcare services.

The Rybar Group, Fenton, MI
Director, Provider Reimbursement Analytics **Oct. 2010 to Apr. 2012**

- Led a department consisting of three service lines related to hospital reimbursement and regulatory issues with a primary focus on Medicare. Managed a team of consultants and support staff to ensure the timely filing and successful settlement of Medicare and other third-party payer appeals for hundreds of Hospital clients.
- Successfully met strategic goals and achieve profitability of each service line. Built and maintained a client base through various marketing activities including creating and approving content of various mailings; participation in professional associations; and writing a quarterly newsletter sent to rural hospital financial executives nationwide.

Project Manager, Medicare Low Volume Adjustment **Oct. 2006 to Oct. 2010**

- Project manager and lead consultant of the Medicare Low Volume Adjustment division assisting rural hospitals nationwide to receive substantial additional Medicare reimbursement.
- Responsible for coordinating multiple projects and clients at a given time. Wrote all Medicare Hospital Cost Report appeals and successfully negotiated final settlement with various Medicare Audit Contractors.

Education

Loyola Marymount University, Los Angeles, CA; *MBA*

University of Michigan, Ann Arbor, MI; *BA – Economics*

Nancy Connolly, MD, MPH, FACP

PERSONAL DATA

Place of birth: San Francisco, CA
Contact info: 7006 43rd Ave., NE Seattle, WA. 98115
nancycon@uw.edu
nancycsc@gmail.com
(206) 476-8704
(206) 641-0164

EDUCATION

Franklin & Marshall College	1984 - 1986	
University of California, Santa Cruz	1988 - 1990	B.A. (1990)
Ross University School of Medicine	1993 - 1997	M.D. (1997)
University of Pittsburgh, School of Public Health	2000 – 2004	M.P.H. (2004)

POSTGRADUATE TRAINING

University of Illinois – Michael Reese Hospital	1997 - 1999	Medical House Officer Internship, Residency
University of Pittsburgh – Shadyside Hospital	1999 - 2000	Medical House Officer Residency
University of Pittsburgh – Presbyterian Hospital	2000 - 2001	Gen Int Med – Fellow
University of Pittsburgh – Infectious Disease	2001 - 2005	Infectious Disease Fellow
Virginia Mason Medical Center	2012 - 2013	Virginia Mason Production System Leader Certification
Center for Mind-Body Medicine	2017 - 2018	Professional Training
University of Arizona – Integrative Medicine	2017 - 2019	Integrative Medicine Fellow
Society of General Internal Medicine	2020 - 2021	Leadership in Health Policy Fellow

FACULTY POSITIONS HELD

University of Pittsburgh, Division of Internal Medicine, Clinical Instructor 2000- 2001
During General Internal Medicine Fellowship, I served as a Clinical Instructor of Medicine with teaching responsibility for the General Internal Medicine Residents and performed research on depression in primary care.

University of Pittsburgh, Division of Infectious Disease Clinical Instructor 2004-2005
Following completion of my Fellowship in Infectious Disease I served as Clinical Instructor of Medicine in the research track.

University of Pittsburgh, Infectious Disease Clinical Assistant Professor 2005-2007

Clinical research on HIV autonomous Dendritic Cell vaccines. Worked on Study design and implementation, IRB approval, enrollment, treatment and follow-up of phase I Vaccine studies. Provided continuity care for HIV infected patients through the Pittsburgh AIDS Center for Treatment Clinic.

Virginia Mason Medical Center - Lynnwood Regional Medical Director 2013 – 2018

Working in a dyad relationship with a business partner, I supervised 8 physicians, 3 Nurse Practitioners and clinic support staff including nursing, medical assistants, laboratory and radiology staff as well as coordinating a variety of visiting specialists. We were responsible for budget, services and productivity serving about 13,000 patients.

University of Washington, General Internal Medicine Clinical Assistant Professor 2018-present
Primary responsibilities include clinical care for people living in shelters, care of residents at permanent supported housing and clinical care at downtown clinic serving a population regardless of ability to pay. In this role, I have worked in every setting including a variety of shelters and mobile units, maintaining flexibility and

HOSPITAL POSITIONS HELD

University of Pittsburgh, Presbyterian Hospitals	2000 - 2007
Virginia Mason Medical Center	2008 –2018
University of Washington – Harborview	2018 - current

HONORS AND AWARDS

1995 Distinguished Scholar Award for Outstanding Academic Achievement

Ross University School of Medicine
2000 I Arthur Mirsky Award for Competence, Compassion and Curiosity
University of Pittsburgh, Shadyside Hospital

BOARD CERTIFICATION/ELIGIBILITY

2000 Internal Medicine
2011 American Board of Internal Medicine
2006 Infectious Disease - American Board of Internal Medicine
2006 American Academy of HIV Medicine
2019 Integrative Medicine - American Board of Physician Specialties
2021 Addiction Medicine - American Board of Preventive Medicine

LICENSURE

2007 State of Washington, MD00048404, expires 6/12/2024
2017 United States DEA, BC6494679 and XC6494679

PROFESSIONAL ORGANIZATIONS

2000 - present Fellow, American College of Physicians
2019 –present Society of General Internal Medicine
2020 – present IM4US - Integrative Medicine for the Underserved
2022 - present King County Medical Society
2022 - present Washington State Medical Society

BIBLIOGRAPHY

Publications in Refereed Journals

1. **Connolly N**., Manders E., Riddler, SA. *Suction Assisted Lipectomy for Lipodystrophy.* AIDS Research & Human Retroviruses. 20(8):813-5, 2004 Aug. [original work]
2. *__Connolly, N__., Riddler, S., Rinaldo, C., *Pro-Inflammatory Cytokines in HIV Disease – A Review and Rationale for New Therapeutic Approaches,* AIDS Reviews. 2005; 7:169-181. [editorial]
3. Rosenbloom AJ, Ferris R, Sipe D, Riddler SA, **Connolly NC**, Abe K, Whiteside TL. *In Vitro And In Vivo Protein Sampling By Combined Microdialysis And Ultrafiltration.* J Immunol Method 2006; 309:55-68. [original work]
4. Hoji, A., **Connolly, N**., Buchanan, WG., Rinaldo, CR., *CD27 and CD57 expression reveals atypical differentiation of HIV-1 Specific Memory CD8+ T cells,* Clinical and Vaccine Immunology, Jan 2006, 14(1): 74-80. [original work]
5. *__Connolly, N.,__ Colleton, B., Rinaldo, CR. *Treating HIV-1 infection with Dendritic Cells.* Current Opinions in Molecular Therapeutics, 2007 9(4), 353-363. [editorial]
6. *__Connolly, N__., Riddler, SA., Stanson, J., Gooding, W., Rinaldo, CRR., Ferrone, S., Whiteside, T., *Expression of antigen processing machinery (APM) components in monocyte-derived dendritic cells generated for therapeutic vaccines in HIV-1-infected subjects* AIDS, Aug 2007, 21(13) 1683-92. [original work]
7. *__Connolly, N.,__ Whiteside, TL., Wilson, C., Kondragunta, V., Rinaldo, CR., Riddler, SA., *Therapeutic Immunization of HIV-1-Infected Individuals with Mature, HIV-1 Peptide Loaded Dendritic Cells.* Clinical Vaccine Immunology, 2008 Feb;15(2):284-92. Epub 2007 Oct 17. [original work]
8. Quratulain Syed, MD, Stacie Schmidt, MD, Rhea E. Powell, MD, MPH, Tracey L. Henry, MD, MPH, MS, **Nancy Connolly, MD, MPH,** Jennifer B Cowart, MD, and Celeste Newby, MD, PhD, *Gerrymandering and Political Determinants of Health.* Population Health Management, Volume 00, Number 00, 2022 [original work]

OTHER

Presentations

2022	Workshop: Chronic Pain: Reframing our Clinical Conversations	Society of General Internal Medicine Annual Conference - 2022
2017	Beyond Mere Medicine: The Biopsychosocial Approach to Persistent Pain (with J Babington)	Virginia Mason Addiction Conference
2007	Progressive Multifocal Leukencephalopathy	Internal Medicine Grand Rounds University of Pittsburgh

