Council Members	AGENDA
Scott Jacobson, Chairman Eileen Sullivan, Vice Chairman Earl Arbuckle, Treasurer Nelly Clotter-Woods, Member Chris Hooper, Member Salina Imam, Member Norma Muñoz, Member William O'Neill, Member Essen Otu, Member Wayne Tormala, Member Jane Wilson, Member	**Valleywise Community Health Centers Governing Council** **Mission Statement** The Valleywise Health's mission is to provide exceptional care, without exception, every patient, every time.

▪ Virginia G. Piper Charitable Trust Pavilion ▪
▪ 2609 East Roosevelt Street ▪ Phoenix, Arizona 85008 ▪
▪ 2nd Floor ▪ Auditoriums 1 and 2 ▪

Wednesday, March 5, 2025
5:30 p.m.

Access to the meeting room will start at 5:20 p.m., 10 minutes prior to the start of the meeting.

One or more members of the Valleywise Community Health Centers Governing Council may be in attendance by technological means. Council members attending by technological means will be announced at the meeting.

Please silence cell phone, computer, etc., to minimize disruption of the meeting.

5:30 **Call to Order**

Roll Call

Call to the Public
This is the time for the public to comment. The Valleywise Community Health Centers Governing Council may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism, or scheduling a matter for further consideration and decision at a later date.

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

Agendas are available within 24 hours of each meeting at Valleywise Community Health Centers and at Valley Comprehensive Health Centers, and on the internet at https://valleywisehealth.org/about/governing-council/. Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice via the Clerk's Office, Virginia G. Piper Charitable Trust Pavilion, 2609 East Roosevelt Street, Phoenix, Arizona 85008, (602) 344-5177. To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

2/27/2025 12:24 PM

General Session, Presentation, Discussion and Action:

5:35 1. Approval of Consent Agenda: 5 min

Any matter on the Consent Agenda will be removed from the Consent Agenda and discussed as a regular agenda item upon the request of any voting Governing Council member.

a. Minutes:

i. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated February 5, 2025

b. Contracts:

i. Intentionally Left Blank

c. Governance:

i. Intentionally Left Blank

d. Medical Staff:

i. **Acknowledge** the Federally Qualified Health Centers Medical Staff and Advanced Practice Clinician/Allied Health Professional Staff Credentials

End of Consent Agenda

5:40 2. Mission Moment – A Patient Story 5 min - No Handout
Nicole Parker-Walker, FQHC Manager

5:45 3. Discuss, Review and **Approve** the Maricopa County Special Health Care District dba Valleywise Health, Organizational Chart for the Federally Qualified Health Centers 5 min
Michelle Barker, DHSc, Chief Executive Officer, Federally Qualified Health Centers

5:50 4. Discuss and Review the 2025 Federal Poverty Level Guidelines; Discuss and Review the Federally Qualified Health Centers Sliding Fee Discount Program/Policy, and Utilization of the Program; **Approve** Revisions to Appendix C, Federally Qualified Health Center Sliding Fee Discount Schedule, of Policy #23624 D - Federally Qualified Health Centers Sliding Fee Discount Program/Policy 10 min
Amanda De Los Reyes, MBA, CRCR, Vice President, Revenue Cycle

6:00 5. Discuss and Review the Federally Qualified Health Centers Semiannual Compliance and Internal Audit Work Plans and Ethics Line Report 10 min
L.T. Slaughter, CPA, MBA, Chief Compliance Officer

6:10 6. Annual Compliance Training and Conflict of Interest Education 20 min
L.T. Slaughter, CPA, MBA, Chief Compliance Officer

6:30 7. Meeting Update/Report from the Valleywise Community Health Centers Governing Council's Connecting with Community Ad Hoc Committee 10 min - No Handout
Chris Hooper, Committee Chair

General Session, Presentation, Discussion and Action cont.;

6:40 8. Federally Qualified Health Centers' Chief Executive Officer's Report, including Ambulatory Operational Dashboards 10 min
Michelle Barker, DHSc, Chief Executive Officer, Federally Qualified Health Centers

6:50 9. Valleywise Health's President and Chief Executive Officer's Report 5 min - No Handout
Steve A. Purves, FACHE, President and Chief Executive Officer, Valleywise Health

6:55 10. Governing Council Member Closing Comments/Announcements 5 min - No Handout
Valleywise Community Health Centers Governing Council

7:00 **Adjourn**

1.a.i. