Foundation for Health Care Quality History

Vision

Quality health care grounded in evidence, centered on people.

Mission

Catalyzing health care quality improvement through public and private collaboration.

The Foundation for Health Care Quality has served our health care ecosystem as a neutral convenor, a source of innovation, and a change agent since our founding in 1988. Collaboration takes down silos, generates new ideas, and changes culture.

Our organization originally formed to develop a more accurate way to measure patient risk adjustment. From those early conversations with local health care leaders, we worked with key organizational partners to slowly grow infrastructure, holding discussion forums and conferences, to identify how to measure and improve clinical care quality. By including competitive organizations and health care sectors who do not traditionally partner with one another, we were able to build an environment of trust that continues today.

Our work has centered on quantifying clinical quality and patient profiles, improving information exchange within health care, and driving improvement in care processes and outcomes. Funding has come from State Government (e.g., the Department of Health, the Health Care Authority) and Federal Government (e.g., Agency for Healthcare Research and Quality, the Department of Defense) individual hospitals, health carriers, associations, collaboratives, private foundations (e.g., Skyline, Ballmer Group), and other key partners.

One of our earliest programs in 1990, the Statistical Obstetrics Review Quality System, used risk adjusted quality indicators to merge birth certificate data; Comprehensive Hospital Abstract Reporting System data; and infant death records. This was one of the first studies in the country to link clinical data to patient outcomes and establish quality measures based on that information. This same model was then applied through the Back Pain Outcomes Assessment Team to develop patient and provider engagement models, patient decision support, and standards for measuring back conditions.

The success of using chart-abstracted, clinical data to examine and target specific areas of variation led to the creation of our Care Outcomes Assessment Programs, starting with cardiac procedures in 1994. Cardiac COAP is clinician-led and uses near to real time data to drive measurement and improvement for open heart surgery and less invasive cardiac procedures. The program established a culture built on transparency, trust, peer learning, and the belief that clinicians are most effective when they work together to identify and improve variation in care. Cardiac COAP has had a profound impact by significantly lowering blood transfusions during and after surgery (43% to 24%), increasing early removal of a patient's artificial breathing tube (42% to 71%), reducing door to balloon times after an acute heart attack, and many other successes.

Obstetrical COAP built on these strong foundations with a focus on labor and delivery services in 2010. The program uses benchmarked clinical data and targeted educational efforts and has led to an increase in collection of cord gases from (33% to 60%); a three-fold increase in the rate of timely treatment of acute severe high blood pressure at one large hospital, and improvements in breastfeeding rates across one large system, among other successes. Obstetrical COAP includes both hospital births and community births, a unique and impactful model. In 2023, the Foundation launched the Community Birth Data Registry, created by midwives for midwives. This registry has experienced substantial geographic expansion, with midwives and community birth practices in eleven states.

Health data exchange has been a key strategy for the Foundation beginning in 1993 with the Community Health Information Management Systems Initiative focused on sharing information between and among organizations. This work morphed into the Health Care Quality Measurement Advisory Service in 1995, which

assisted state and local health care coalitions, purchasing groups and health information organizations measure quality for value-based purchasing, and in 1996 into the the Community Health Information Technology Alliance, a collaborative model bridging the gap between the pre-Internet era, focused on building a shared network to replace proprietary private networks, and the Internet era which brought a focus on security, data standards, and policies. From 2004-2007, the Foundation was home to the Outbreak Detection Information Network, that used emerging syndromic surveillance science to capture data from health encounters to predict disease outbreaks ahead of clinically verified laboratory results. The Foundation is currently working with the Department of Health and the state health information exchange to build a multidisciplinary governed clinical data resource.

Driving improvements in clinical care has been a key part of the work listed above and a specific focus of individual programs and initiatives, not all of which are discussed here. Early programs in the 1990s focused on an integrated strategic and quality improvement plan in public and private laboratories for public surveillance and in collaborative education on diabetes care. Current programs include:

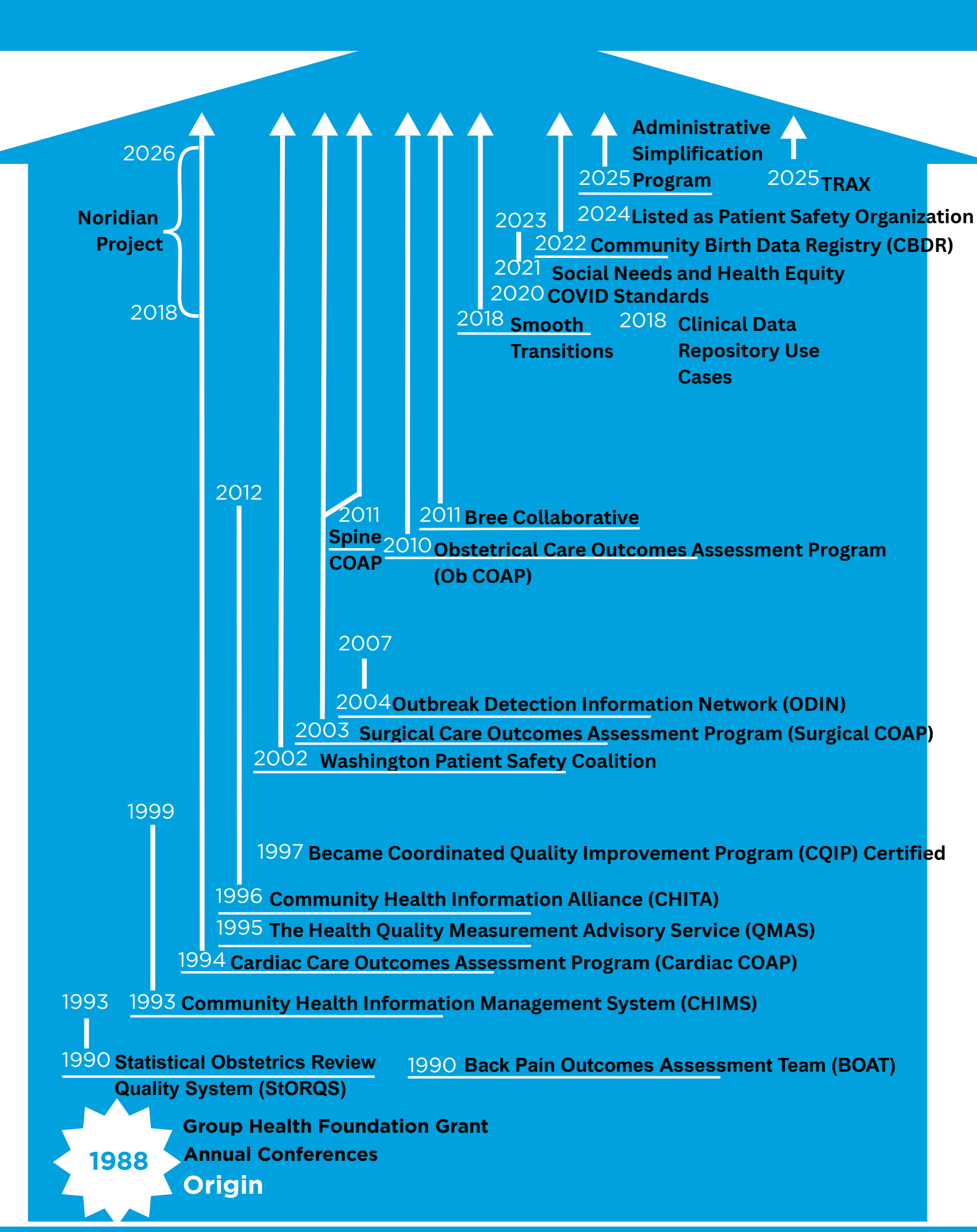
- The Washington Patient Safety Coalition formed in 2002 with a request from the Washington State Governor's office and is comprised of member hospitals, health carriers, professional organizations, medical groups and others. The Coalition facilitates targeted patient safety initiatives like the Speak Up! award that recognizes good catches to prevent errors and holds an annual patient safety conference.
- The Bree Collaborative is a public/private group founded by state Legislation that develops, implements, and evaluates evidence-based clinical, payment, and policy guidelines for health care services that are highly variable, are high cost but have poor outcomes, or have a patient safety or equity issue (e.g., opioid prescribing, behavioral health). These guidelines have been integrated into state contracting, the commercial sector, and widely throughout the state.
- The Smooth Transitions™ Quality Improvement Program, which moved from the Department of Health to the Foundation in 2008, improves communication and enhances collaboration between community midwives, hospital-based providers, and EMS to achieve better outcomes for birthing people and babies and increase patient satisfaction with care. The program is being adopted outside of Washington and continues to grow.
- The Administrative Simplification program was developed by the Washington Healthcare Forum and moved to the Foundation in 2025. The program makes it easier for health plans and providers to do business together by finding consensus solutions to shared operational problems.

We have been supported by subject matter experts who have volunteered many hours to our initiatives and programs; visionary board members, listed in **Appendix A**, dedicated staff members who have served their communities through our work, and Chief Executive Officers including:

- Keith McCandless 1989 – 1992
- David Friedman 1992 – 1993
- Rick Rubin 1993 – 1999
- Elizabeth Ward, RN, MN 1999 – 2001
- Dorothy Teeter, MHA 2001 – 2002
- Andrew Fallat, FACHE 2002 – 2008
- Terry Rogers, MD 2008 – 2016
- Peter Dunbar, ChB, MBA 2016 – 2020
- John Vassall, MD 2020
- Ginny Weir, MPH 2020 – Present

See **Appendix B** for a list of our peer reviewed articles, abstracts, and presentations. This document is based in large part on the work of Kathleen O'Connor, health care advocate and former board member

In community,
Ginny Weir, MPH,
CEO, Foundation for Health Care Quality


2026
Noridian Project
2018
2025 Administrative Simplification Program
2025 TRAX
2024 Listed as Patient Safety Organization
2023
2022 Community Birth Data Registry (CBDR)
2021 Social Needs and Health Equity
2020 COVID Standards
2018 Smooth Transitions
2018 Clinical Data Repository Use Cases
2012
2011 Spine COAP
2011 Bree Collaborative
2010 Obstetrical Care Outcomes Assessment Program (Ob COAP)
2007
2004 Outbreak Detection Information Network (ODIN)
2003 Surgical Care Outcomes Assessment Program (Surgical COAP)
2002 Washington Patient Safety Coalition
1999
1997 Became Coordinated Quality Improvement Program (CQIP) Certified
1996 Community Health Information Alliance (CHITA)
1995 The Health Quality Measurement Advisory Service (QMAS)
1994 Cardiac Care Outcomes Assessment Program (Cardiac COAP)
1993
1993 Community Health Information Management System (CHIMS)
1990 Statistical Obstetrics Review Quality System (StORQS)
1990 Back Pain Outcomes Assessment Team (BOAT)
1988
Group Health Foundation Grant
Annual Conferences
Origin

ORIGINS

The 1980s saw rising health care costs and in response, an increase in utilization review, as well as disagreement around illness severity data and scoring. Clinicians, administrators, and health care purchasers had little confidence in conclusions from private vendors.