2007	Dendritic Cell Based Therapeutic Vaccine for HIV:	Infectious Disease Grand Rounds University of Pittsburgh Research in Progress
2006	Case Presentation: Lymphoma n the Setting of HIV Infection	Infectious Disease Grand Rounds University of Pittsburgh
2002	HIV in Women and Infants Practitioners then Patients	Polyclinic at Donetsk City Hospital #25 Donetsk, Ukraine
2002	HIV in Women and Infants	Kramatorsk Central City Hospital. Kramtorsk, Ukraine
2000	Nosocomial Infections	Medical Residents Conference Series UPMC Shadyside Hospital

Poster Presentations

1. **Connolly, N.,** Rinaldo CR, Whiteside TL, Wilson CC, Kondragunta, V, Riddler SA
   Dendritic Cell-HIV Peptide Therapeutic Vaccination Is Safe and Immunogenic in HIV-infected Subjects with Virologic Suppression
   Poster Presentation: Conference on Retroviruses and Opportunistic Infections 2006, Denver, CO.
2. **Connolly, N**., Rinaldo, C., Wilson, C., Whiteside, T., Richards, T., Riddler, S.,
   Therapeutic Dendritic Cell Vaccination Augments HIV Specific Immunity.
   Poster Presentation: AIDS Vaccine 2004, Lausanne, Switzerland.
3. **Connolly N**., Riddler SA, Rinaldo CR, Wilson CC, Ferrone S, Whiteside TL.;
   Pre-clinical Characterization of Peptide-Loaded, Autologous Dendritic Cells (DCs) as a Novel Therapy for HIV-1-infected Subjects Receiving Highly Active Antiretroviral Therapy (HAART)
   Poster Presentation: XV International AIDS Conference, Bangkok, Thailand. 2004.
4. **Connolly N**., Manders E., Riddler, SA. *Suction Assisted Lipectomy to Treat Morphologic Complications of HIV and HAART in 6 Patients*
   Poster Presentation: Infectious Disease Society of America Annual Meeting 2002
5. **Connolly N**., Hanusa B., Rollman B., *Patient Satisfaction with their Primary Care Provider Predicts Recovery from Major Depression*
   Poster Presentation: Society of General Internal Medicine Annual Meeting 2001

Volunteer Activities

2006 – 2007	Member: Institutional Review Board, University of Pittsburgh
2011 - 2014	Northeast Seattle Together: Board of Directors
2017 – 2018	Virginia Mason Bioethics Committee
2017 - present	Doctors for America – from 2020 DFA representative to Healthcare is Human Right Washington Policy committee
2021 - present	Board Member – Seattle King County Coalition on Homelessness
2021 - present	Membership Chair – Society of General Internal Medicine

Northwest Chapter

Interests

Reading, Writing, Sailing, Hiking, Traveling, Cooking – with a special interest in fermentation
A little bit of French language skill

Sarah C. Stokes

25329 232nd Ave SE, Maple Valley, WA – sarahcstokes1@gmail.com - 206-388-9109

PROFESSIONAL EXPERIENCE

KAISER PERMANENTE

***Associate Director of Network Strategy and Operations**, May 2021 – Present* *Renton, WA*

- Directly responsible for the implementation and maintenance of Kaiser Permanente's Cost and Utilization tool. Collaborate with stakeholders to develop metrics, dashboards and reports, market tool to external stakeholders, train on identifying areas to reduce total cost of care, and maintain high-quality data standards for internal and external users
- Co-develop value-based contracting models and reporting tools with Contracting and Care Delivery leaders to improve member experience, quality and cost in the contracted network
- Represent Kaiser Permanente's position at the Multi-Payer Collaborative forums to transform Primary Care Payment Models
- Research, develop and support team execution of network value creation strategies
- Lead the network, contract and pricing of claims workstream to transition self-funded product administration to a third-party administrator
- Manage a team of 5 supporting hospital and professional contracting tools, processes and analytics

***Senior Project Manager**, May 2018 – May 2021* *Renton, WA*

- Managed a multi-million-dollar value creation portfolio of network management strategies, overseeing the implementation on claim-cost containment edits, coding documentation, provider and hospital contracting strategies, product development, and district strategies.
- Program Manager for COVID-19 Command Center for Kaiser Permanente Washington. Developed and oversaw 20+ workstreams to stand-up short- and long-term COVID-19 disease management response
- Established command center structure to track execution of work in response to the COVID-19 pandemic
- Established a strategic accountability office for executive leadership to monitor, measure and evaluate successful execution of regional strategic plan for 2019 – 2022
- Built a portfolio tracking system to monitor program and project execution and benefit tracking performance
- Developed an access management department, partnering with leadership to develop the team structure, roles and responsibilities, management systems and tools, and service level agreements between internal departments.
- Developed 7 specialty service line improvement plans, and oversaw execution on communication, change management and specialty improvement plans to develop capacity with minimal investment

***Project Manager**, October 2016 – April 2018* *Seattle, WA*

Internalization of Cardiology, ENT and GI services, *August 2017 – April 2018*

- Researched, developed and executed on opportunities to internalize Cardiology, Otolaryngology, and Gastroenterology services
- Partnered closely with leadership to implement best practice physician schedules, workload expectations, and process to design to ensure operational efficiency in all service lines
- Developed and executed business plans and shared service agreements to transition 7 regional departments to national departments. Developed communication and change management plans to support job role changes, operational process changes, and human resource reduction planning
- Led multiple workstreams to oversee the Kaiser Permanente brand transition during and post-acquisition of Group Health Cooperative. Partnered with leaders to develop change management activities and employee events, legacy activities, employee internal promotion gear, and oversaw brand transition memorabilia
- Rebranded and launched the Bartell-KP Care Clinic brand

WOLTERS KLUWER/EMMI SOLUTIONS

***Account Manager/Patient Engagement Strategist**, July 2015 – October 2016* *Seattle, WA*

- Managed a territory-based portfolio of 22 large hospital and medical group clients
- Completed 10 successful client renegotiations and upsell opportunities valued over $10 million annually
- Strategized patient engagement opportunities, and developed product and project deployment plans for successful execution

Sarah C. Stokes

25329 232nd Ave SE, Maple Valley, WA – sarahcstokes1@gmail.com - 206-388-9109

- Performed account management activities, such as: strategy development with hospital and medical group executives, ongoing executive leadership status updates and check-ins, implementation plan and resource allocation oversight, and contract renewals and product add-ons
- Aligned implementation specialists team plans to contract, deployment schedule, and implementation and customer satisfaction requirements
- Consulted clients on product alignment for key hospital risk and improvement efforts: risk mitigation, population health management outreach strategies, Accountable Care Organizations: consumer-based, commercial payer, Medicare, and clinically integrated networks
- Managed a team of 6 implementation specialists
- Performed human resource duties and developed career plans. Review and approve project timecards, developed and maintained employee SMART goals, provided career development opportunities, and conducted training and monthly performance evaluations.

***Client Services Specialist, Performance Manager**, May 2013 – July 2015* *Seattle, WA*

- Managed a portfolio of Emmi product implementation and process improvement projects
- Increased Emmi's total product utilization by 30% in two years
- Managed multiple enterprise wide projects with cross functional teams, including: Epic ORM-ORU interface integration, ACO and population health outreach campaigns, HCAHPS and ROI data evaluation, product implementation and training, and ongoing optimization of care pathway and workflow designs
- Managed projects using Lean, agile and traditional project management methodology

PROVIDENCE SACRED HEART MEDICAL CENTER

***Administrative Intern**, June 2012– October 2012* *Spokane, WA*

- Established and developed the Providence Spokane Heart Institute's dashboard to track financial performance, volume trends, quality indicators, and service line performance
- Researched, assessed, and identified performance indicators important to Providence's senior leaders: CMS core measures, Press Ganey, Society of Thoracic Surgeons and American College of Cardiology metrics

SENIOR HELPERS

***Project Manager, Human Resource Coordinator**, August 2011 – May 2012* *Spokane, WA*

- Managed operational projects to increase community staffing contracts, standardize employee recruitment, hiring, and training, and improve payroll and billing cycle processes
- Recruited, hired, trained, and managed 60 Certified Nursing Assistants
- Standardized hiring qualifications and processes regarding employee hiring and managing; reducing employee turnover by 50%

AVALON CARE CENTER

***Certified Nursing Assistant**, December 2009 – June 2011* *Pullman, WA*

- Provided direct nursing care for a large spectrum of diagnoses: Alzheimer's, Diabetes, Stroke, CHF, and Cancer

