

# PROVIDER FOCUS

JULY 2006



## *ER Utilization is on the Rise* By Tom Culhane, MD

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NOTE: The *Provider Focus* is published 3 times a year in March, July, and November.

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A recent article in USA today reported that "Emergency Room use is up across the population, including more middle-class folks with private insurance, with visits up 26% from 1993 to 2003." CUP is experiencing a similar trend! I recently walked through the waiting room of a local Emergency Room in the middle of a sunny and warm weekday and I was impressed with how healthy everybody waiting looked. Most were calmly watching TV or



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## Formulary Update By Tom Culhane, MD

The following are recent modifications made to the CUP formulary:

- Plain Naphcon® and Ocuclear® have been added for Healthy Options patients. Naphcon-A® eye drops were already covered on the Healthy Options formulary.
- Bactroban® cream was recently removed from both formularies. Generic Bactroban® (mupirocin) is now available generically as an ointment. Mupirocin ointment will be covered for both Healthy Options and Basic Health patients.
- Aerochamber® spacers have been dropped from both formularies. Easivent®, Vortex® and Breathright® spacers will now be covered but should be ordered with the additional mask for patients being treated for asthma.
- Zoloft® (sertraline) is now available generically. CUP network pharmacists will be automatically switching CUP patients to generic sertraline with each new or refilled prescription. CUP providers are now being informed that Lexapro® will likely be dropped from both CUP formularies later this summer. CUP now covers four generic serotonin specific reuptake inhibitors (SSRI's): sertraline, fluoxetine, citalopram and paroxetine. It is the feeling of the CUP Pharmacy & Therapeutics Committee



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reading a magazine. Admittedly I realize that a certain basic triage had already been performed and that some of the people relaxing were supporting others seeking care. But not a single person among the several dozen there looked obviously ill. The 2002 edition of Merriam-Webster's Medical Dictionary defines the term emergency as an "unforeseen combination of circumstances or the resulting state that calls for immediate action such as a sudden bodily alteration (like a ruptured appendix or surgical shock) that is likely to require immediate medical attention."



Why were most of these people here in the Emergency Room when at that hour every primary care clinic in Vancouver was open for business? Some of the waiting patients were probably CUP members. Analysis of CUP claims indicates that over a third of Emergency Room visits occur between the hours of 9:00 a.m. and 5:00 p.m. Monday through Friday.

Among the top ten CUP Emergency Room diagnoses are URI, fever, otitis media, bronchitis, viral infection, urinary tract infection, and gastroenteritis. Only a tiny fraction of these daytime patients seeking care with apparent minor diagnoses were ever admitted to the hospital. I suspect that virtually none of these visits fulfilled Webster's aforementioned definition of "emergency." It is clear that the two local Emergency Rooms have become the convenience centers of choice for minor conditions.

As a Medicaid health plan, CUP is legally barred from instituting any sort of required co-payment for Healthy Options visits to the Emergency Room. The unfunded mandate of EMTALA (Emergency Medical Treatment and Active Labor Act) guarantees at least a basic triage exam will be performed for any person presenting to any Emergency Department anywhere in the United States. The combination of barred co-payments and EMTALA makes it very difficult to institute any direct financial disincentives for Healthy Options members who choose the Emergency Room for minor problems.

Further analysis of CUP claims data shows wide variation among PCP clinics with regard to member Emergency Room visit rates. Some area clinics are simply doing a much better job of providing access for minor problems. CUP would like to see all PCP offices provide CUP members with a "medical home" as defined by the American Academy of Pediatrics as "accessible, continuous, comprehensive, coordinated, compassionate and culturally effective."

(Continued from page 1) **Formulary Update**

that these choices are adequate for the treatment of depression for CUP members. Since they are uniquely different from the SSRI's, coverage for brand name Effexor® and Cymbalta® will continue for both Healthy Options and Basic Health patients.

- Flonase® (fluticasone nasal spray) has recently gone generic. Coverage for brand name Rhinocort® and Nasacort® will likely end on both formularies by the end of the summer. CUP providers are being advised ahead of this discontinuation so that a smooth transition to fluticasone of those patients prescribed ongoing Rhinocort® and Nasacort® can be accomplished over the next three months.