Common work with hospitals, physicians and data systems provided an opportunity for Andrea Castell, RN, BSN, MBA, Executive Director, Health Care Purchasers Association; Jim Nell, Executive Director, Seattle Area Hospital Council and Rick Rubin, President and co-founder, EconoMetrics to begin discussions on how to collaborate around a shared strategic interest. The group hosted a series of meetings with the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA) and other practitioners to discover what they might be able to do collaboratively and elected to focus on patient illness severity.

In order to foster trust in the face of a competitive health care marketplace, the group sought to create a neutral organization separate from and not embedded in any existing organization. The Foundation for Health Care Quality was founded on March 17, 1988. WSHA, WSMA, Health Care Purchasers Association, and Seattle Area Hospital Council each made an initial financial commitment of $5,000. WSHA volunteered to house the the Foundation, provided no-cost accounting services, and contributed in- kind salary support for an interim Executive Director.

With this initial resource, the Foundation surveyed the community on severity classification methods and held a conference as a discussion forum. The community elected to continue collaboration after the conference and joined together to identify and define key elements to assess quality— clinical information, data needs on clinical information, and quality and performance measures. The Foundation then hosted a series of additional conferences on a range of issues around electronic data and quality. Conferences generated income, created visibility, and served to build trust in the new organization.

> ***"The only reason we were successful was the receptivity of local leaders to a collaborative approach. The Washington health community was fertile ground for collaboration and still is. The three of us could have done exactly the same thing in many other places and we would have failed. I give much credit to Tom Curry, WSMA and Leo Greenawalt, WSHA, and the Foundation's first Board Chair—Phil Nudelman, then CEO of Group Health Cooperative. We had the idea—they were the ones who took the risk and gave it life."***
>
> -Rick Rubin, former CEO, Foundation for Health Care Quality.

In 1988, the Group Health Foundation awarded the Foundation a $25,000 grant to conduct a pilot study on severity adjusted risk indicators. James LoGerfo, MD, Director, Robert Wood Johnson Foundation Clinical Scholars Program at the University of Washington, and Medical Director, Harborview Medical Center, served as the principal investigator. This partnership with external subject matter expert academic clinicians gave legitimacy to the Foundation's early work and became a hallmark of future collaborations and opportunities.

Founding philosophy: Voluntary, cooperative efforts by purchasers and providers to promote health quality will be more effective than, and preferable to, government intervention through prescribed regulatory standards.

Dr. LoGerfo appointed a technical advisory committee to help examine six of the severity vendors in terms of reliability, limitations, costs, and proposed new capabilities. The study included a literature review on outcome indicators and work with an expert panel. The study's goal was to answer the question: "Is severity indexing combined with outcome measures, useful in assessing quality of care?" This was one of the first research studies to include patient outcomes with risk adjusted quality measures to identify meaningful quality indicators.

One of the outcomes was the formalization of policies for the release, confidentiality, distribution and application of data. The final report recommended starting research on a few common, well understood conditions or procedures.

Founding purpose: to promote high quality health care for consumers within the community.

Annual Quality Conferences

1988
1989
1990

"Partnerships grew the the Foundation."
-Andrea Castell, Ex. Director, Health Care Purchasers' Association

Early programs

In 1990, armed with this study on risk adjusted quality indicators, Dr. LoGerfo approached the Washington State Department of Health to partner around maternity care address the growth of C-section deliveries. The study, called the Statistical Obstetrics Review Quality System (StORQS), used new risk adjusted quality indicators to analyze and merge three data sets: birth certificates in prenatal care and complications data; Comprehensive Hospital Abstract Reporting System (CHARS) data; and infant death records, which had never previously been linked with birth records. Merging these three data sets produced a risk adjusted report and created indicators for quality of care for presentation to hospital medical staff. The data showed statewide averages, hospital-specific data, and also allowed identification of indicators for C-section. Reports could also be produced to determine whether there were statistical differences between expected and actual outcomes.

The StORQS study was one of the first in the country to link clinical data to patient outcomes and establish quality measures based on that information.

The process also raised the issue of how data would be presented and shared with participating hospitals and providers. In the first study, hospitals saw only their specific data and aggregated statewide data. Individual hospitals were not publicly compared with each other. The research team created a reporting system that identified indicators to suggest when to send an infant to neonatal intensive care, as well as create a data system that was a useful learning tool for hospital medical staff. Because the work was not punitive to hospitals or doctors and because hospitals could see how they ranked against statewide quality standards, the hospitals continued to participate in the second study. By the second year, outlier hospitals had changed their care patterns and by the end of the study gave permission for the participating hospitals to be identified by name.

StORQS set programmatic standards for the Foundation including: being physician-driven using clinical data; and the data was confidential until hospitals and providers were ready and comfortable. Importantly, StORQS discovered the possibility creating risk adjusted measures and applying those measures to quality outcomes. However, StORQS was unsuccessful in securing funding through a proposed $2 fee per birth from participating hospitals and was disbanded.

Back Pain Outcomes Assessment Team

To further test the feasibility of using the StORQS approach to other clinical areas, in 1991, Richard Deyo, MD, MPH, another University of Washington Robert Wood Johnson Clinical Scholar, developed the Back Pain Outcomes Assessment Team (BOAT) within the Foundation to evaluate variations in care patterns for back pain. BOAT, which was part of a larger project by the Agency for Health Care Policy and Research (now Agency for Health Care Research and Quality) had a range of deliverables including patient and provider engagement models, patient decision support, and standards for measuring back conditions. BOAT used the StORQS model in its research design to determine if the quality measures developed in StORQS would be applicable to other clinical specialties.

Care Outcomes Assessment Programs

In the 1990s, significant pressure was building in Washington State to direct cardiac surgery patients to Centers of Excellence. To determine what might constitute a Center of Excellence, the Health Care Authority (HCA) sent out a request for information to hospitals across the state to learn what they would consider to be criteria. When hospitals returned their materials, Richard Whitten, MD, Medical Director for the HCA and others reviewed the data and found strong concerns about the potential for selective contracting to pose a significant risk to access across the state. Surgical volume had no obvious relationship to patient outcomes and the state had no rigorous means to measure clinical care or outcomes. There was support for improved risk-adjustment models and an expansion of clinical outcomes measures beyond hospital mortality only.

A year after StORQS completed its work in 1993, Rick Goss, MD, a Robert Wood Johnson Foundation Clinical Scholar working with LoGerfo, was interested in the impact of pre-surgical procedures on outcomes.

Drs. Whitten and Goss were introduced based on shared interests and developed a program to examine cardiac surgery outcomes, called the Cardiac Outcomes Assessment Team (COAT). Funding was established from the HCA, Veterans Administration, and the Health Services Commission as part of the RWJ scholar work and then moved the program to the Foundation to further build the program and serve as a neutral convenor.

Learning from New England's approach of mandating cardiac surgery data transparency that served to dampen enthusiasm for quality improvement, Drs. Goss and Whitten approached cardiologists and cardiac surgeons who supported a more collaborative approach. A group of cardiac surgeons from 13 different hospitals formed a physician -driven collaborative to work hand in hand with state government to develop an analytical, consensus driven approach to cardiac care rather than just focusing on mortality. Leadership changed the name from COAT to the Clinical Outcomes Assessment Program (COAP).

"COAP was successful because the process, analysis and methods were well received. It was not a front page of the Seattle Times score card. Our open process and the broad array of participants from a range of hospitals gave us credibility. Physician leadership was essential. We asked questions people wanted answers to: What is the best approach for dealing with patients who are diabetic? What is the best approach to transfusion management? What do we know about these new technologies and the impact of stents on platelets? What is the best approach to prevent dialysis and strokes? COAP was able to contribute meaningfully to these and other questions."

Rick Goss, MD, COAP Founder

The first COAP study looked at a broad range of patient reported outcomes, rather than only mortality data. This voluntary effort showed patients reporting significant improvement in quality of life six months to one year after surgery. There were no indications these improvements differed statistically across surgical sites. This was also the first time the state had used data other than CHARS in their studies.

The Foundation had received a grant from the John A. Hartford Foundation in 1994, to support the COAP study to examine clinical outcomes from coronary bypass surgery and to demonstrate a collaborative method in the collection, analysis and dissemination of outcomes data. The HCA and other state agencies also gave the Foundation a $100,000 grant to pursue this work. In 1997, COAP was presented to the State Interagency Quality Committee and was endorsed as an HCA-sponsored quality improvement activity and was subsequently registered with the state Department of Health as a Coordinated Quality Improvement Program (CQIP), providing discovery limitation during lawsuits under Washington State statute. The first cardiac surgery data was collected in 1998. In 1999, after the successful completion of this pilot, COAP added the less invasive percutaneous coronary interventions (PCI). In 2006, valve procedures were added to the registry. In 2007, Cardiac COAP began data transparency for member hospitals and in 2014, the community began public reporting.