EDUCATION

Washington State University

- *Master of Health Policy & Administration* May 2013
- *Bachelor of Science, Kinesiology* May 2011

PROFESSIONAL CERTIFICATIONS

Project Management Professional (PMP)	June 2019
Green Belt Six Sigma Lean Certification	April 2013
Lean Certification	December 2012
Certified Nursing Assistant	June 2009

SHARON R. BROWN
Ph: (509) 521.2245
Email: sharonrayebrown@gmail.com

PROFILE:

Accomplished in formulating strategy – Successful in building coalitions

EXPERIENCE:

Greater Health Now- Formally Greater Columbia Accountable Community of Health Nov. 2021-Present, Executive Director. Responsible for strategy, development and daily operations of the third largest ACH in Washington State

State Senator Washington February 2013- Present
Deputy Minority Leader
Senate Vice President Pro Tem 2014-2016
Committees:
Business, Financial Services and Trade
Ways and Means, Assistant Ranking
Environment, Energy and Technology
(Previously served on) Health and Long Term Care

ACCOMPLISHMENTS:

- **PNNL Energy Science Center Building.** Pacific Northwest National Lab (PNNL) needed financial resources from the State as first money in to increase it's likelihood of obtaining funding from the Federal Department of Energy for building a world class energy sciences building housing ground breaking technology. **Obstacles**- Republican caucus did not support the source of funding, Democrat Budget Chair wanted Federal Government to be first money in, and project needed the support of two State Universities with a history of fighting each other for resources. **Strategy**– Engaged employees of PNNL to meet with members of legislature and Governor's staff. Prepared white paper and supporting documents about the project, Organized and held Republican Caucus presentation, Held subsequent meetings with Senate and House Democrat Budget Leads, Worked with the Governor and his executive branch to garner support and assure no veto. Met with each University to assure cooperation between the two on this project. Met with Federal Representatives to obtain commitment for federal funding. **Resolution**- Republicans supported the Governor's Clean Energy Fund as long as a significant portion was allocated to this project. Democrat Budget leads agreed to fund it as long as Republicans supported the Governor's Clean Energy Fund. Governor's office agreed to not veto it as long as Republicans supported the entire Clean Energy Fund. The University of Washington (UW) and Washington State University (WSU) entered into a historic Memorandum of Understanding to cooperate with each other to support this project. The Federal government after learning of the State's support agreed to allocate funds. The 119 million dollar Energy Sciences Center will be completed in late 2021.
- **State Wide Youth Suicide Prevention Tip Line. Obstacles-** When I first proposed this legislation there was a lot of push back from a statewide police organization and the Attorney General's office. **Strategy-** I involved Chief Hohenberg, Kennewick Police Chief, who worked with me and other officers from around the state, to educate those in opposition about the benefits. I also held community conversation roundtables with community leaders and parents who had been affected by suicide. Included in conversations were representatives from the Attorney Generals office. Kirk Williamson emerged as a leader in this space and he testified in front of numerous committee hearings. I was able to get state funding to complete a study examining the need. Subsequent to the results of that study I proposed legislation to establish the TIP line with the support of the Police and Sheriffs and the AGs office. We recognized that several other states had successfully deployed a TIP line, we engaged their help and were able to utilize their resources as a result. The Senate embraced the concept and it was voted out of the Senate. Upon

landing in the House several new house members voiced concerned. I engaged community members to reach out to those legislators. **Resolution-** After two years of working this legislation with many community members from diverse backgrounds we were able to get the program fully funded in the final budget negotiations for the State. The success of establishing this program was a direct result of building coalitions both locally, state wide and nationally.

- **SSB 5779 Concerning Behavioral Health Integration In Primary Care.** Prime sponsored legislation that required the HCA to review its payment codes and make adjustments to payment rules to facilitate bidirectional integration of behavioral health with primary care and primary care with behavioral health. HCA and DSHS required to establish a performance measure to be integrated into the Statewide Common Measure Set tracking effective integration of behavioral health services in primary care settings. HCA was also required oversee coordination of mental health resources and services for Medicaid-eligible children covered through the managed care system and health care provided through tribal organizations, regardless of whether the referral occurred through primary care, school-based services, or another practitioner. Bill passed Senate unanimously and House nearly unanimously.
- **SSB 6452 Expanding The Activities Of The Children's Mental Health Services Consultation Program.** My bill required the HCA to convene stakeholders and recommend a funding model for the Partnership Access Line (PAL) and further expansion of the line to include PAL for moms and kids. Passed Senate and House unanimously.
- **SB 6514 Concerning Suicide Prevention And Behavioral Health In Higher Education, With Enhanced Services To Student Veterans.** I was the prime sponsor of this bill to address the lack of services in mental health resources for students. Passed unanimously by Senate and the House.
- **SSB 6429 Medical Condition Designation.** Prime sponsored this legislation, which will enable a person or care provider to obtain a special designation on a driver's license or identicard that a person has a developmental disability. This will provide first responders with accurate information. Signed by Governor and will become law effective 1/1/2022.
- **SB 6663 Eating Disorders and Type 1 Diabetes.** Requires the Department of Health (DOH) to make links available on its website regarding information on Diabulimia. Passed unanimously through both Senate and House.
- **Human Trafficking Awareness**. I obtained significant resources to enable localities to host Human Trafficking Awareness events.
- **Key Note Speaker.** Invited to speak at Global and National conferences on working with diverse groups to achieve effective public policy.
- **Guest lecturer**. University of Washington, MBA program and WSU Tri Cities.
- **Regulatory Sandbox and DeFi.** Prime sponsor of first state legislation.
- **Blockchain/Distributed Ledger.** Developed the first state policy.
- **SciTech Caucus and robotics competition**. Co-Founder of this bicameral, bipartisan caucus.

EDUCATION:

Certificate Straus Institute for Dispute Resolution, Pepperdine School of Law, Ranked #1 in Dispute Resolution
J.D. University of New Hampshire School of Law, Franklin Pierce Center for Intellectual Property, Concord, NH. Top 5 school Intellectual Property Law.
B.A Drew University, Madison, NJ, London School of Economics, United Nations and Parliament
Languages- Conversational Spanish

AWARDS:

Washington STEM Education Foundation Recognition 2019
Washington STEM Leadership and Dedication Recognition 2014
Associate of General Contractors Legislator of the Year Award 2018
Association of Washington Cities City Champion Award 2021 and 2017 recognition of economic development
Supported Living Champion Award 2017 from the Developmentally Disabled (DD) Community

BOARDS:
Boys and Girls Club Board of Directors, Appointed in 2019 to Diversity, Equity and Inclusion (DEI) Subgroup
Visit Tri Cities Board of Directors
Washington Economic Development Finance Authority
Legislative Committee on Economic Development and International Relations (LCEDIR)

Sharon I. Eloranta, MD

3302 NE 70th Street, Seattle WA 98115 | 206-499-7925 | sharoneloranta@gmail.com

Experience

Medical Director, Performance Management and Practice Transformation, Washington Health Alliance CURRENT

- Provide senior-level strategic and clinical leadership for the Alliance's work.
- Lead the Alliance's Quality Improvement Committee in overseeing the Alliance's reporting to ensure adherence to best clinical evidence and sound statistical reliability
- Lead care transformation efforts from a clinical perspective
- Serve as statewide clinical ambassador for the Alliance
- Communicate with all stakeholders to further the mission to improve healthcare value in Washington State; reduce variation in care; eliminating wasteful, low value care; and ensuring maximum uptake of high value services
- Leads statewide, multi-stakeholder initiatives as developed by the Board and leadership
- Serves as lead for diversity, equity and inclusion efforts
- Participates with outside groups including the HCA's Primary Care Certification workgroup

QUALITY MANAGER, VERA WHOLE HEALTH 4/20 – 10/5/21

- Provided support to assigned care centers, to ensure the achievement of Performance Guarantees related to quality, risk adjustment, and patient/member experience; engage clients to understandclient priorities and guide care center staff understanding, priority setting, and workflows.
- Provided quality support that led a first-year, three-site primary care practice to success in 100%of its 19 performance guarantees, including both clinical quality and risk adjustment metrics.
- Guided and led quality improvement initiatives related to closing care gaps, improving survey response rates, developing new programs to reduce total costs of care, and to improve health equity.
- Served as subject matter expert and researcher as requested regarding various Federal and otherprograms, including Medicare Advantage, direct contracting and associated value-based-purchasing initiatives, policies, and programs.
- Served on the diversity and inclusion committee, heading up health equity strategies and approach;working to enable the organization to collect and use social determinants of health to stratify health indicators and then to develop effective approaches to close gaps (includes use of the Neighborhood Atlas/ADI and zip code data to analyze access/engagement and indicator performance).
- Worked as one of three subject matter experts comprising the Vera Whole Health Operations Centerof Excellence, to create and standardize a common methodology, set of tools and practices for conducting quality and process improvement efforts across the company, and creating a training program for champions and facilitators.