## The “320” Club By Tom Culhane, MD

Over the past two years, the State Plan Medical Director at HRSA (Health Recovery and Services Administration), Dr. Jeff Thompson, initiated a special intervention program intended to address the difficult combination of high number of Emergency Room visits and multiple narcotic prescriptions for Medicaid fee-for-service clients. Patients were first identified who had at least nine narcotic prescriptions per month for six consecutive months and who visited Emergency Rooms frequently as their prime source of ongoing medical care. Patients with known significant diagnoses causing pain, such as a cancer, were excluded from the intervention.



Three Hundred and Twenty (320) high narcotic, frequent Emergency Room patients were identified and the following interventions were started:

- Sharing the individual prescription and Emergency Room visit history with providers involved
- Restricting patients to one primary care physician for all narcotic prescriptions
- Restricting patients to just one retail pharmacy
- Prior authorization at the state level for all narcotic prescriptions
- Mandatory chemical dependency screening for those patients wanting to continue their controlled substance pharmacy benefits

The State Plan Medical Director also initiated quality reviews and possible contract determination for unresponsive providers.

So far, the plan has met some success. The average number of monthly narcotic prescriptions written dropped from 12-15 per month to less than nine for those members identified by this special intervention program. HRSA now notifies CUP about the limitations already in place whenever these members are transferred to CUP membership.

At least four members of the “320 club” have now become CUP members. The CUP Medical Management Department plans to continue the same prescription restrictions after the member has transferred to CUP. If the member is new to the PCP, CUP plans to contact that PCP regarding the restrictions already in force. Quantity limitations on controlled medications, the designated single pharmacy choice, as well as the designated single writer of prescriptions, will be entered into our pharmacy claims system. Any controlled substance prescription presented to the non-preferred pharmacy, not written by the PCP, or written in excess of the limitations already created will be automatically blocked.

It is felt that these particular cases represent not only an excessive utilization issue but also one of poor quality. Dr. Thompson has been rightfully concerned regarding the diversion of these prescribed narcotics into the underground market. The State of Washington has worked hard to corral possible over-usage and diversion of these potentially addictive medications. CUP is therefore committed to continue to this diligent effort aimed at limiting potential abuse of these medications. The proper expenditure of what are entirely public funds supporting Medicaid managed care must be ensured. It is simply the right thing to do.

## ***Sports Physicals May Be Billed as Adolescent Well-Care Exams This Summer By David Killaby, MPA:HA***

Providers will see a change to sports physical forms for students in the Vancouver School District this summer. CUP has revised the sports physical form to include the missing domains of care for a qualifying adolescent well-care (AWC) exam. Providers will be able to bill the revised sports physical form as an AWC if all elements on the form are complete. In addition, this may increase your clinic's HEDIS® quality rating for this measure. Click [here](#) to view the revised Athletic Pre-Participation Health Assessment form.

### **Benefits to Providers**

**Reimbursement** - Washington Medicaid reimburses for one AWC exam every two years. CUP will reimburse for one exam AWC every year.

**Quality Improvement** - Sports physicals are often the only time adolescents present in the clinical setting and thus represent a unique opportunity to increase AWC exam rates and provide more effective adolescent preventive health screening.

**Less Chart Review** - Completing and billing AWC exams reduces the amount of medical chart review CUP completes at your office in the spring.

### **Benefits to Adolescents**

**Improved Adolescent Care** - Research shows that pre-participation exam (PPE) sports physicals in their current format are inadequate in reducing adolescent morbidity and mortality and do not promote adolescent health. Because PPE's lack a follow-up care component, evaluations are seldom associated with follow-up care as recommended by the PPE-provider.

**Health Education** - AWC exams build rapport with an adolescent, which frequently leads to discussion about other issues. The exam represents an opportunity for providers to address the major issues in adolescent health education, such as alcohol and drug (including steroid) use, suicide, sexually transmitted diseases, pregnancy prevention, and nutrition and weight control.