The HCA ended up suspending its selective contracting and instead worked with Goss and his colleagues to create a medical community collaborative approach to cardiac surgery. HCA also required every hospital that contracted with them for cardiac surgery to use the severity adjusted data used by the Society of Thoracic Surgeons or the risk adjusted data/protocols developed by the Foundation through StORQS. Participation was not a legislative mandate and participation was voluntary. Hospitals that did not participate could not contract for services with the HCA.

Cardiac COAP's registry began with data definitions defined by Washington-based clinical leaders. In 2008 the management committee elected to use the same data definitions as the Society for Thoracic Surgeons National Registry to reduce administrative burden on participating sites. In 2010, a similar decision was made for the PCI registry to align with the National Cardiovascular Data Registry.

"This greater transparency of data has led the continuous improvement of care. On the rare occasions when there are data of concern and services seem to be heading in an unfavorable direction, the transparency usually leads to a rapid and robust response."

- Rick Goss, MD

Cardiac COAP has undertaken many collaborative projects with external groups, including several on diabetes testing and management with the State Department of Health and working in collaboration with PRO-West (now CoMagine Health) on a cardiovascular collaborative for atrial fibrillation management. In 2017, the program partnered with Yale University to collect data on patient reported outcomes.

In 2017, CEO Dr. Peter Dunbar, was approached by Dr. Dick Whitten, now a medical director with Noriadian Healthcare Solutions and proposed a new partnership with Medicare data to look at long term outcomes and cost. This partnership found significant cost savings within Washington State as well as significantly better outcomes in patients receiving care in Washington State hospitals compared to the national average using claims data. Washington had significantly better rates of risk adjusted kidney failure, prolonged ventilation, cardiac related re-operation, deep sternal wound, any intra- or post-operative blood product use, and early extubation compared to the national average. This partnership lasted until 2026 when funding was cut in the the second Trump administration.

Cardiac COAP has had a profound impact on the quality of care in Washington State and beyond through the many articles sharing clinical findings and best practices. Cardiac COAP has:

- Lowered intra and post-operative blood transfusion from 43% to 24%
- Increased early extubation (i.e., post-operative ventilation time of less than six hours) from 42% to 71% in coronary artery bypass surgery.
- Increased use of internal mammary artery grafting and
- Lowered door to balloon times with acute heart attacks.

In 2019, Cardiac COAP began offering performance recognition awards to participating sites with high scores on specific metrics. The program began with 13 hospitals and has grown to include over 32 hospitals providing cardiac procedures. In 2023, Cardiac COAP's scope expanded to include transcatheter aortic valve replacement, allowing a more comprehensive view of cardiac care. Cardiac COAP continues to offer statewide programs, meetings to engage the cardiac community; as well as quarterly and annual reports with selected risk-adjusted quality indicators. The mix of physician and hospital leadership with participants across the region, clinical data and metrics to drive improvement with near real-time data, and transparent reporting with collaboration to share best practices and drive accountability and increased the quality of cardiac care in the pacific northwest.

Surgical Care Outcomes Assessment Program

In the early 2000s, Washington State faced growing concerns about variation in surgical outcomes, rising healthcare costs, and increasing demand for accountability in healthcare delivery. Building on the success of Cardiac COAP, leaders at the Foundation, the HCA, and the surgical community recognized an opportunity to apply the same physician-led, data-driven quality improvement model to surgical care. The need for a surgical collaborative became increasingly evident as policymakers and healthcare leaders looked for ways to improve outcomes for high-risk, high-cost procedures where outcomes varied significantly across hospitals. Bariatric surgery quickly emerged as a logical starting point. Not only was demand for these procedures increasing, but concerns about safety, morbidity, mortality, and cost made it an ideal area in which to test whether a statewide, clinically led quality improvement model could improve outcomes while informing healthcare policy and coverage decisions.

In 2003, the state was experiencing considerable challenges with expensive bariatric surgeries that carried high mortality and morbidity rates. At the same time, the Public Employee Benefits Board (PEBB) was considering whether bariatric surgery should become a covered benefit. Because of the existing partnership between the HCA and the Foundation, as well as the demonstrated success of Cardiac COAP, the HCA funded a feasibility study to determine whether COAP's methodology could improve outcomes in surgery, beginning with bariatric care. The study was led by David Flum, MD, who served as the program's founding Medical Director and is widely recognized as the architect of Surgical COAP. Dr. Flum brought together hospitals, surgeons, and healthcare leaders to develop a new model of collaborative surgical quality improvement.

The program launched with five participating hospitals in 2004-2005 and quickly gained momentum. Enthusiasm and commitment of participating surgeons and hospitals fueled rapid growth, expanding participation to 16 hospitals by 2006. Early support from healthcare leaders including Nancy Fisher, MD, Medical Director of the Health Care Authority; Jeff Thompson, MD, Medical Director for Medicaid within the Department of Social and Health Services; Foundation Board leader Peter Dunbar, MD; and surgeon champions Mike Florence, MD, E. Patchen Dellinger, MD, Richard Thirlby, MD, and Paul Lin, MD helped establish the collaborative culture that remains a hallmark of Surgical COAP today.

As the program grew, governance evolved to support both strategic leadership and active clinical engagement. In its formative years, Surgical COAP was guided by a multidisciplinary Advisory Board composed primarily of practicing surgeons along with representatives from hospitals, purchasers, and state agencies. The Advisory Board played a critical role in shaping the collaborative's priorities, developing measures, recruiting participating hospitals, and ensuring that quality improvement efforts remain clinician-led rather than regulatory.

Under the guidance of physician leaders such as Mike Florence, MD, who served as Chair of the Advisory Board, the program established a culture built on transparency, trust, peer learning, and the belief that clinicians are most effective when they work together to identify and improve variation in care. This culture of collaboration and physician leadership distinguished Surgical COAP from many traditional quality initiatives and remains central to its success today.

As participation expanded and the program matured, governance transitioned from the original Advisory Board structure to the Surgical COAP Management Committee. While the governance framework evolved to better support an increasingly complex statewide quality collaborative, the founding principles remained unchanged: physician leadership, data-driven improvement, collaboration, and accountability to patients, providers, and participating organizations.

> **"This was an exciting time as we were building the program. We now had more surgeons coming on board who were willing to join our Advisory Board. With this work under our belt, we were able to demonstrate the validity of our approach and our finding which led to our $1.3 million grant from the Life Sciences Discovery Fund in 2007,"** - David Flum, MD

A significant milestone came in 2007 when Surgical COAP received a $1.3 million grant from the Life Sciences Discovery Fund. The grant enabled the program to dramatically expand its reach, eventually recruiting more than 50 hospitals from across Washington State. During this period, Surgical COAP partnered with the University of Washington's Surgical Outcomes Research Center (SORCE), establishing a strong analytical foundation that would support future quality improvement and research efforts.

Surgical COAP quickly expanded to address an increasingly broad range of surgical conditions. Program leaders realized that the methodology was valuable not only for examining quality and safety, but also for assessing effectiveness, appropriateness of care, and resource utilization. Benchmarking allowed hospitals and clinicians to compare performance, identify best practices, and learn from high-performing organizations. As Dr. Flum often observed, these benchmarks "gave us something to chase."

The impact of the program soon became apparent. Between 2003 and 2005, Surgical COAP's work reduced re-interventions in colorectal surgery from 7.2% to 3.2% while shortening hospital stays by an average of three days for elective colorectal procedures. Gastric bypass patients experienced average length-of-stay reductions of approximately 1.5 days, demonstrating that improvements in quality and safety could also reduce healthcare costs.

> **"Not only did such work improve care, it reduced costs. SCOAP...reported that in the first three years of launching, SCOAP methods and programs saved more than $50 million by reducing complications and improving efficiency."**
> -Life Sciences Discovery Fund Now, Washington State, February 2010

One of Surgical COAP's most visible and influential achievements was the development and statewide adoption of the Surgical Checklist in 2009. Modeled after safety checklists used in commercial aviation and aligned with emerging national patient safety initiatives, the checklist was designed to improve communication, teamwork, and reliability in the operating room. What began as a simple tool quickly became a catalyst for cultural change across Washington hospitals.

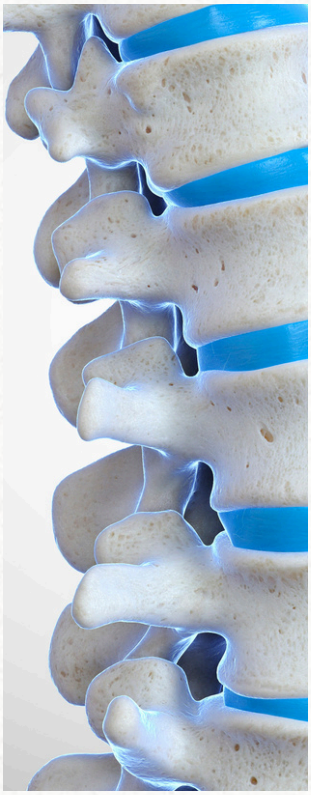
Prior to the checklist's implementation, communication failures, inconsistent processes, and preventable errors were recognized contributors to surgical complications. Surgical COAP leaders understood that improving outcomes required more than measuring results after the fact; it required creating systems that helped care teams consistently deliver best practices in real time. The checklist established a standardized process for the entire surgical team to review critical elements of care before incision, including patient identity, procedure verification, anticipated risks, equipment needs, and postoperative planning. By ensuring that surgeons, anesthesiologists, nurses, and operating room staff shared the same information before every procedure, the checklist strengthened communication and reinforced a culture of safety.

Washington became the first state in the nation to implement a surgical safety checklist across virtually every hospital. The initiative demonstrated the power of a physician-led collaborative to move evidence-based practices from concept to widespread adoption. Rather than relying on mandates, Surgical COAP engaged clinicians directly in the development, refinement, and implementation process, creating broad buy-in and ownership among frontline providers.

The checklist also marked an important turning point in Surgical COAP's evolution. While the collaborative initially focused on collecting data and benchmarking outcomes, the checklist initiative demonstrated how Surgical COAP could directly influence clinical practice and change behavior at the bedside. As Dr. Flum described, the goal was to move beyond simply reporting outcomes and toward creating a statewide learning community capable of turning ideas into action. The Surgical Checklist remains one of the most enduring examples of Surgical COAP's ability to translate data into meaningful, measurable improvements in patient care.

As the collaborative matured, Surgical COAP continued to expand into additional surgical domains—appendicitis, colorectal surgery, vascular and interventional procedures, gynecology, urology and other specialties. New modules and quality initiatives addressed increasingly complex clinical conditions and procedures. In 2017, the Management Committee added small bowel obstruction to the program's portfolio, reflecting the collaborative's ongoing commitment to improving outcomes for high-risk and high-cost conditions; this was the first module to include medically managed cases.

Spine Care Outcomes Assessment Program



One of the most significant developments occurred when Spine COAP evolved from a Surgical COAP module into an independent quality collaborative in 2011. Recognizing that spine surgery involved unique clinical expertise and a distinct physician community, the the Foundation Board, with recommendations from Surgical COAP leadership, established Spine COAP as its own program with separate membership and governance. This decision reflected both the maturity of the spine registry and the success of the broader COAP model in supporting specialty-driven quality improvement.

Spine COAP chart abstraction captures clinical information on elective cervical and lumbar procedures on four or fewer spinal levels, with an emphasis on fusion. In addition to procedures, abstraction includes patient demographics, history, risk factors, comorbidities, operative care, perioperative interventions, as well as post-operative events. Trauma, tumor and infection diagnoses are excluded at this time. Like the other COAPs, central premise of Spine COAP is that quality of care can best be enhanced through collaborative, not punitive, mechanisms.

Spine COAP participants receive regular reports of hospital level data that provide the information they need to effectively make improvements in care by comparing and tracking their own processes and outcomes: surgeons and hospitals will identify opportunities to improve outcomes and identify unexpected outcomes and can benchmark themselves and organizations to their colleagues and organizations across the state.

"We want to build real grass roots energy to engage doctors in the state. Our Surgical Checklist is now in every hospital in Washington State. We have also moved from just reporting on outcomes to changing behaviors by using benchmarks appropriate to the best practice...The Foundation's real gift to the community is offering a venue where you can take ideas and turn them into action." - David Flum, MD

Obstetrical Care Outcomes Assessment Programs

The Obstetrical Care Outcomes Assessment Program (OB COAP) is built on the same foundation as Cardiac COAP and focuses on the decisions made during labor and delivery. Ellen Kauffman, MD, approached the Foundation with a plan to develop a neutral mechanism to drive quality improvement in obstetrics care. She developed a pilot program in 2010, and recruited four hospitals as well as members of the Midwives Association of WA State to participate. The inclusion of births across all settings in a comprehensive quality improvement effort was a unique and unprecedented model.

At its largest, OB COAP has included 18 sites, representing over 1/3 of the births occurring in WA State as well as some hospitals outside of WA. Members represent hospitals of maternal and perinatal levels I, II, III and IV; urban, suburban and rural; sites with annual birth volumes of less than 100 to over 4500; and births taking place as planned in homes or birth centers or intrapartum transfers from community to hospital settings.

OB COAP uses provider-specific, chart-abstracted data about the care given to women during labor, delivery and the postpartum period as the basis for analysis and discussion. Outcomes for newborns as well as moms are also included. These data are analyzed to evaluate labor management practices and interventions commonly used in labor and delivery and compare implications of care decisions. The collaborative nature of the discussions that follow, allow for opportunities to explore methods for actionable and sustainable improvements. The OB COAP database captures social determinants of health such as whether a person has been screened for housing and food insecurity, lack of transportation, preferred language, and experience of domestic violence. These person-specific, clinical data can assist delivery sites in building pathways for intervening and connecting birthing people to resources, benchmark a community standard of care, and hold organizations and communities accountable. Clinical outcomes data can be stratified, for example, by race, ethnicity, insurance provider, risk factors, or the inclusion or absence of certain efforts (e.g. presence of a doula), all of which allows for more precise identification of where improvement opportunities exist. Interventions can target improvement towards poorer performing health professionals, medical groups, or delivery site.

Participants have reported benefiting from:

- Improvements in patient charting and documentation
- Increased reimbursement by comparing clinical documentation to coding
- More accurate attribution of outcomes through the ability to examine metrics by practitioner role – leading to improved practitioner confidence in reporting.

OB COAP has formed many partnerships with external organizations and stakeholders, including:.

- Microsoft Research – using predictive modeling and causal interference to understand and improve the quality of maternity care
- Secure Anonymized Information Linkage – an international collaboration studying maternal outcomes during the Covid-19 pandemic.
- Surgo Ventures – linking patient and hospital-level data with zip-code level information from Surgo's Maternal Vulnerability Index, allowing sites to better understand barriers to care, risk, and health-related social needs and targeted support and intervention efforts for pregnant patients.
- Ariadne Labs, Harvard School of Public Health – using nurse-specific reports to improve cesarean section rates and measure the impact of the patient-centered decision-making effort, TeamBirth™, in first-time birthing moms.

In 2024, OB COAP received a three-year grant from the Ballmer Group to capture and link patient experience of care survey information with clinical data, measure and evaluate changes related to TeamBirth, and create new metrics reflecting the integration of qualitative and quantitative data. Initial reports reflect 86% of comments as completely positive and 14% partially or all negative. Primary themes of negative comments are related to specific provider/nurse interactions, lack of respect for birth plan preferences, and post-partum challenges including lack of patient-centered decision making after delivery, lack of lactation support, and pain control/medication issues.

OB COAP quality improvement successes include:

- An increase in collection of cord gases from ~33% to over 60% across participating sites following a targeted educational effort to increase awareness of why, when, and how to collect.
- A three-fold increase in the rate of timely treatment of acute severe hypertension intrapartum or postpartum at one of OB COAP's largest participating sites.
- Identification of significantly higher rates of 3rd and 4th degree lacerations following vaginal birth among Asian patients resulting in targeted and ongoing improvement efforts.

OB COAP has a robust and impactful research program contributing to a dramatic influence on the profession led by Dr. Vivienne Souter, MD, MPH. As of June 2026, over 25 papers have been published along with 9 oral presentations and over 40 abstracts presented using OB COAP clinical data.

Communication and Resolution

Community Birth Data Registry

In 2014, data collection became mandatory for licensed midwives in Washington as a condition for licensure renewal. Recognizing the value of having data on planned home and birth center outcomes captured in the same database as hospital data, but seeking to reduce the data burden on community midwives, the Midwives Association of Washington State (MAWS) entered into a data-sharing agreement with the Foundation that allowed Midwife member data to be exported from MANA Stats into OB COAP. In 2019, MANA Stats dissolved due to financial insolvency, creating a gap in midwifery data collection.

In 2023, the Foundation launched the Community Birth Data Registry (CBDR), created by midwives for midwives, that allows capturing and measuring perinatal care across all birth settings and provider types. Funding was secured from the Skyline Foundation, a private San Francisco, CA based foundation with an interest in community birth.

In 2025, the CBDR experienced substantial geographic expansion, with midwives and community birth practices in 11 states (CA, CO, HI, ID, LA, NY, OK, OR, TX, VA, and WA) adopting the registry. Alongside this growth, we have held meetings with midwifery associations in Texas, New York, California, and Maine and maternal health partners, such as departments of health, in Nebraska, Massachusetts, and Maine as part of our ongoing strategy for national scale-up, contributing to broader efforts to advance maternal, perinatal, and birth equity. Across 11 states, the CBDR currently has 84 participating practices and 196 unique users, including midwives, administrative personnel, student midwives, and dedicated data entry staff – who have collectively contributed 1,824 birth records.

The next phase of work will focus on strengthening the CBDR's role as a national resource for community birth data, supporting research, QI, and policy discussions related to maternal and newborn outcomes. Additional strategic priorities will continue to be refined as our management committee begins meeting regularly. A key component of this work will be partnering with midwifery associations, practices, and relevant regulatory stakeholders to support state-level adoption and ensure the CBDR aligns with local priorities. Future steps include improving the registry's technical infrastructure and usability by expanding collaborations with electronic health record companies to streamline data entry and reduce administrative burden for participating practices.

Health Information Exchange

In 1990, the large funder the Hartford Foundation began a focus on health information exchange and awarded a grant to Health Care Purchasers Association. Titled the Community Health Information Management Systems Initiative (CHMIS) and focused on sharing information between and among organizations, CHMIS aimed to collect accurate clinical data in a timely manner for providers and purchasers; share data; develop clinical measures to improve quality; reduce costs; and enable employers to purchase value. In 1993, as Rick Rubin became CEO, the grant was moved to the Foundation.

This focus on health information exchange became a space where the Foundation could add value in a competitive health care marketplace. Funding in 1995 from the Robert Wood Johnson Foundation to the Foundation led to the creation of the Health Care Quality Measurement Advisory Service (QMAS) which assisted state and local health care coalitions, purchasing groups and health information organizations to measure health care quality for value-based purchasing and related purposes. QMAS was a joint collaboration of the Foundation, the National Business Coalition on Health, and the Institute for Health Policy Solutions in Washington DC.

Over the course of the three years, Rick Rubin, CEO; Dale Shaller, Executive Director, Minnesota Health Data Institute; Richard Curtis, Institute for Health Solutions, and Richard Sharpe, former program director of the Quality and Marketplace initiative, John A. Hartford Foundation, served as a resource team on how to define and collect quality measures within a given marketplace.