DIVISION DIRECTOR, CLINCAL EXCELLENCE AND QUALITY | CHI FRANCISCAN HEALTH | 9/17

– 11/19 (POSITION ELIMINATED DUE TO CORPORATE MERGER)

- Directed team of 35 including data abstractors, analysts, and a quality improvement team including quality program managers at each of our seven hospitals; quality improvement. coordinators; sepsis coordinator, and three regional QI project managers; 15 direct reports
- Worked closely with clients and partners including Kaiser Permanente and Northwest Physician Network to help develop shared quality goals and processes to ensure success in joint operations.
- Set clear goals and expectations, redesigned department structure; implemented changes to improve the culture, structures and processes related to quality and safety improvement in acute care/service lines; worked to improve CMS STAR ratings for our hospitals.
- Conducted multiple process improvement sessions using a combination of Model for Improvement/PDSA, Lean, and high reliability techniques to push quality forward and create a culture of continuous improvement.
- Achieved improvements on both Quality and Safety composite metrics as designed and ranked by CHI corporate offices, bringing the Pacific Northwest region from the bottom of the CHI rankings to current ranking as top in CHI in both Quality and Safety.
- Achieved improvements in Leapfrog safety grades from B, C and F grades to all As and Bs (Fall 2019 grades).
- Worked to bring people together to discuss health equity and how equity interfaces with patient experience.
- Represented CHI Franciscan on multiple statewide committees and task forces including WHA's Quality Improvement Committee.

MEDICAL DIRECTOR, QUALITY AND SAFETY INITIATIVES | QUALIS HEALTH |

· Over my tenure at Qualis Health, I held multiple titles including VP of Federal Programs. Medical Director QSI was the last title held there.

- Worked closely with clients and partners including the Centers for Medicare and Medicaid Services, Washington State Department of Health, the Commonwealth Fund, and others, collaborating to align priorities; responsible for RFP responses, contract management, client relationships.
- Developed and implemented numerous local, regional, and national QI and PI initiatives, resulting in improved care (including development of the national Surgical Infection Prevention Program); utilized Lean, MFI/PDSA and high reliability methodologies to change culture and create lasting improvements across the healthcare continuum.
- Supervised teams across three states; facilitated countless PI initiatives.
- Wrote multiple successful RFP responses including those for EQR programs in Washington and Oregon and many CMS special innovation projects.
- Served as an NCQA HEDIS Compliance Auditor.
- Participated as faculty in development of the Commonwealth Fund's Patient Centered Medical Home Initiative and on multiple additional primary care transformation initiatives.
- Conducted front-and back-office in person consultative and supportive visits to primary care practices to implement patient centered medical home transformation and preparing for NCQA PCMH Certification.
- Completed Institute for Healthcare Improvement Fellowship, with concentration on the 100K Lives Campaign.
- Created and fostered effective partnerships with multiple local, regional, and national entities and utilized those partnerships to help grow the company and to foster a culture of learning across the state.

PRIMARY CARE PEDIATRICIAN: NORTHWEST PEDIATRIC ASSOCIATES

PEDIATRIC RESIDENT PHYSICIAN: CHILDREN'S HOSPITAL, LOS ANGELES

Education

MD | GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE

BACHELOR OF ARTS | UNIVERSITY OF WASHINGTON

· Major: Zoology cum laude

QUALITY IMPROVEMENT FELLOW | INSTITUTE FOR HEALTHCARE IMPROVEMENT, 2004 – 2005

CERTIFICATE IN MEDICAL MANAGEMENT | UNIVERSITY OF WASHINGTON

Skills & Abilities

PARTNERSHIPS AND INTEGRATION

· Success depends on ability to partner effectively within and outside of the organization. Partnerships include:

- Longtime member of Washington Patient Safety Coalition's steering committee, including serving as Chair.
- Participation on Washington Health Alliance Quality Improvement Committee and Choosing Wisely taskforce; multiple additional workgroups.
- Current member: Bree Collaborative; participant on several Bree Collaborative workgroups.
- Associate Clinical Faculty, University of Washington School of Public Health, Health Services Division (past).
- Past member of multiple Washington State Hospital Association steering and advisory committees including antimicrobial stewardship and readmission prevention.
- Past member of Washington Department of Health committees: antimicrobial stewardship, healthcare associated infections, readmissions for Apple Health, state reportable adverse events reporting.
- Active member of IHI Fellows Group.

PARTNER AND CLIENT RELATIONSHIP MANAGEMENT

Worked closely with multiple partners, including but not limited to CMS, DOH, WHA, WSHA, WSMA, WSNA, insurers, and providers across the healthcare continuum to develop effective and mutually beneficial relationships; effectively managed contracts and client expectations where applicable.

QUALITY IMPROVEMENT/PROCESS IMPROVEMENT

Proven ability to lead successful improvement projects across the continuum.

- Led national QI Program that led to the formation of the CMS SIP and SCIP metrics.
- Led multiple primary care improvement collaboratives focusing on diabetes care.
- Directed a seven-hospital system's QI program, including achievement of large gains in quality and safety composite metrics and improvements in Leapfrog safety grades across the system.

- Led a first-year, three-site primary care practice to success in 100% of its 19 performance guarantees, including both clinical quality and risk adjustment metrics.

- Served as faculty and consultant for multiple patient-centered medical home initiatives in primary care practices, including the Commonwealth Fund's Safety Net Medical Home Initiative.
- Served for four years as a NCQA HEDIS Compliance Auditor.
- Served as IHI Fellow and faculty member.
- Received Lean training and conducted multiple workshops, webinars and in-person process improvement initiatives using Lean concepts in multiple settings.
- Received IHI Patient Safety Officer training, Flow and High Reliability trainings.
- Led national QI program to train all Medicare Quality Improvement Organizations (QIOs) in the Institute for Healthcare Improvement's Breakthrough Series Collaborative Improvement Model.
- Led multiple regional and local initiatives for the QIO.

MANAGEMENT AND LEADERSHIP

- Managed a team of 65 across three states in the QIO program.
- Managed a team of 35 hospital-based QI personnel including data analysts, data abstractors, QI consultants, hospital-based quality program managers, quality improvement coordinators and project managers.
- Hold a certificate in medical management from the University of Washington.
- Leadership style: Collaborative and data driven; deference to expertise; focus on development of highly reliable processes, culture of continuous improvement, and standard work.

COMMUNICATION

- Delivered more than 100 presentations locally, regionally and nationally on topics including health equity, Lean concepts, Model for Improvement and PDSA, reliability, culture change, spread and sustainability, nursing home QI, PCMH change concepts and tactics including incorporation of behavioral health into primary care and vice versa; and multiple clinical topics including antimicrobial stewardship, sepsis, readmissions, end of life care, and the role of the medical director in long term care. Audiences include state hospital and nursing home associations, WSNA, WSMA, Washington Patient Safety Coalition members and many others.

Shawn H.D. West, MD

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Objective

To exceed the expectations of my employer while improving the health and quality of life of those I serve.

Experience

Chief Medical Officer, Embright LLC **Seattle, WA** **9/19 to present**

Lead population health efforts across multiple health systems and a 7000 provider Clinically Integrated Network, including clinical performance improvement, care management, member engagement and digital health integration activities. Assist team with contracting, business development, and network development. Have a direct role in strategic planning, product development, vendor selection and management, CIN governance, and staff professional development. Promote advanced primary care and promulgate the collaborative care model of behavioral health integration across the network. Collaborate across a diverse set of constituents while maintaining a supportive, consistent leadership style that helps our team function well and navigate uncertain, ambiguous, and constantly changing circumstances.