**Effectiveness of Preventive Services** - As most adolescents use PPE as their only planned contact with a provider each year, this visit affords the opportunity to address non-sports causes of morbidity and mortality in adolescents. Even minimally effective interventions aimed at smoking cessation, for instance, would result in much larger improvements in overall adolescent health, given the relative prevalence of smoking versus sports-related morbidity and mortality.

### **Coding and Reimbursement**

CUP will be working with your clinic office managers to ensure the form is billed using one of the following CPT codes:

- ◆ CPT CODE - 99384 Preventive visit, new, age 12-17
- ◆ CPT CODE - 99385 Preventive visit, new, age 18-39
- ◆ CPT CODE - 99394 Preventive visit, established, age 12-17
- ◆ CPT CODE - 99395 Preventive visit, established, age 18-39

### **Washington State Focuses on Four Domains of Care**

In Washington State, a qualifying well-child checkup must meet Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements at each visit by addressing a minimum number of elements within four health "domains"- physical health, developmental health, mental health, and health education.



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(Continued from page 4) **Sports Physicals May Be Billed as Adolescent Well-Care Exams This Summer**

The Athletic Pre-Participation Health Assessment form has been revised to include the two domains of care missing from a PPE sports physical form: mental health and health education. These are the two domains of care that are also most often not documented on the Washington State form.

**Health Education Topics and Checkboxes**

CUP added the following topics with accompanying check boxes to the form as a means of prompting providers to document health education. At least one topic must be discussed during the AWC exam and properly documented with a checkmark on the form.

- √ Nutrition/weight control
- √ Adequate sleep
- √ Smoking
- √ Injury prevention/safety



**Format**

To ensure that a copy of the completed exam form could be placed in the chart, the form was printed in a two-page NCR format. Once completed, the top copy (white) is given to the athlete and the bottom copy (canary) goes to chart.

**Distribution**

The Vancouver School District will include the revised form in 5,000 pre-participation packets mailed to student athletes this summer.

**Questions?**

Please direct questions about the form, coding or reimbursement to David Killaby at (360) 449-8936 or via e-mail to [dkillaby@cuphealth.com](mailto:dkillaby@cuphealth.com).

**Fast, Easy Fax Referral for your Medicaid Patients Who Smoke**  
*By David Killaby, MPA:HA*

**Washington State QuitLine Fax Referral Program**

The Washington State QuitLine (WAQL) has a fast, easy way for your Medicaid patients to receive tobacco cessation services. If the patient is ready to quit and gives written consent to be contacted by WAQL, an office staff member can fax the completed form to get your patient registered in the program. WAQL will fax the outcome of the intervention to your office to include in the patient's chart. Click [here](#) for a copy of the WAQL fax referral form.

WAQL participants receive:

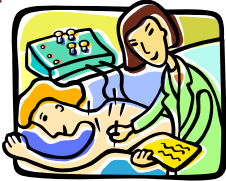
- √ 8 Weeks of nicotine replacement patches or gum mailed to their home
- √ Telephone counseling calls by Free & Clear "Quit Coaches"
- √ Unlimited toll-free telephone support
- √ "Quit Guide" mailed to their home
- √ Re-enrollment, if necessary
- √ Referrals to community resources



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## Over 60% of CUP's Basic Health Members With Cardiovascular Disease are Women

*By David Killaby, MPA:HA*



Among CUP's Basic Health population, Chest Pain, Hyperlipidemia, and Hypertension were ranked 4th, 6th, and 7th among the Top 30 Diagnoses by Claims from January 1, 2005 - September 30, 2005. Approximately one in every ten Basic Health members has hypertension and over 60% of CUP's Basic Health members with cardiovascular disease are women.

### **CUP Cardiovascular Disease Program**

CUP has a Cardiovascular Disease Program to help our members reduce their personal risk factors for hypertension and hypercholesterolemia. If you have a member you would like to refer to the program or would like to learn more about CUP's **Cardiovascular Disease Program**, please call CUP Member Services Department at: (360) 891-1520, or Toll Free (800) 315-7862. TDD (360) 449-8860 or Toll Free TDD (866) 287-9962. Our office is open Monday-Friday, 8:00 a.m. to 5:00 p.m.