QMAS services included:

Educational meetings and guides on quality measures, including consumer assessments of health plans

Workshops

Trainings and technical assistance

Direct consulting services, collaborative projects, and information exchange Partnerships included the RAND Corporation and Foundation for Accountable Quality Measures as well as the Joint Committee on Accreditation of Healthcare Organizations, National Center for Quality Assurance, and Agency for Health Care Quality and Research

A series of publications on quality: Measuring Health Care Quality for Value Based Purchasing, 1996; Organizing and Financing a Health Care Quality Measurement Initiative: A Guide for Getting Started, 1997; Assessing Hospital Performance, 1997; Arm in Arm, A Guide to Implementing a Coordinated Quality Measurement Program, 1999

The Community Health Information Technology Alliance (CHITA) was created in 1996, built on many of these same ideas, and initially funded by the Robert Wood Johnson Foundation. CHITA was a collaborative model that bridged the gap between the pre-Internet era, which had focused on building a shared network to replace proprietary private networks, and the Internet era which brought a greater focus on security, data standards, and policies.

CHITA's founding members included the WSMA, WSHA, large health carriers, Providence Health System, Swedish Hospital and Medical Center, University of Washington Medical Center, the Washington State Department of Health (DOH), and Clinitech Information Resources. The program's initial focus was interoperability and data security within e-commerce. Initially, the intention was to have Chief Information Officers work collaboratively to share information securely, identify data they could or would share, and create standards needed to enable secured data sharing. Because of marketplace changes and the rapid growth of the Internet, CHITA evolved focus on public education and outreach activities to develop standards, holding quarterly conferences, and creating support for special projects.

CHITA demonstrated secure transmission of clinical data from labs to the DOH and the Centers for Disease Control and Prevention, enabling disease outbreak data to be transmitted in two days compared to three weeks and developed a standard referral form for providers and payers. CHITA also served as the strategic national implementation process for a Workgroup on Electronic Data Interchange (WEDI) and staffed quarterly Health Insurance Portability and Accountability Act (HIPAA) readiness forums. In 1999, the original CHMIS grant ended. CHITA shifted to being funded by quarterly conference registrations, sponsorships of the CHITA Forums and grants. At the September 2012 Foundation board meeting, members voted to end the CHITA program due to development of other organizations and the lack of conference registration. Health information exchange continued to be a key part of the Foundation's work after the formal dissolution of these programs.

Outbreak Detection Information Network (ODIN)

Peter Dunbar, MD, ChB, MBA, served as principal investigator for the Outbreak Detection Information Network (ODIN) Study, funded by a 2.5 million grant from the Department of Defense (DOD) to develop an electronic infectious disease tracking system in the Northwest from 2004 to 2007. ODIN was designed to use the emerging syndromic surveillance science to capture data from health encounters to predict disease outbreaks ahead of clinically verified laboratory results. A major goal was to yield a product that would have extensive functionality for the public health departments to use and to provide a longer term toolset for other epidemiology projects.

The project also focused on improving the safety of civilian and military populations by improving the accuracy, timeliness, communication and analysis and interpretation of novel sources of health-related data. Such a system would provide surveillance that supports rapid intervention of biologic threats to the military and civilian populations. Potential bioterrorism threats as well as adverse health events from natural causes, created a need for rapid and effective detection and response. The Foundation collaborated with the DOD and local public health departments to create minimum standards for health indicator data collection in Puget Sound region, adopt techniques to improve interpretation of collected health indicator data, and improve techniques and capability to respond to and communicate with appropriate communities regarding surveillance findings.

Improving Clinical Care

Driving improvements in clinical care is a key part of the work listed above and a specific focus of individual programs. Early programs in the 1990s focused on an integrated strategic and quality improvement plan in public and private laboratories for public surveillance and patient care and safety and on collaborative educational endeavors on diabetes care.

Washington Clinical Laboratory Initiative

In 1994, Jon Counts, DrPH, MPH, faculty, School of Public Health and Community Medicine, University of Washington, and former Director of Public Health Laboratories in Washington and Arizona, developed the Washington Clinical Laboratory Initiative to improve the quality and use of clinical laboratory testing. The initiative developed and coordinated an integrated strategic and quality improvement plan in public and private laboratories for public surveillance and patient care and safety. Key priorities were to create and demonstrate a new approach to develop and implement voluntary laboratory practice standards and policies; determine factors that influence delivery of medical and public health testing services; investigate factors that affect adherence to voluntary laboratory practice and policy recommendations; and identify opportunities for improvement in the services at state public health laboratories and other referral laboratories.

Studies were funded by the Centers for Disease Control and Prevention (CDC) to implement a quality improvement project in collaboration with laboratory managers in rural critical access hospitals to identify and develop criteria for the evaluation of microbiology services to be provided on-site and/or outsourced to referral laboratories. Other studies surveyed clinicians and infectious disease specialists to evaluate if physicians used laboratory practice guidelines developed by the State Department of Health's Clinical Laboratory Council, CDC, professional medical societies, health plans and/or individual practices.

The Diabetes Collaborative

With funding from the Department of Health, CDC, and Pharmaceutical Researchers and Manufacturers Association, DOH worked with the Foundation to develop a program to support participation in a series of yearlong collaborative educational endeavors. Foundation staff worked with the DOH to develop criteria to select the grant recipients, selected the participants, and evaluated the program. Additionally, training materials were prepared to help the clinics understand the best practices, as well as how they could change their clinical operations to provide better care. These included criteria for frequency of patient visits and foot care among others. With additional funding from PhRMA, the Collaborative offered a "Booster Shot" program designed to address "just one thing that would get a clinic over the hump" to provide optimal care. The program would highlight changes as simple as purchasing a color printer so a clinic could read the black, red, and green codes for population measures.

"...the Foundation's value is that every time there is a new initiative or program [we] offer a venue where people who don't normally trust each other actually want to work together...[we have] demonstrated that diverse groups—given the right environment—can work together on important goals. These are real impacts for real people."

- Miriam Marcus- Smith, former staff member

Washington Patient Safety Coalition

The Washington Patient Safety Coalition is a member-driven group of hospitals, health carriers, professional organizations, medical groups and other organizations, individuals and agencies concerned about patient safety. The Coalition is funded by membership fees based on the size and type of the organization, such as covered lives, number of beds and number of employees, from the annual conference, and from registration for workshops.

The Coalition grew out of the first Institute of Medicine Report: Crossing the Quality Chasm that reported on the 100,000 patients who die each year from preventable medical errors in hospitals. The Governor's Office approached Dorothy Teeter, the Foundation's Interim CEO, for guidance on next steps. Teeter attended a national meeting hosted by the Agency for Health Care Research and Quality on patient safety and the important role multi-stakeholder coalitions could play to improve patient safety.

"Patient safety was an emerging issue for both health care providers and the public health system across the state and the country. It was an issue that seemed a perfect fit for the Foundation's leadership and focus: it was highly relevant and needed collaboration and sharing of best practices in order to start improving care." - Dorothy Teeter, former CEO

Teeter returned from the meeting excited about the prospects of creating such a coalition in Washington State and convened an invitational conference in June 2002 as the first step in a broader statewide initiative. A broad agreement emerged that patient safety improvement had to be statewide and that the Foundation would be the formal home—the participants believed it would be impossible to establish statewide priorities without such a neutral home. After the inaugural conference, the Coalition began fundraising, drafted the mission and vision statements, held monthly meetings and began to identify patient safety priorities.

The first initiative on wrong site surgeries (i.e., surgeries that are performed on the wrong body part) led to a statewide conference on steps to prevent such mistakes. This became an annual conference that has shifted from in-person to virtual and grew to include British Columbia and Oregon.

Other initiatives included:

- The My Medication List campaign, that addressed adverse drug interactions by encouraging education of the importance of patients carrying a list of their medications, and sharing of best practices through the Puget Sound Safety Network.
- On congestive heart failure to improve quality of patient transfer between hospitals and community providers and promoted statewide adoption of a standard set of policies for any surgical procedure and setting.

In 2023, the the Foundation received funding from the Washington State general fund to support continuing an earlier initiative on communication and resolution programs (CRPs). This is a process health care organizations can utilize to address and prevent patient harm. At the highest level, CRPs provide a systematic approach for openly engaging with patients and moving toward a positive resolution after an adverse event. CRP is a practice that moves healthcare culture away from “deny and defend.” They increase transparency, allow the care team to express sympathy and regret, and promote fair and reasonable compensation. CRPs contribute to patient safety by ensuring that what’s learned after an adverse event is put into practice. CRPs are characterized by transparent and prompt communication, support for involved patients, families, and care providers, rapid investigation and closure of gaps that contributed to the adverse event, proactive resolution, and collaboration across all involved stakeholders. Unfortunately, no health care facilities supplied data to review and the program was sunsetted in 2025.

In 2022, a working group on improving psychological safety developed the Speak-Up! Award, a statewide recognition program that acknowledges the efforts of individuals and teams at all Washington healthcare organizations who demonstrate a commitment to keeping patients and staff safe by speaking up and voicing their concerns to promote health care safety. The award is recognizing health care staff who make the “good catches” and speak up to keep patients and staff safe.

In 2025, WPSC opened the Health Equity: Innovation in Patient Safety Award, recognizing WPSC member organizations that improve patient safety through innovative ways of addressing health disparities and advancing health equity. This is an annual award for WPSC member organizations that elevate health equity as a safety priority and improve patient safety and health outcomes through activities, policies, and procedures that identify as well as close gaps in unequal treatment in the populations they serve.

Bree Collaborative

Washington State government has prioritized increasing the quality and affordability of health care through innovative work such as the Health Technology Assessment program, the Prescription Drug Program, the Advanced Imaging Management Project, and Healthier Washington. The Bree Collaborative is structured after the work of the Advanced Imaging Management project and named in memory of a key member, Dr. Robert Bree, a radiologist and leader working to reduce inappropriate use of advanced imaging (e.g., CT, PET, and MRI scans) who died during the project. In 2011, Representative Eileen Cody and clinical leaders developed House Bill 1311 to create the Bree Collaborative. The Bree Collaborative has been part of the Foundation since beginning to hold meetings in 2011. All meetings are open to the public and follow the Open Public Meetings Act.