Medical Director for Collaborative Health Solutions, Premera Blue Cross of Washington and Alaska

Mountlake Terrace, WA **8/14 to present**

Developed and iterated a de novo position that supported improved health care for members in Washington and Alaska. Impact included significantly higher levels of medical group engagement and subsequent financial success through improvements in performance related to appropriate risk-adjustment and quality measures.

Served as the plan medical director for the state of Alaska, including provider, employer and state-facing roles.

Helped design and implement meaningful quality incentives for value-based contracts.

Advanced the concept of the quadruple aim though design, implementation and iteration of an innovative program to assure evidence-based and appropriate clinical ordering decisions at the point of care, which reduced the need for prior authorization of medical services by several network provider organizations.

Served in a client/employer-facing medical director role, helping develop programs that deliver cost savings and improved outcomes for employees with local and national accounts.

Assisted in the evaluation and implementation of vendor solutions for fully and self-insured accounts.

Supported benefit design, provider network management, and development and implementation of value-based contracts utilizing up/downside risk models.

Developed and scaled the process to intake, onboard, and expand functionality of direct medical group EHR access which reduced transaction costs for plan and providers while improving acquisition of appropriate data for risk adjustment and HEDIS performance measures.

Represented the plan at local, state, and regional healthcare stakeholder groups, participated in legislative initiatives, and articulated corporate priorities in a public-facing role with print, online, and television media.

Led the clinical work-streams on the design and execution of a unique ACO product for a large employer in the Puget Sound region.

Developed and led enterprise-wide behavioral health program to improve access to, quality of, and member experience, related to mental health and substance use disorder care for clients/members. Helped select, manage, and execute several new behavioral health solutions for plan members, and convinced executive leadership to reopen the BH provider network, with a focus on onboarding those that represent diverse constituencies within the network. Nurtured, developed, and helped roll out three new BH vendor solutions that improved member access to virtual Medication Assisted Therapy, virtual/telephonic behavioral health, and in-person Substance Use Disorder treatment. Helped bring together several locally-situsued, national employers to discuss and share ways to destigmatize BH conditions, train managers, and improve access to resources that support them in getting appropriate, timely care.

Chief Medical Director at Centene/Coordinated Care **Tacoma, WA** **2/13 to 8/14**

Inaugural CMD of the Washington market, Medicaid Managed Care plan. Recruited, hired, and trained associate medical directors, managed quality, pharmacy, and utilization management teams, and represented plan at state and national meetings. Led clinical aspects of collaborative and productive work with medical provider group relationships, the Washington State Health Care Authority, and other regulatory bodies.

Family Physician, Edmonds Family Medicine **Edmonds, WA** **1/10 to 7/18**

Provided high quality, compassionate, and evidence-based care to individuals and families, with a focus on behavioral health and optimizing functionality and quality of life.

Physician Partner, The Polyclinic **Seattle, WA** **4/07 to 11/09**

Physician and shareholder in a large, multispecialty clinic in Seattle.

Physician Partner, Seattle Primary Physicians **Seattle, WA** **8/00 to 4/07**

Physician and board member, practicing full-scope primary care including ICU/inpatient, obstetrical, procedural, and outpatient clinic services

Professional Appointments and Elections

Board Member on the Foundation for Health Care Quality 4/21 to present

Provide leadership, guidance, support, and direction to CEO and staff that manage a host of state-wide, multi-stakeholder, quality improvement initiatives, including the OB, Cardiac, Surgery, and Spine Care Outcome Assessment Programs, the Washington Patient Safety Coalition, and the Dr. Robert Bree Collaborative.

Governor-appointed Member of the Dr. Robert Bree Collaborative 6/14 to present

Serve on this multi-stakeholder group tasked with identifying and developing evidence-based recommendations toward improvement in health care cost, quality, and experience for all Washingtonians. Serve as Chair of the workgroup on virtual care.

Secretary-Treasurer and Member of the WAFP Board of Directors 5/17 to 5/21

Active member of the Washington Academy of Family Physicians since medical school, having served as University of Washington medical student liaison, Residency Trustee to the board, Chair of the Governmental Affairs Committee, and helped start the Academy Political Action Committee. Worked with WAFP lobbyists to represent the Academy thought legislative relationships in Olympia, and at the national/AAFP level.

Member of the Committee on Quality and Practice for the AAFP 1/13 to 12/14

Served on the committee of the American Academy of Family Physicians that sets academy priorities, standards of care, and efforts to support improved patient care at the national level.

Chief of Staff at Swedish Medical Center, Ballard Campus 1/05 to 1/07

Served on the Swedish Medical Executive Committee, setting direction for campus medical staff, and directing disciplinary actions with providers who did not follow medical staff bylaws or code of conduct. Previous to this, served as the Chief of Family Medicine, and Chair of the CME Committee.

Education

Certificate in Medical Management, University of Washington **12/13**
Seattle, Washington

Graduate and Chief Resident, Providence St. Peter Hospital **7/98**
Olympia, Washington

Doctor of Medicine, University of Washington **6/95**

Seattle, Washington

Bachelor of Science in Psychology, University of Washington **6/90**

Seattle, Washington

Active and unrestricted license to practice medicine and surgery (WA)

References provided upon request.

CURRICULUM VITAE

Sheryl A. Morelli, MD, MS, FAAP

CONTACT INFORMATION

Sheryl A. Morelli, MD, MS, FAAP
818 Stewart Street Suite 603
818-S PO Box 5371
Seattle, WA 98145
206-884-2882
sheryl.morelli@seattlechildrens.org

1. PERSONAL DATA

Place of Birth: Gross Pointe, MI; USA
Date of Birth: 04/10/1969

2. EDUCATION

06/1991	BS, Human Ecology, The Ohio State University, Columbus, Ohio
08/1993	MS, Child Development/Early Childhood Education, The Ohio State University, Columbus, Ohio
06/2000	MD, Wright State University, Dayton, Ohio

3. POSTGRADUATE TRAINING

07/2000-06/2003	Resident, Integrated Pediatric Residency Program, Children's Medical Center; Dayton, Ohio

4. FACULTY POSITIONS HELD

08/1993-07/1994	Early Childhood Specialist/Adjunct Faculty Instructor, The Ohio State University, Columbus, Ohio
08/2003-08/2008	Assistant Professor, Department of Pediatrics, The Ohio State University, Columbus, Ohio
08/2008-Present	Clinical Professor, Department of Pediatrics, University of Washington; Seattle, Washington

5. HOSPITAL POSITIONS HELD

08/2003-08/2008	Staff Pediatrician, Nationwide Children's Hospital
08/2008-2015	Informatics Staff Physician, Seattle Children's Hospital
02/2013-Present	Staff Pediatrician, University of Washington Primary Care – Kent/DesMoines
07/2016-Present	Chief Medical Officer, Seattle Children's Care Network
2017-2020	Community Member, Medical Executive Committee, Seattle Children's Hospital
08/2018-Present	Section Chief, Community Pediatrics, Seattle Children's Hospital
10/2021-Present	Medical Director, ACE Kids Program, Seattle Children's Hospital
10/2020-Present	Elected Medical Staff Advisor, Medical Executive Committee, Seattle Children's Hospital

6. CURRENT (NON-UW) EMPLOYMENT

None

7. HONORS

06/1991	Cum Laude, The Ohio State University
2008	Grant Morrow III Teaching Award, Nationwide Children's Hospital
2013	Washington State Medical Association Leadership Development Scholarship
2013	Patient Reported Assessment In Satisfaction and Excellence (PRAISE), University of Washington
2014	PRAISE, University of Washington Primary Care
2016	PRAISE, University of Washington Primary Care
2017	PRAISE, University of Washington Primary Care
2018	PRAISE, University of Washington Primary Care
2019	Richard A. Molteni Award for Excellence in Professionalism and Quality of Care, Seattle Children's Hospital
2022	Special Achievement Award, Washington Chapter of the American Academy of Pediatrics

8. BOARD CERTIFICATION

10/2003 – Present	Certified, American Board of Pediatrics, General Pediatrics (MOC cycle 1/2021-12/2026)
10/2015 – 12/2025	Certified, American Board of Preventive Medicine, Informatics (MOC cycle 10/2015-12/2020)