### **WISE Study Reveals Coronary Microvascular Syndrome Frequently Undiagnosed in Women**

In as many as three million U.S. women with coronary heart disease, cholesterol plaque may not build up into distinct plaques or major blockages but instead is more diffusely distributed throughout the artery wall. As a result, diagnostic coronary angiography reveals "clear" arteries that incorrectly indicate low risk and a false negative diagnosis. Yet many of these women have a high risk for heart attack, according to a new study by the National Institutes of Health (NIH).

The condition - *coronary microvascular syndrome* - results in plaque accumulation in small arteries in the heart, causing narrowing and reduced oxygen flow to the heart. Women with coronary microvascular syndrome feel fatigued and short of breath, but do not feel as much pain as men. The study titled Women's Ischemia Syndrome Evaluation (WISE), by the National Heart, Lung, and Blood Institute (NHLBI), followed 1,000 women for five years. The results were published in a special supplement to the February 6 issue of the *Journal of the American College of Cardiology*.

The WISE study, which began in 1996, was intended to increase scientific knowledge about ischemic heart disease in women. Specifically, the study was designed to develop accurate diagnostic approaches for ischemic heart disease detection in women, to better understand the ways in which heart disease develops in women (including the significance of ischemia without coronary blockages in women), and to evaluate the influence of hormones on ischemic heart disease development and diagnosis.

Gender-specific clinical practices are not well understood or implemented. Much of the current understanding of heart disease, heart attack, and diagnostic and treatment modalities are the result of research on men. This has severely limited the findings and generalization of many clinical studies and trials. The WISE study delivers a message that coronary microvascular syndrome in women is hard to detect and physicians should exercise caution when it comes to diagnosis. Those diagnostic methods that work well for men will likely fail to work for women.

Gender differences in cardiovascular risk factors and in the clinical presentation of coronary artery disease may explain why some women with coronary arteries that appear to be clear on angiography are actually at high risk for ischemic heart disease, reported investigators who analyzed data from the WISE study. Those women who are not diagnosed will continue to have symptoms, declining quality of life, and repeated hospitalizations and tests, according to the investigators.

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**(Continued from page 6) Over 60% of CUP's Basic Health Members With Cardiovascular Disease are Women**

**Additional findings from the WISE study:**



- Men have higher rates of smoking and hypertension than women, but women who smoke have an enhanced risk compared with men who smoke. Women who smoke increase their risk of death from coronary heart disease by an amount equivalent to that of non-smoking women who weigh about 42 kg (92 lb) more.
- When lipid levels are considered, men and women are at comparable risk when total cholesterol and LDL levels are similar, but women are at increased risk compared with men when their HDL levels are 50 mg/dL or lower.
- Women with diabetes have significantly higher cardiovascular mortality rates than men with diabetes, and diabetic women have an age-adjusted prevalence of cardiovascular disease that is nearly twice that of non-diabetic women. African-American women have the highest risk for cardiovascular mortality associated with diabetes.
- Greater loss of physical functioning in post-menopausal women compared with men of a similar age leads to greater weight gain, insulin resistance, and hypertension.
- The waning of estrogen production further contributes to deposition of abdominal and increased body mass index. There is evidence to suggest that endogenous estrogen provides protection against ischemic heart disease in pre-menopausal women, the authors noted.
- Traditional risk markers for cardiovascular disease appear to underestimate risk in women.
- Conventional stress testing based on demand ischemia may miss a significant proportion of women who have obstructive coronary artery disease but no apparently significant coronary stenosis. Stress echocardiography and single positron-emission computed tomography studies appear to be much better at estimating near-term prognosis (event-free survival) in women with chest pain symptoms.

**Additional conclusions from the WISE study:**

**Identifying Candidates for Exercise Stress Testing** - Use of the evaluative tool Duke Activity Status Index (DASI) in women with heart disease symptoms can help to determine who can withstand the rigors of an exercise stress test, and who should be tested instead with pharmacologic stress imaging. Current guidelines offer physicians little guidance on how to identify women who would not be able to sufficiently complete the exercise test. The DASI has been previously validated as a useful tool for determining functional capacity.