Members and the chair are appointed by the Washington State Governor. In August 2011, the Washington State Hospital Association, the Washington State Medical Association, the Association of Washington Healthcare Plans, large employers, and other community stakeholders nominated health care experts who served as the first 23 members after appointment by former Governor Chris Gregoire. Members represent public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. Steve Hill, former director of the Washington State Department of Retirement Systems and former director of the HCA served as the first Chair from 2011 to 2014. Dr. Hugh Straley, former medical director and president of Group Health Physicians, served as chair from 2014 to 2021. From 2021 to present, Dr. Emily Transue, medical director CoMagine Health, has chaired the Collaborative.

Each year, members identify three to five health care services with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. The Collaborative then convenes a workgroup made up of clinical experts, health care administrators, patients, and others to develop evidence-based recommendations. Recommendations take into account existing quality improvement programs, work done by other organizations, and clinical best practice and are sent to the Washington State Health Care Authority to guide the type of health care provided to Medicaid enrollees, state employees, and other groups. The Collaborative also develops recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector.

ESHB 1311, Section 3 calls for the Bree Collaborative to:
"... report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs."

Implementation of the guidelines was dictated through the original legislation to the Health Care Authority for integration into contracts for Medicaid, Public Employees, and School-Based Employees. In 2019 through 2021, the Foundation received funding from the Washington State general fund with dedicated implementation funding. Bree leadership elected to focus this work on integrating behavioral health into primary care. In 2022, similar funding was reinstated which has continued through 2027. This funding has been dedicated to implementation of guidelines into clinical practice and policy through webinars, tools, intensive working groups, and other partnerships and to evaluation through data gathering, partnerships, and developing case studies. This has led to additional uptake and insight than what would have been otherwise possible.

Chronic and Acute Pain
Collaborative care for chronic pain (2018)
Low back pain management (2013)
Opioid prescribing metrics (2017)
Opioid prescribing for postoperative pain (2018)
Opioid prescribing in dentistry (2017)
Long-term opioid prescribing management (2019)
Opioid prescribing in older adults (2021)

Behavioral Health
Integrating behavioral health into primary care (2016)
Addiction and substance use disorder screening and intervention (2014)
Suicide care (2018)
Treatment for opioid use disorder (2016)
Prescribing antipsychotics to children and adolescents (2016)
Risk of violence to others (2019)
First episode psychosis (2025)
Behavioral health: Early interventions for youth (2024)

Oncology
Oncology care: breast and prostate (2015)
Prostate cancer screening (2015)
Oncology care: inpatient service use (2020)
Colorectal cancer screening (2020)
Cervical cancer screening (2021)
Lung cancer (2026)

Aging
Advance care planning for the end-of-life (2014)
Alzheimer's disease and other dementias (2017, 2026)

Inpatient Care
Bundled payment models and warranties:
Total knee and total hip replacement (2013, 2017, 2021)
Lumbar fusion (2014, re-review 2018)
Coronary artery bypass surgery (2015)
Bariatric surgery (2016)
Hysterectomy (2017)
Data collection on appropriate cardiac surgery (2013)
Spine COAP (2013)
Hospital readmissions (2014)
Complex hospital discharge (2023)
Complex patient discharge (2024)
Surgery optimization (2025)

Reproductive Health
Obstetric care (2012)
Maternity bundle (2019)
Reproductive and sexual health (2020)
Perinatal behavioral health (2023)
Menopause (2026)

General
Palliative care (2019)
LGBTQ health care (2018)
Shared decision making (2019)
Primary care (2020)
Telehealth (2021)
Diabetes care (2023)
Asthma care (2022)
Hepatitis C (2022)
Infection control (2022)
Blood pressure screening and control (2025)

Clinical Data Repository Use Case Project

In 2017, OneHealthPort operated Washington State's Health Information Exchange, part of which was a clinical data repository of Medicaid managed care covered lives. The HCA required all providers who treat clients to have a certified electronic health record that could contribute data to the repository on each encounter. The registry would then aggregate demographic data, claims data, and clinical information.

OneHealthPort approached the Foundation to develop use cases for the registry by convening stakeholders to explore applications of the blended data set to improve quality of care. Use cases were developed for: point of care (i.e., an individual clinician utilizing the registry to treat an individual patient); coordination of care (i.e., a care team utilizing the registry to treat an individual patient or groups of patients across the continuum of care); and patient safety (i.e., utilizing the registry to improve patient safety within a given health care facility and/or across the community).

Washington Healthcare Forum Projects

Founded in 1999, the Washington Healthcare Forum is a coalition of leading physician practices, hospitals, health plans and state associations that have joined together to improve the local health services system. The Forum's mission is to advance a dialogue on sustainable solutions to challenges facing the health services system and streamline and simplify health services financing and delivery across Washington state. The Forum has contracted with the Foundation as a "think tank" on multiple occasions including:

- **COVID Standards:** In response to the massive threat to public health from COVID-19 in March 2020, to develop standards for patient care in areas without clear operational or clinical guidance. Staff formed workgroups focused on addressing key community -identified issues through the year as they arose.

- **Social Needs and Health Equity:** To improve alignment across Washington state, the Foundation conducted an exploratory project on assessing and addressing social needs and health equity from 2020-2021. The results from that project were summarized in a report that outlined initial activities to facilitate sociodemographic data collection and follow-up on identified disparities or social need.

  Through 2022 and 2023, the Foundation convened a steering committee to turn recommendations into action and create a state-wide standard for addressing social needs and health equity. The Foundation developed a roadmap to define specific program priorities for collaborative action. The steering committee identified four key areas to address program priorities and plans to convene ad-hoc workgroups to address each focus area including: screening, intervention, storing and sharing data, advancing equity, and alignment.

Smooth Transitions

In 2005, the Washington State Perinatal Advisory Committee (now called the Washington State Perinatal Collaborative) convened a multi-stakeholder entity comprising obstetricians, midwives, consumers, and DOH staff, and charged the group with "studying and improving the process of transferring women and their babies from a planned home or birth center birth to an acute-care hospital when a higher level of care becomes necessary." This may occur between the community setting (home/birth center) and a hospital, between hospitals, or between practitioner types within a hospital. Improving relationships, protocols, and follow-up during these transfers improves quality of care, enhances the patient experience, and strengthens professional relationships among practitioners regardless of the setting and circumstances in which it takes place.

In 2009, the group launched the Smooth Transitions™ Quality Improvement Program, an initiative aimed at improving communication and enhancing collaboration between community midwives and hospital-based providers. The goals were to achieve better outcomes for mothers and babies, increase patient satisfaction with care, and decrease practitioner liability. In January 2018, the Smooth Transitions QI Program moved to the Foundation.

Smooth Transitions™ brings together community midwives, hospital providers and staff, and EMS personnel to build a collaborative model of care that puts birthing families at the center. Staff offer presentations throughout Washington state and provide direct support to participating hospitals. The program is focused on:

- Improved whole person safety (i.e., emotional, psychological, social, cultural, spiritual, and physical processes and outcomes) and efficiency of the transfer process through the establishment of system-wide protocols.
- Collecting and analyzing transfer outcome data for the purpose of quality improvement.
- Building greater collaboration between community midwives, emergency medical services (EMS), and the hospital care team.
- Enhancing the patient experience of care when transfers occur.

Funding and in-kind support from the Washington State Hospital Association, the Washington State Obstetric Association, the state affiliate of the American College of Nurse-Midwives, the Midwives' Association of Washington State, the Washington Alliance for Responsible Midwifery, the OB Hospitalist Group and grants from the American Institute for Research, The Skyline Foundation, and the DOH have sustained the program.

Transfer Surveys

In 2025, 1750+ transfer surveys were conducted, collecting qualitative data to provide a 360 degree view of the transfer process for holistic care improvement.

Administrative Simplification

The Administrative Simplification program was founded by the Washington Healthcare Forum in 2000 with the objective to make it easier for health plans and providers to do business together by finding consensus solutions to shared operational problems. The program operated as a private sector program until 2009 when Washington state government approached the Forum to collaborate. The outcome of this joint effort was SSSB 5346, passed by the Washington state legislature unanimously in 2009. The bill resulted in the Forum and OneHealthPort being designated by the Office of the Insurance Commissioner (OIC) as the “Lead Organizations” for Admin Simp in Washington state. From 2009 to the present, the Admin Simp program has operated as a model public/private partnership. The program has deployed a proven process to fulfill its Lead Organization role while also continuing to address private sector priorities and participate in national standard setting. The Lead Organization was directed to:

- Manage the implementation of administrative simplification in a transparent and inclusive manner under the oversight of the OIC
- Create solutions for an assigned list of sixteen tasks in the legislation, and establish a process to continuously improve the solutions over time
- Craft additional consensus solutions as needed
- Pursue voluntary adoption of the solutions by plans and providers
- Report to the Legislature, the OIC and the community
- Fund the costs of the work entirely on its own (e.g., no state money could be used)

In 2024, The Forum contracted with the Foundation to manage the program and the OIC designated the Foundation as a co-Lead Organization for Admin Simp along with the Forum.

As said in SB 5346, “The greatest opportunity for improved efficiency and administrative cost reduction in our health care system would involve standardizing and streamlining activities between providers and payors. To address these inefficiencies, constrain health care inflation, and make health care more affordable for Washingtonians, the legislature seeks to establish streamlined and uniform procedures for payors and providers of health care services in the state. It is the intent of the legislature to foster a continuous quality improvement cycle to simplify health care administration. This process should involve leadership in the health care industry and health care purchasers, with regulatory oversight from the office of the insurance commissioner.”

In November 2024, the the Foundation took over convening an over-the-counter contraceptive work group to provide information and establish best practices around the “how to” of administering the contraceptive and breast pump benefit. This increased awareness of covered services, enhanced consumer understanding, and provided information, standardization, and training for pharmacists processing a claim. Staff and consultants have continued to convene a business and technology workgroup that develops consensus recommendations related to implementation of the HIPAA EDI transactions between health plans and provider organizations. Other working groups include around pre-service and credentialing. In 2026, staff developed a white paper proposing that prior authorization can be significantly improved through collaboration and convened a workgroup focused on increasing use of patient portals, specifically MyChart.