9. CURRENT STATE LICENSE

7/2008-4/2023	State of Washington License: Number MD00049402

10. DIVERSITY, EQUITY AND INCLUSION ACTIVITIES (optional)

2019	Participant, Equity, Diversity and Inclusion Training, Seattle Children's Hospital
2020- Present	Participant, Anti-Racism Organizational Change Leadership Training, Seattle Children's Hospital
2020 - Present	Leader, Race, Ethnicity and Language Data Reporting, Seattle Children's Care Network
2021 - Present	Participant, Equity Series, Washington Chapter of the American Academy of Pediatrics
2022 – Present	Founding Member, Seattle Children's Research Institute, Practice Based Research Network, Health Equity Learning Laboratory

11. PROFESSIONAL ORGANIZATIONS

10/2003 - Present	Fellow, American Academy of Pediatrics
10/2008 - Present	Member, Washington Chapter of the American Academy of Pediatrics (WCAAP)
07/2016 - Present	Seattle Children's Hospital Board Representative, WCAAP
07/2016 - Present	Member, Health Care Transformation Committee, WCAAP
10/2013 - Present	Member, Washington State Medical Association

12. TEACHING RESPONSIBILITIES

(a) Medical Students and Students in other Health Professions

UW SOM courses taught

Course	Title	Credits	Years	Students	Responsibility

HuBio 513	Introduction to Clinical Medicine I	3	2009-2010	~ 30-40	Instruct and facilitate class
HuBio 559	Problem-Based Learning	3	2009-2010	~ 10-12	Lead and facilitate class discussion
HuBio 522	Introduction to Clinical Medicine II Pediatrics Tutorial	4	2010-2011	~ 30-40	Instruct and demonstrate pediatric specific skills in interviewing

(b) Pediatric Resident

TABLE: Pediatric resident teaching responsibilities

2004-2008	Preceptor, Pediatric Residency-Continuity Clinic Nationwide Children's Hospital Primary Care Clinic. The Ohio State University, College of Medicine and Public Health.
2006-2007	Preceptor, Pediatric Residency-Journal Club. The Ohio State University, College of Medicine and Public Health.
2006-2008	Preceptor, Introduction to Clinical Interviewing. The Ohio State University, College of Medicine and Public Health.
2006-2008	Instructor, Introduction to Clinical Medicine. The Ohio State University, College of Medicine and Public Health.
2008-2012	Preceptor, Pediatric Residency – Continuity Clinic, North Public Health Clinic. University of Washington School of Medicine.
2012 - present	Preceptor, Pediatric Residency-Continuity Clinic. University of Washington Neighborhood Clinic, Kent/DesMoines. Univesity of Washington School of Medicine

(c) Subspecialty Fellows

None

(d) Other Venues

TABLE: The Ohio State University: School of Nursing

2005-2008	Preceptor, Pediatric Nurse Practitioner Program.

(e) Mentoring

TABLE: Resident Mentoring Responsibilities (last 5 years)

2019 - 2022	Pediatric resident advisor

13. EDITORIAL RESPONSIBILITIES

None

14. SPECIAL NATIONAL RESPONSIBILITIES

2016-2020	Co-Chair Measures for Value-based Contracting Workgroup, Accountable Health Learning Collaborative, Children's Hospital Association
2017-2019	Pediatric Value-Measurement Advisory Group, Children's Hospital Association
2017-2020	Advisory Board Member, National Science Foundation Center for Health Organization Transformation (CHOT)
2020-2022	Pediatric Population Health Learning Network, Cincinnati Children's

15. SPECIAL LOCAL RESPONSIBILITIES

2004	Contributing Author, Columbus Parent Magazine, Nationwide Children's Hospital
2005-2007	Member, EMR eChart Ambulatory Project Team, Nationwide Children's Hospital
2005-2008	Physician Leader, Ambulatory Pediatrics Electric Medical Records (EMR), Nationwide Children's Hospital
2005-2008	Member, EMR eChart Ambulatory Advisory Group, Nationwide Children's Hospital
2005-2008	Member, EMR eChart Ambulatory Advisory Group, Nationwide Children's Hospital
2005-2008	Pediatrician Consultant, Healthy Child Care Ohio
2008-2013	Member, Enhancement Review Team, Clinical Information Systems, Seattle Children's Hospital
2009	Member, Health Resources and Services Administration Pediatric Public Health Curriculum Workgroup
2009-2012	Medical Director, North Public Health Clinic Reach Out and Read
2010-2013	Board Member, Wonderland Developmental Center
2011	Member, Clinical Information Systems Improvement Project Executive Steering Committee, Seattle Children's Hospital
2011-2013	Board President, Wonderland Developmental Center
2012	Member, PathNet Executive Steering Committee, Seattle Children's Hospital
2012-2014	Member, Clinical Standards Committee, Seattle Children's Hospital

2012-2016	Pediatric Continuity Clinic Coordinator, Kent/DesMoines, University of Washington
2012-2016	Member, Neighborhood Clinics Medical Education Committee, University of Washington
2013-2015	Member, Neighborhood Clinics Patient Education Committee, University of Washington
2014-2016	Member, Clinical Competency Committee, University of Washington
2016-2017	Member, Care Management and Patient Health Committee, University of Washington
2016-2017	Member, Clinical Practice Value Improvement Sub-committee, Children's University Medical Group
2016-2018	Member, ACN Quality and Care Transformation Committee, University of Washington
2016-Present	Member, Clinical Practice Committee, Children's University Medical Group
2016-2019	Member, ACN Finance and Quality Analysis Workgroup, University of Washington
2016-Present	Ex officio member, Board of Managers, Seattle Children's Care Network
2016-Present	Chair, Quality and Care Integration Committee, Seattle Children's Care Network
2016-Present	Member, Governance Committee, Seattle Children's Care Network
2016-Present	Member, Finance Committee, Seattle Children's Care Network
2016-Present	Member, Network Development and Credentialing Committee, Seattle Children's Care Network
2017-2018	Chair Pediatric Sub-Committee, ACN Quality and Care Transformation Committee, University of Washington
2017-2018	Member, Ambulatory Steering Committee, Seattle Children's Hospital
2017-2018	Member, ER is for Emergencies Workgroup, Washington State Health Care Authority
2018-2021	Member, Pediatric Value-Based Payment Reform Workgroup, Washington State Health Care Authority
2019-2020	Member, Patient Access Oversight Committee, Seattle Children's Hospital
2019-Present	Seattle Children's Research Institute-Seattle Children's Care Network Practice Based Research Network Review Committee, Seattle Children's Hospital
2019-2021	King County Child Health Improvement Partnership (KCHIP) Steering Committee, King County Public Health, Washington

2020-2021	Member, General Pediatrics Social Determinants of Health Workgroup, University of Washington
2021-Present	Member, Children & Youth Behavioral Health Work Group, BH Integration Sub-group, Washington State Health Care Authority
2021-Present	Co-Leader, Division of General Pediatrics Primary Care Transformation Task Force, University of Washington
2022-Present	Molina Healthcare of Washington, Quality Improvement Committee
2022-Present	Regence BlueShield of Washington, Provider Advisory Counsel

16. RESEARCH FUNDING

Active Funding

None

Pending Funding

HRSA-22-098	Arti Desai (PI)	9/2022-9/2027
HRSA		Total: $400,000
Enhancing Systems of Care for Children with Medical Complexity (Demonstration Projects)		
Role: Operational Director		

Not Funded

SM-21-009	Larry Wissow, Sheryl Morelli (PI)	9/2021-9/2026
SAMHSA		Total: $3,000,000
Pediatric Integrated Care Collaborative		
Role: Co – Principal Investigator		

Completed Funding

RO1 HS019862	Joel Tieder (PI)	2010-2014
AHRQ		Total: $9,000,000

PHIS + "ARRA-AHRQ Recovery Act 2009 Limited Competition: PROSPECT Studies: Building New Clinical Infrastructure for Comparative Effectiveness Research."