**Low Coronary Flow and Scores on Function Test Indicate Poor Outcomes** - Women who have low DASI scores also have lower coronary flow velocity, a combination which may explain the poor outcomes seen for women with heart disease but no stenotic arteries.

**Role of Pre-menopausal Hypertension in Disease Risk** - Among women who are undergoing angiography for suspected ischemia, elevated systolic blood pressure and pulse pressure indicate a particularly high risk for coronary artery disease. The findings suggest that pre-menopausal women with hypertension, especially elevated systolic pressure, should be evaluated for additional coronary artery disease risk factors.

**CUP Guidelines**

CUP's Cardiovascular Team recently adopted the JNC-7 hypertension guidelines from the National Heart, Lung, and Blood Institute (NHLBI) and the Adult Treatment Panel III guidelines from the National Cholesterol Education Program. These are available as PDF files on CUP's newly enhanced website. If you would like copies of these guidelines, please call David Killaby at (360) 449-8936 or via e-mail at [dkillaby@cuphealth.com](mailto:dkillaby@cuphealth.com). References available upon request.

(Continued from page 5) **Fast, Easy Fax Referral for your Medicaid Patients Who Smoke**

### **Treating Tobacco Dependence During Pregnancy**

Smoking during pregnancy is the primary modifiable risk factor for perinatal complications leading to infant morbidity and mortality in the US today, and is known to cause premature births, low birthweight babies and SIDS. Quitting smoking at any time during pregnancy decreases the risk of birth complications, newborn illnesses and neonatal deaths, but fewer than half of pregnant women who smoke are able to quit.

The FDA has not approved the use of over-the-counter nicotine medications (NRT patch, gum and lozenges) for pregnant women who smoke; however, there is accumulating evidence from European countries (where NRT has been approved for use in pregnancy since 1997) that use of NRT reduces smoking among pregnant women and decreases the risk of adverse smoking-related outcomes.

WAQL, in conjunction with the Free & Clear program, offers direct mail order (DMO) NRT patch, gum and/or lozenge for eligible pregnant callers, along with a standard counseling program. However, WAQL is unable to provide NRT to pregnant women without the approval of their physician (or other licensed healthcare provider). Therefore, **if you would like your patient to receive NRT as part of her treatment for quitting tobacco, please discuss this with her and sign the authorization on the front of the fax referral form.** WAQL will assess your patient's need for NRT and deliver up to eight weeks of nicotine medication to augment the counseling program and help your patient quit, if NRT is indicated and your patient is eligible.



### **A Message From the Free & Clear Medical Team**

While quitting without the use of NRT would be preferred, using NRT is clearly safer for maternal-child health than continuing to smoke, as ingredients in tobacco smoke other than nicotine are the primary causes of the conditions leading to adverse pregnancy outcomes. Benowitz and colleagues, while recognizing that animal studies have shown risk of neuro-developmental defects with high doses of nicotine, have determined that there is low to minimal risk to the human fetus associated with judicious NRT use during pregnancy and recommend that such treatment be considered for women who are otherwise unable to quit. Additionally, they advise that NRT can be used without restriction post-partum, as only trace amounts of nicotine are absorbed by breast-fed infants.

### **Free & Clear Medical Staff Physicians are Available to Answer Your Questions**

If you have any questions, would prefer to prescribe NRT directly to your patient, or would like additional information, please call one of the Free & Clear medical staff physicians, Tim McAfee or Abigail Halperin at (206) 876-2100.

### **References:**

- 1) Cnattingius S. The epidemiology of smoking during pregnancy: Smoking prevalence, maternal characteristics and pregnancy outcomes. *Nicotine and Tobacco Research*. 2004, vol. 6, sup 2, pp. s107-124.
- 2) MMWR, Smoking during Pregnancy, United States 1990-2002. Centers for Disease Control and Prevention. October 8, 2004:53(39):911-915.
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- 4) Benowitz NL, Dempsey DA. Pharmacotherapy for smoking cessation during pregnancy. *Nicotine and Tobacco Research*. 2004, vol. 6, sup 2, pp. s189-202.
- 5) Dempsey DA, Benowitz NL. Risks and benefits of nicotine to aid smoking cessation in pregnancy. [Drug Safety](#), 2001, vol. 24, no. 4, pp. 277-322.