Appendix A: Board of Directors 1988-2026

1988: Founding Board of Directors and 1989 Board

- Phil Nudelman, Chairman, Executive Vice President, Group Health Cooperative
- John Bencich, Associate Executive Director, Swedish Hospital Medical Center
- David Bjornson, Administrator, St. Peter Hospital, Olympia
- Nancy Cannon, Manager, Employee Benefits, Boeing
- Andrea Castell, RN, BSN, MBA, Health Care Purchasers' Association
- Mark Chassin, MD, MPP, MPH, Senior Vice President, Value Health Sciences, Santa Monica, CA
- Jeffery B. Clode, MD, Internal Medicine, Spokane Tom Curry, Executive Director, Washington State Medical Association
- V. Mark Droppert, Vice President, Human Resources, Paccar
- Monte DuVal, MD, Senior Vice President of Medical Affairs, Samaritan Health Services, Phoenix, AZ
- Leo Greenawalt, President, Washington State Hospital Association
- Jim Nell, President, Seattle Area Hospital Council Joseph Nichols, MD, orthopedic surgeon, Tacoma
- A.H. "Bud" Towsey, Executive Vice President, First Interstate Bank
- Michael Wilson, Vice President, Ambulatory Services, Sacred Heart Medical Center, Spokane

1990

- Chair: Dave Bjornson
- John Bencich, MD
- Nancy Cannon
- Andrea Castell
- Jeffrey Clode, MD
- Tom Curry
- V. Marc Droppert
- Leo Greenawalt
- Brian Heinrich, MD
- James LoGerfo, MD, Director, Robert Wood Johnson Foundation Clinical Scholars, University of Washington
- Jim Nell
- Joseph Nichols, MD
- Phil Nudelman
- Cynthia Sonstelie
- Michael Wilson

1991

- Chair: Dave Bjornson
- John Bencich MD
- Nancy Cannon
- Andrea Castell
- Jeffrey Clode, MD
- Robert Crittenden, MD, Executive Policy Office, Governor's Office, Washington State
- Tom Curry
- V. Marc Droppert
- Leo Greenawalt
- Brian Heinrich, MD
- James LoGerfo, MD, Director, Robert Wood Johnson Foundation Clinical Scholars, University of Washington Keith McCandless
- Jim Nell
- Joseph Nichols,MD
- Phil Nudelman
- Cynthia Sonstelie
- Michael Wilson

1992

- Chair: David Bjornson
- John Bencich, MD
- Nancy Cannon
- Andrea Castell
- Mark Chassin,
- Jeffery Clode, MD
- Robert Crittenden, MD
- Tom Curry
- Nancy Dapper, Regional Administrator, Health Care Financing Administration, Region X
- V. Marc Droppert
- Kristine Gebbie, Secretary, Washington State Department of Health
- Leo Greenawalt
- James LoGerfo, MD
- Jim Nell
- Joseph Nichols, MD
- Phil Nudelman
- Don Sacco, CEO, Pierce County Medical Association
- Cynthia Sonstelie
- Michael Wilson

1993

- Chair: David Bjornson
- Tom Byron, Washington State Hospital Association
- Andrea Castell
- Tom Curry
- Nancy Dapper
- V. Marc Droppert
- Brian Goddell, MD, Executive Director, Swedish Hospital Medical Center
- Irwin Goverman, Vice President and CIO, Group Health Cooperative
- Leo Greenawalt
- Beverly Jacobson, Seattle Area Hospital Council
- James LoGerfo, MD
- Bruce Miyahara, MD, Secretary, Washington State Department of Health
- Jim Nell
- Joseph Nichols, MD
- Phil Nudelman
- Linda Parker
- Don Sacco
- George Schneider MD, Spokane
- Elizabeth Ward, Assistant Secretary, Washington State Department of Health
- Steve Welsh, Vice President,
- Todd Shipyards

1994-1995 *incomplete

This list includes the board members from 1993, who presumably served part of the time in 1994 and 1995. Complete records resume in 1996.

- David Bjornson, Chair
- Tom Byron Andrea
- Castell Tom Curry
- Nancy Dapper
- V. Marc Droppert
- Brian Goddell, MD
- Irwin Goverman
- Leo Greenawalt
- Beverly Jacobson
- James LoGerfo, MD
- Bruce Miyahara, MD
- Jim Nell
- Joseph Nichols, MD
- Phil Nudelman
- Linda Parker
- Don Sacco
- George Schneider MD,
- Elizabeth Ward
- Steve Welsh

1996

- William M. Dean, MD, Chair, Urologist, Tacoma
- David Bjornson, immediate past chair
- Gary Christenson, Administrator, Health Care Authority
- Nancy Dapper
- Richard Deyo, MD
- V. Marc Droppert
- Andrew Fallat, FACHE, CEO, Evergreen Hospital
- Irwin Goverman
- Bruce Miyahara, MD
- Joseph Nichols, MD
- Terry Rogers, MD, Executive Vice President and COO, King County Medical Blue Shield
- Steve Welsh

1997

- William M. Dean, MD, Chair, Urologist, Tacoma
- David Bjornson
- Gary Christenson
- Nancy Dapper
- Richard Deyo, MD
- V. Marc Droppert
- Peter Dunbar, MD, Anesthesiologist, Harborview Medical Center
- Andrew Fallat
- Irwin Goverman
- Bruce Miyahara, MD
- Terry Rogers, MD
- Steve Welsh

1998

- William Dean, Chair
- David Bjornson
- Gary Christenson
- Nancy Dapper/Linda Ruiz, Regional Administrator, Health Care Financing Administration
- Richard Deyo, MD
- Marc Droppert
- Peter Dunbar, MD, Department of Anesthesiology, Harborview Medical Center, University of Washington
- Andy Fallat
- Irwin Goverman
- Tanis Marsh, Health Care Director, League of Women Voters
- Bruce Miyahara/ Mary Selecky, Secretary, Department of Health
- Terry Rogers, MD
- Dorothy Teeter, Vice President, Quality and System Resources, Group Health Cooperative
- Steve Welch

1999

- Chair: William Dean
- David Bjornson
- Gary Christenson
- Jac Davies
- Richard Deyo, MD
- Peter Dunbar, MD
- V. Marc Droppert
- Andrew Fallat
- Irwin Goverman
- Tanis Marsh
- Terry Rogers, MD
- Linda Ruiz
- Elizabeth Ward, Assistant Secretary, Department of Health

2000

- Chair: Peter Dunbar, MD
- David Bjornson
- Richard Deyo, MD
- Andrew Fallat
- Irwin Goverman
- Tanis Marsh
- Terry Rogers, MD
- Linda Ruiz
- Dorothy Teeter
- Mary Selecky

2001

- Chair: Peter Dunbar, MD
- Mark Adams, MD, Thoracic and Vascular Surgeon
- David Bjornson
- Deb Cablao, Director of Marketing, Intel Internet Health Division, Beaverton, Oregon
- Richard Deyo, MD
- Andrew Fallat
- Tanis Marsh
- Jeff Robertson, MD, Vice President, Health Care Services, Regence Blue Shield
- Terry Rogers, MD
- Linda Ruiz
- Mary Selecky (represented by Jac Davies, IRM/ Assessment Coordinator, Department of Health)
- Dorothy Teeter

2002

- Chair: Peter Dunbar, MD
- Mark Adams, MD, Thoracic and Vascular Surgeon
- David Bjornson
- Deb Cablao
- Richard Deyo, MD (represented by Daniel Lessler, MD, Associate Medical Director, Harborview Medical Center during Deyo sabbatical)
- Andrew Fallat Tanis Marsh
- Jeff Robertson, MD
- Terry Rogers, MD
- Linda Ruiz
- Mary Selecky (represented by Jac Davies)
- Dorothy Teeter

2003

- Chair: Peter Dunbar, MD
- Mark Adams, MD
- David Bjornson
- Deb Cablao
- Jac Davies, Director, Program Development, Inland Northwest Health Services, Spokane
- Victor Dirksen, Administrator, Jefferson General Hospital, Port Townsend
- Andrew Fallat
- Jeffery Gingold, JD, Attorney, Lane Powell Spears Lubersky
- Daniel Lessler, MD
- Tanis Marsh
- Jeff Robertson, MD
- Terry Rogers, MD
- Linda Ruiz
- Melvin Sorensen, Principal, Carney Bradley Spellman
- Dorothy Teeter
- Jude Van Buren, DrPh, MPH, RN, RS, Washington State Department of Health
- *Christine L. Rubadue, ND, MN,RN, Associate Regional Administrator, Health Care Financing Administration, Centers for Medicare and Medicaid Services (non- voting board liaison)

2004

- Chair: Dorothy Teeter
- David Bjornson
- Deb Cablao
- Jac Davies
- Victor Dirksen
- Jeffery Gingol, JD
- Daniel Lessler, MD
- Tanis Marsh
- Jeff Robertson, MD
- Terry Rogers, MD
- Melvin Sorensen
- Jude Van Buren
- *Christine L. Rubadue

2005

- Chair: Dorothy Teeter
- David Bjornson
- Deb Cablao
- Jac Davies
- Jeffery Gingold, JD
- Daniel Lessler, MD
- Tanis Marsh
- Jeff Robertson, MD
- Terry Rogers, MD
- Melvin Sorensen
- Jude Van Buren
- *Christine L. Rubadue

2006

- Chair: Dorothy Teeter
- Deb Cablao
- Michael Cochran, First Vice President, Health and Wellness Benefits, Washington Mutual Bank
- Jac Davies
- Jeffery Gingold, JD
- Mike Glenn, Administrator, Olympic Medical Center, Port Angeles
- Daniel Lessler, MD
- Tanis Marsh
- Jeff Robertson, MD
- Terry Rogers, MD
- Melvin Sorensen
- Jude Van Buren
- *Kenneth S. Fink, MD, CMS, Region X (non-voting board liaison)