Role: Co-Investigator

17. BIBLIOGRAPHY

(a) Peer-Reviewed Publications

1. Leu MG, **Morelli SA**, Chung O, Radford SM. Systematic Update of Computerized Physician Order Entry (CPOE) Ordersets to Improve Quality of Care: A Case Study. Pediatrics. 2013 Mar;131 Suppl 1:S60-7. doi: 10.1542/peds.2012-1427g

(b) Collaborative Authorship

None

(c) MedEdPORTAL or other Peer-Reviewed Curricula

None

(d) Book Chapters

None

(e) Published Books, Video, Software

None

(f) Other Publications

None

(g) Submitted Manuscripts

None

(h) Abstracts (last 5 years only)

None

18. INVITED TALKS

(a) National/International

10/2009	Invited Speaker. "Adding A Diagnosis: When Two Clicks Is One Too Many." Cerner Health Conference, Kansas City, MO.
10/2012	Invited Speaker. "Implementation of an Enhancement Review Process." Cerner Health Conference, Kansas City, MO.
03/2019	Invited Speaker. "Come Together: Dyad Leadership, Project Management and Disparate Data Come Together to Identify Opportunities and Drive Change." Children's Hospital Association Accountable Health Learning Collaborative, Atlanta, GA.
03/2020	Invited Speaker. "Inspiration for Integration: Creating An Integrated Care Management and Behavioral Health Program In A Pediatric Primary Care Setting." Pediatric Ambulatory Quality Symposium, Phoenix, AZ.
03/2020	Invited Speaker. "Returning the Joy in Medicine to Pediatric Primary Care through a Quality Improvement Lens." Pediatric Ambulatory Quality Symposium. Phoenix, AZ.
03/2020	Invited Speaker. "Lessons Learned: Integrated Behavioral Health in Pediatric Primary Care." Children's Hospital Association Behavioral Health Summit, Columbus, OH.
08/2021	Invited Speaker. "Developing the Medical Home Delivery Model with Extended Support Network Across the State." Children's Hospital Association, ACE Kids Learning Group, Virtual.
11/2021	Invited Speaker. "Realizing the Promise of ACE Kids: A National Approach to Improving Care for Children with Medical Complexity." Children's Hospital Association Annual Leadership Conference, Virtual.
1/2022	Invited Speaker. "Consulting Effectively with Pediatricians and Other Primary Care Providers: The Pediatrician's View." The American Professional Society of ADHD and Related Disorders Annual Conference, Virtual.
07/2022	Invited Speaker. "Integrated Care for Children with ADHD: How to Form a Cross-Functional Care Team." ADDitude Magazine Expert Webinar and Podcast Episodes, Virtual.

(b) Regional

09/2018	Invited Speaker. "Inspiration for Integration: Bringing Behavioral Health to Pediatric Populations." WCAAP – Transforming Clinical Practice Initiative (TCPI), Yakima, WA.
09/2018	Invited Speaker. "ED Phone Home: Implementing a Team Approach to Emergency Department Follow-Up Care and Reduction of Potentially Avoidable Visits." WCAAP Population Health Forum, Yakima, WA.
06/2019	Invited Speaker. "Inspiration for Integration: Creating An Integrated Care Management and Behavioral Health Program In A Pediatric Primary Care Setting." WCAAP Population Health Forum, Seattle, WA.
11/2021	Invited Speaker. CoLab for Community and Behavioral Health Integrated Care Webinar Series Part 2 "Best Practices To Implement Evidence-Informed Integrated Mental Health Care." University of Washington CoLab, Seattle, WA.

(c) Local

08/2012	Invited Speaker. "Systematic Update of Computerized Physician Order Entry (CPOE) Ordersets to Improve Quality of Care: A Case Study." Cerner Pediatric Special Interest Group Webinar, Seattle, WA.
09/2012	Invited Speaker. "Making It Easy to Do the Right Thing: Leveraging Clinical Decision Support for Patient Safety." Patient Safety Conference, Seattle Children's Hospital, Seattle, WA.
09/2018	Invited Speaker. "EDIE/Premanage Implementation: Seattle Children's Care Network." WCAAP – TCPI Webinar Seattle, WA.
12/2019	Invited Speaker. "Pediatric Integrated Care: Rationale, Model, Collaborative." Community Health Plan of Washington Medical Director's Round Table, Seattle, WA.
03/2021	Invited Speaker. "Preparing for Care Transformation and Value Based Payment Reform: Care Coordination in Pediatric Primary Care." WCAAP Health Care Transformation Committee, Seattle, WA.

19. OTHER EMPLOYMENT

None

Staici West

Spokane, WA

509-844-1614

suealanwest@gmail.com

ACHIEVEMENTS

CEO Award Winner
Premera Blues Cross, 2010

Leadership Horizon Participate
Premera Blue Cross, 2010

Leadership Spokane Graduate
Spokane, 2009

SKILLS

- Leadership
- Mentoring
- Human Relations
- Strategy Development
- Project Management
- Team Building

EXPERIENCE

Coordinated Care, 2019- Current

Vice President Network Development & Contracting
- Provider Network Development/Expansion & Stability
- Unit cost management
- Value-based development & execution
- Developing and implementing network strategies
- Staffing and hiring
- Team development and design

Premera Blue Cross, 1995 – 2019

Director, Provider Network Management
- Unit cost management
- Value- based development and negotiation
- Provider Network Stability
- Leading and executing network strategies
- Staffing and hiring
- Professional development of the team

Regional Contracting Manager
- Developing and implementing contracting strategies
- Network development/ monitoring adequacy
- Quality monitoring, contract implementation and client service
- Achieve Premera Blue Cross financial objectives/budgetary objectives
- Staffing and hiring decisions
- Professional development of team

Provider Network Executive Lead
- Oversee the accounts managed by other staff
- Negotiate contractual arrangements with strategic providers
- Develops and implements contracting strategies

Provider Network Executive II
- Lead, develop and maintain strong relations with providers
- Negotiate contractual arrangements with strategic providers
- Execute Premera's strategic initiatives for provider & product

Provider Network Associate
- Resolve provider issues regarding benefits, claims adjudication, eligibility
- Lead Provider workshop presentations
- Provider education on new policies and procedures

EDUCATION

Yale School of Management
Leading Effective Decision Making, 2021

University of Washington Foster's School of Business
Executive Development Program, 2011-2012

TONY BUTRUILLE, MD

12692 Ranger Road Leavenworth, WA 98826 (509) 433-8651 tonyb@cascademedical.org

RESIDENCY/INTERNSHIP

Family Practice Residency of Idaho — July 1997 – June 2000
Chief Resident — July 1999 – June 2000

MEDICAL SCHOOL

M.D. – Oregon Health Sciences University School of Medicine — June 1997

UNDERGRADUATE

B.S. – Oregon State University, Corvallis, OR — June 1991
Graduated with Highest Scholarship in Civil Engineering

MEDICAL WORK EXPERIENCE

Staff Physician. Cascade Medical Center. — Sep 2002 – Present
Leavenworth, Washington. Full spectrum small town family Medicine, including colonoscopy. Volunteer, free clinic.

Staff Physician. Clearwater Valley Hospital and Clinics. — Sep 2000 – Aug 2002
Orofino, Idaho. Provided full-spectrum medical services in ER, Hospital and Clinic, including obstetrical services with c-sections.

MEDICAL VOLUNTEER EXPERIENCE

Washington Academy of Family Physicians

Chair, Primary Care Investment Task Force — Oct 2018 – Nov 2021
- OFM Study Group (Baseline Primary Care Measurement) — June - Dec 2019
- HCA Primary Care Summit Series Participant — June 2019 - present
- PCPCC Primary Care Investment Workgroup — April 2019 - present
- Bree Collaborative Primary Care Workgroup — Dec 2019 – Jan 2021
- Primary Care Model Measures Workgroup, HCA — March 2021 – present
- Co-Chair, Primary Care Transformation Model Certification Work Group. — Dec 2021 - present

East Side Alternate Delegate to AAFP — May 2016 – June 2022
President — May 2015 – May 2016
President-elect — May 2014 – May 2015
Vice President — May 2013 – May 2014
Co-Chair, Governmental Affairs Committee — May 2009 – May 2012
Member, GAC — Sep 2008 – May 2009
Member, Practice Enhancement Committee — Feb 2017 – June 2022

Member, Healthier WA Practice Transformation Support Hub Portal — Sep 2016 – Sep 2017

Member. Healthier WA Clinical Engagement Accelerator Committee — Dec 2015 – Sep 2017

Member. Advisory Panel for Healthy Hearts NW — July 2015 – Aug 2018

Member. Washington State Adult Partnership Access Line Advisory Workgroup, WA State Legislature. — July – Nov 2014

WSMA Representative. Chelan-Douglas Medical Society — Oct 2012 – Oct 2013

Member. WSMA Health Equity Task Force — March 2012 – May 2013

Member. Workforce Development Advisory Group, Washington State Legislature. — July 2010 – June 2011

Volunteer.