## Member Satisfaction and Accessibility of Services By Sharon Brooks, RN

Annually, Columbia United Providers (CUP) analyzes measures of member satisfaction across the continuum of health plan operations in order to facilitate improvement opportunities to increase member satisfaction. The aggregate data was summarized with the following highlights noted:



### Availability and Access of Practitioners and Service

CUP contracts with 95% of non-Kaiser physicians in Clark county and promotes additional access with a 24-hour nurse advice line service. Surveys for after hours access showed 100% compliance.

### Utilization Management Procedures

Of the total number of prior authorization request submitted, less than 3% were denied, mainly due to non-covered service requests. Mid-year prior authorization requirements to in-plan specialists were relaxed in addition to some procedures, imaging, and DME requests.

### Communication and Attitude of Practitioners and Staff

Members continue to be pleased with their interactions with practitioners and their office staff, receiving some of the highest ratings on the satisfaction survey. Service complaints related to communication issues dropped by 30% from the prior year.

### Quality of Clinical Care and Service Delivery in the Practice Setting

Service grievances decreased significantly from the prior year. Ongoing monitoring of clinical grievances did not disclose any practitioner with excessive complaints.

### Quality of Member Services and Claims Processing and Payment

Satisfaction with Member Services continues to rate equal or better than other health plans nationally. Claims processing for Basic Health members continued to outpace national averages by 6 percentage points.

### The Scope of Benefits and Services Provided

In addition to medically necessary benefits and services mandated by the state, some services related to Health Management programs are covered outside of the benefit by CUP.

Interventions initiated during 2005 included the following:

- ◆ Promotion and education on Member Rights and Responsibilities for both members and staff;
- ◆ Enhanced education for members via the CUP website;
- ◆ Initiation of a quality incentive program for both providers and members;
- ◆ Expansion of the "New Member Contact" project to include Healthy Options members in addition to Basic Health members; and
- ◆ Streamlining the prior authorization process to allow more emphasis on case management.

During 2006 the following opportunities for improvement have been identified:

- ◆ Identify the reasons for PCP changes and address issues if appropriate;
- ◆ Evaluate the trends in Emergency Department utilization;
- ◆ Explore the accessibility trends with increased hospital choices;
- ◆ Seek additional opportunities to address language and cultural issues; and
- ◆ Monitor the effect of contacting new members proactively.



## **CAHPS® Survey Results** *By Chris Senz, Quality Department Manager*



CUP once again conducted the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS® – formerly Consumer Assessment of Health Plans Survey) of our Basic Health adult population. This annual survey of a random sample of members is conducted using a mixed survey administration methodology (mail and telephone). The 2006 survey yielded a 47.7% response rate.

CAHPS® includes several composite measures that are comprised of the scores of several different questions combined. The 2006 results showed no statistically significant differences from the 2005 results for the composite measures. CUP's rate for the "Getting Needed Care" measure is significantly lower than the national rate for all Commercial plans (74.6% vs. 79.5%). CUP's rate for "Claims Processing" is significantly higher than the Pacific region rate for Commercial plans (93.0% vs. 86.7%). For all other composite measures, CUP's rates are not statistically different from the overall national or regional rates.

On overall rating questions, where members are asked to rank on a scale from 0 to 10, CUP's score for "Rating of Personal Doctor" is significantly improved over the 2005 rate (79.1% vs. 73.0%). CUP's "Rating of Specialist" score is significantly below the national benchmark (70.3% vs. 77.9%). All other rating measures showed no statistical significance as compared to 2005 scores, national benchmarks, or Pacific regional benchmarks.

CUP has an established internal QI team that focuses on member satisfaction issues and that team will use this information along with other sources of member data to determine areas of focus for QI efforts over the coming months.

## **CUP Administration Directory**

<b><u>Position</u></b>	<b><u>Name</u></b>	<b><u>Phone</u></b>	<b><u>E-Mail Address</u></b>
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