2007

- Chair: Terry Rogers, MD
- Deb Cablao
- Michael Cochran
- Jac Davies
- David Dreis, MD, Medical Director of Clinical Outcomes, Virginia Mason Medical Center
- Jeffery Gingold, JD
- Mike Glenn
- Daniel Lessler, MD
- Tanis Marsh
- Jeff Robertson, MD
- Melvin Sorensen
- Jude Van Buren
- *Kenneth S. Fink, MD

2008

- Chair: Jeffery Gingold, JD
- Deb Cablao Michael Cochran
- Marina Cofer-Wildsmith, former CEO, American Lung Association of Washington
- Jac Davies
- David Dreis, MD, Medical Director of Clinical Outcomes, Virginia Mason Medical Center Mike Glenn
- Daniel Lessler, MD
- Tanis Marsh
- Patti Rathbun, Health Policy Coordinator, Office of Legislative and Constituent Relations, Dept. of Health Jeff Robertson, MD
- Melvin Sorensen
- *Kenneth S. Fink, MD

2009

- Chair: Jeff Gingold, JD
- Marina Cofer-Wildsmith
- Tom Curry, Executive Director, Washington State Medical Association
- Debbie Dexter David Dreis, MD Joe Gifford, MD Tanis Marsh Patti Rathbun
- Jeff Robertson, MD
- Melvin Sorensen
- Hugh L. Straley, MD, Medical Director, Puget Sound Health Partners
- *Kenneth S. Fink, MD

2010

- Chair: Jeff Gingold, JD
- Marina Cofer-Wildsmith
- Debbie Dexter
- David Dreis, MD
- Joe Gifford, MD, Chief Medical Officer, Regence Blue Shield
- Tanis Marsh
- Patti Rathbun
- Melvin Sorensen

2011

- Chair: Jeff Gingold, JD
- Tom Curry
- Marina Cofer-Wildsmith
- Debbie Dexter
- David Dreis, MD
- Joe Gifford, MD, Chief Medical Officer, Regence Blue Shield
- Tanis Marsh
- Patti Rathbun
- Hugh Straley, MD
- Melvin Sorensen

2012

- Chair: Jeff Gingold, JD, Attorney, Gingold Law
- Vice Chair: Tom Curry
- Secretary: David Dreis, MD, Medical Director of Clinical Outcomes, Virginia Mason Medical Center
- Treasurer: Debbie Dexter, VP of Business Development, Pacific NW/National Accounts, Aetna
- Tanis Marsh
- Hugh L. Straley, MD
- Joe Gifford, MD
- Rick Goss, MD, MPH
- Melvin Sorensen, JD
- Peggy Evans, PhD
- Patti Rathbun, Health Policy Coordinator, Office of Legislative & Constituent Relations Washington State Department of Health

2013

- Chair: Jeff Gingold, JD, Attorney, Gingold Law
- Vice Chair: Tom Curry
- Secretary: David Dreis, MD, Medical Director of Clinical Outcomes, Virginia Mason Medical Center
- Treasurer: Debbie Dexter, VP of Business Development, Pacific NW/National Accounts, Aetna
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- Rick Goss, MD, MPH
- Melvin Sorensen, JD
- Peggy Evans, PhD
- Patti Rathbun, Health Policy Coordinator, Office of Legislative & Constituent Relations Washington State Department of Health

2014

- Chair: Jeff Gingold, JD, Attorney, Gingold Law
- Vice Chair: Tom Curry
- Secretary: David Dreis, MD
- Tanis Marsh, Former Health Care Director, League of Women Voters of Washington
- Hugh Straley, MD
- Joe Gifford, MD, Chief Executive, ACO of Washington, Providence Health & Services
- Rick Goss, MD, MPH
- Melvin Sorensen, JD
- Peggy Evans, PhD, Director, WA-ID Regional Extension Center, Qualis Health
- Patti Rathbun, Health Policy Coordinator, Office of Legislative & Constituent Relations Washington State Department of Health

2015

- Chair: Jeff Gingold, JD, Attorney, Gingold Law
- Treasurer: Melvin Sorensen, JD
- Secretary: Rachel Quinn, MPH, MPA
- Debra Brown, President, Forterra, Inc.
- Melanie Curtice, JD, Partner, Perkins Coie LLP
- Joe Gifford, MD, Chief Executive, ACO of Washington, Providence Health & Services
- Rick Goss, MD, MPH
- Kathleen O'Connor
- Kim Moore, MD
- Peggy Evans, PhD, Director, WA-ID Regional Extension Center, Qualis Health
- Patti Rathbun

2016

- Chair: Melvin Sorensen, JD, Principal, Carney Badley Spellman
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Rick Rubin, CEO, OneHealthPort
- Secretary: Kim Moore, Vice President of Quality & Associate Chief Medical Officer, CHI Franciscan Health
- Kathy Lofy, MD, State Health Officer, Department of Health
- Debra Brown, President, Forterra, Inc.
- Melanie Curtice, JD, Partner, Perkins Coie LLP
- Chris Dale, MD
- Rick Goss, MD, MPH
- Kathleen O'Connor
- Julie McDonald
- Bruce Smith, MD, Executive Medical Director, Regence
- Peggy Evans, PhD
- Julie McDonald
- Paj Nandi, State Department of Health
- Mary Kay O'Neill, MD, Partner, Mercer Consulting
- Ben Zaniello, MD, Chief Medical Information Officer, Providence Health & Services

2017

- Chair: Melvin Sorensen, JD, Principal, Carney Badley Spellman
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Rick Rubin
- Kathy Lofy, MD, State Health Officer, Department of Health
- Debra Brown, President, Forterra, Inc.
- Melanie Curtice, JD, Partner, Perkins Coie LLP
- Chris Dale, MD
- Rick Goss, MD, MPH
- John Krueger, MD, MPH, Vice President, Quality, CHI Franciscan Health
- Kathleen O'Connor
- Julie McDonald
- Bruce Smith, MD, Executive Medical Director, Regence
- Ben Zaniello, MD, Chief Medical Information Officer, Providence Health & Services

2018

- Chair: Melvin Sorensen, JD,
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Rick Rubin, CEO, OneHealthPort
- Kathy Lofy, MD
- Melanie Curtice, JD
- Chris Dale, MD
- Rick Goss, MD, MPH
- John Krueger, MD, MPH
- Kathleen O'Connor
- Jonathan Seib, JD, MPA

2019

- Chair: Rick Rubin
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Steve Lovell
- Kathy Lofy, MD
- Chris Dale, MD
- Rick Goss, MD, MPH
- John Krueger, MD, MPH
- Kathleen O'Connor
- Jonathan Seib, JD, MPA

2020

- Chair: Rick Rubin
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Steve Lovell
- Kathy Lofy, MD
- Chris Dale, MD
- Rick Goss, MD, MPH
- Jonathan Seib, JD, MPA

2021

- Chair: Rick Rubin
- Vice Chair: Rachel Quinn, MPH, MPA
- Treasurer: Steve Lovell, MS
- Rick Goss, MD, MPH
- Michele Ritala, MPA
- Ashok Reddy, MD, MS, Provider, Veterans Health Administration, Assistant Professor, Health Services, Medicine, University of Washington Medical Center
- Jac Davies, MS, MPH
- Kristin Peterson, JD, Chief of Policy, Washington State Department of Health
- LuAnn Chen, MD, Medical Director, Community Health Plan of Washington
- Dan Kent, MD
- Jonathan Seib, JD, MPA
- Josephine Young, MD, MPH, MBA, Medical Director, Commercial Markets, Premera Blue Cross
- Shawn West, MD, CEO, Embright, LLC

2022

- Chair: Rick Rubin
- Rick Goss, MD, MPH
- Michele Ritala, MPA
- Ashok Reddy, MD
- Steve Lovell, MS
- Jac Davies, MS, MPH
- Peggy Chin Evans, PhD
- Kristin Peterson, JD
- LuAnn Chen, MD
- Dan Kent, MD
- Josephine Young, MD, MPH, MBA
- Shawn West, MD
- Jonathan Seib, JD, MPA

2023

- Chair: Rick Rubin
- Rick Goss, MD, MPH
- Michele Ritala, MPA
- Steve Lovell, MS
- Jac Davies, MS, MPH
- Peggy Chin Evans, PhD
- Kristin Peterson, JD
- LuAnn Chen, MD
- Dan Kent, MD
- Josephine Young, MD, MPH, MBA
- Shawn West, MD
- Jonathan Seib, JD, MPA
- Heather Martin, CNRN, EdD, Director of Quality, Swedish Medical Center
- Ashok Reddy, MD, MS

2024

- Chair: Shawn West, MD
- Vice Chair: Jonathan Seib, JD
- Treasurer: Josephine Young, MD, MPH, MBA
- Secretary: Kristin Peterson, JD
- Michael Bota, MD, Medical Director, Population Health, MultiCare Connected Care
- LuAnn Chen, MD
- Christopher Chen, MD, MBA
- Jim Freeburg, MPA, Patient Advocate
- Richard Goss, MD, MPH
- Dan Kent, MD
- Heather Martin, CNRN, EdD
- Michele Ritala, MPA
- Ashok Reddy, MD, MS

2025

- Chair: Shawn West, MD
- Vice Chair: Jonathan Seib, JD,
- Treasurer: Josephine Young, MD, MPH, MBA
- Secretary: Kristin Peterson, JD
- Michael Bota, MD
- LuAnn Chen, MD
- Christopher Chen, MD, MBA
- Jim Freeburg, MPA
- Richard Goss, MD, MPH
- Ashok Reddy, MD, MS

2026

- Chair: Shawn West, MD
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- Secretary: Kristin Peterson, JD
- Michael Bota, MD
- LuAnn Chen, MD
- Christopher Chen, MD, MBA
- Jim Freeburg, MPA,
- Richard Goss, MD, MPH
- Katie Kolan, JD, Principal, Leonard and Kolan
- Martha Lanman, Executive Director, Southeast Washington Alliance for Health
- Ashok Reddy, MD, MS

Appendix B: Articles, Abstracts, and Presentations

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