Northwest Medical Teams.

Oaxaca, Mexico	2000 and 2002
Cambodia	2013

Sacred Valley Health. Ollantaytambo, Peru — 2017

Clinic Director. Ak'Tenamit Project, Rio Dulce, Guatemala. — Feb – June 1996
Responsible for clinical staff and facilities serving over 7,000 Mayan Indians in jungles of Eastern Guatemala. Developed formal education for local health promoters. Maintained and expanded "outreach programs" bringing immunizations, health education and fundamental health care directly to outlying villages. Medical volunteer at project Oct – Dec, 1995.

National Student Representative. Commission on Legislation and Government Affairs, AAFP — 1993, 1994

Congressional Fellow, Washington, D.C. — Summer 1993
Joined legislative staff of U.S. Senator Mark O. Hatfield to promote rural health care legislation.

ACADEMIC AFFILIATIONS/AWARDS

Clinical Assistant Professor. Dept of Family Medicine, University of Washington School of Medicine. — June 2017 – present

Assistant Site Director. Family Medicine Clerkship, Cascade Medical. — June 2013 – present

Staff Professionalism Award. Department of Family Medicine, UW. — 2012, 2016

Master Preceptor Award. Society of Teachers of Family Medicine — 2020

OTHER WORK EXPERIENCE AND VOLUNTEER ACTIVITIES

Avid Tutor. *Cascade High School.* Sep 2018 – June 2019

Board Member. *Wenatchee River Institute.* Oct 2009 – Oct 2012

Research Assistant. Biomedical Information Communication Center. Sep 1991 – Oct 1992
Oregon Health Sciences University. Analyzed usefulness, applications of digital imagery within the field of tele-dermatology.

Valet Attendant, Bartender, Waiter, Dishwasher. Sep 91 – Dec 95
Chart House Restaurant. Portland, Oregon. Worked part-time through medical school.

Construction Engineer. Granite Construction Co. Reno, NV. Summer 1990

Engineer, Surveyor. Water Bureau. Portland, Oregon. Summer 1989

Fire Crew Boss. Department of Natural Resources. State of WA. Summers 87 and 88

PUBLICATIONS/RESEARCH

WAFP Journal Articles

"Reflections on the AAFP Annual Leadership Forum"	July 2014
"Every Family Physician That I've Ever Met"	August 2015
"US Healthcare System – Creating Health or Wealth?"	Nov 2015
"Two Patients"	Jan 2016
"Branding Family Medicine"	April 2016

Perednia, Douglas A., John A. Gaines, and Tony W. Butruille.
"Comparison of the Clinical Informativeness of Photographs and Digital Imaging Media with Multiple-Choice Receiver Operating Characteristics (ROC) Analysis."
Archives of Dermatology. 1995; 131: 292-297.

PRESENTATIONS

Keynote Speaker. WAFP Student and Resident Retreat 1/25/2020
"Advocating for Increased Primary Care Investment"

Primary Care Spend Panelist, State Legislative Conference, AAFP Oct 2020

Speaker, WA HCA Primary Care MOU Signing Ceremony. Oct 2020

Panelist, Clinician Wellness and Endurance Strategies, Bree Aug 2020

Panelist, Aligning Quality Measures, Bree/HCA July 2021

PROFESSIONAL AFFILIATIONS

American Academy of Family Physicians
Washington Academy of Family Physicians
Washington State Medical Association

LICENSURE

Washington State Board of Medicine
U.S. DEA: BBxxxxxxx.
Board Certified, American Board of Family Practice, current.
Current Certification: ACLS, PALS, ATLS.

INTERESTS/PERSONAL

Hobbies include backpacking, skiing, fly fishing, travel, reading, and exercise.
Wife: Meleah is a nurse practitioner, currently working as a clinical instructor at Wenatchee Valley College School of Nursing.
Children: Sarah and Evan, 20 and 17 years old, respectively.
Language Skills: Spanish

REFERENCES Provided Upon Request

Tracy Corgiat

tracy.corgiat@confluencehealth.org • 425.765.4444

Health Economist. Healthcare Leadership – Strategy & Operations

Dedicated to creating systems and change aimed at providing all people with quality, affordable, and accessible healthcare.

Diverse professional background. Experience with multiple payor and delivery models including: value-based care/full risk capitation, direct-to-consumer and concierge primary care, Medicaid, Medicare, commercial, and ACO populations.

Highly collaborative individual, known for innovative and effective problem solving, long-term vision, timeliness, and follow through. Leader focused on outcomes. Excels in complex environments. Builds teams of intelligent and talented individuals with diverse skills and viewpoints.

Key Experience

Confluence Health, Central Washington Hospital Wenatchee, WA
- Vice President Primary Care, September 2021 – Present
- Service Line Director – Medical Specialty, Primary Care, Women's Health & OB/GYN, March 2021 – Sept 2021

Accountable for patient care, business performance, and workforce satisfaction and productivity for outpatient primary care, OB/GYN and behavioral health services in Grant, Okanogan, Chelan, and Douglas Counties. Serve more than 100,000 patients; leading 200 providers and 500 staff.

The Polyclinic – An Optum Company Seattle, WA
- Vice President of Development, June 2011 – March 2021
- Director of Marketing, Communications & Public Affairs, April 2008 – June 2011
- Director of Marketing & Communications, September 2004 – April 2008

Multi-specialty, physician-led medical practice made up of 250 providers working in ambulatory and hospital settings. Serves on the senior leadership team, reporting to the CEO, and contributing to all areas of business.

Significant Accomplishments:

- Brought 200 providers live with telemedicine capability in 10 days.
- Led planning for regional facility and service expansion and achieved board of directors' support.
- Partnered with Chief Operating Officer, Chief Financial Officer, and Director of Facilities to execute on facility expansion and improvements.
- Launched and marketed 15 new service lines.
- Partnered with a small group of other key executives and physician leaders to lead COVID-19 operations:
  - Created acute respiratory clinics, immediately separating them from our other 11 facilities
  - Kept all essential services running by meeting clinical, equipment, and personnel needs, and redeploying clinical and non-clinical staff
- Co-authored and passed House Bill 1777 during 2019 legislative session, protecting key interests of the clinic and its patients related to ambulatory surgery and certificate of need regulations in Washington state.

- Continued -

Polyclinic Community Health Foundation Seattle, WA
Executive Director April 2008 – December 2016

Mission-driven 501c3 aimed at improving the lives of patients struggling with chronic illness. Led the organization, managing programs, development, P&L, and staff. Programs provided patients with critical medication through grants and pharmaceutical industry programs and aimed at improving social aspects of health for patients. Recruited and developed board of directors and external partnerships.

Partnered with larger entities to create four-times the value of patient services delivered for every dollar donated.

Education

London School of Economics
Master of Health Economics, Policy & Management. With Merit.
London, England

Washington State University
Bachelor of Arts in Communication. Public Relations emphasis, minor in Political Science. Honors College.

Core Competencies

- Strategic Planning, Goal Setting & Prioritization
- Healthcare Operations
- P&L Management
- Contracts, Legal & Regulatory Affairs
- Physician Recruitment
- Market & Program Development
- Facility Expansion
- Value-Based Care, Full Risk Capitation
- Employee Engagement
- Communications
- Marketing
- Public Affairs/Policy
- Project Management
- Lean/Continuous Process Improvement
- Patient & Employee Safety
- Quality & Cost Measures

Community

- **Primary Care Certification Workgroup**
  Washington State Health Care Authority
  January 2022 – Present
- **Project Access Northwest**, Seattle, WA
  Member of the Board of Directors
  April 2018 – March 2021
- **Church on the Ridge**, Snoqualmie, WA
  Music Volunteer
  September 2015 – March 2021
- **Wenatchee Row & Paddle Club**
  Rower; Member
  August 2022 - Present
- **Washington Health Alliance**
  Communications Committee Chair 2010-2012
  Committee Member, 2006–2010
- **Juvenile Diabetes Research Foundation**
  Member of the Board of Directors, NW
  2010-2011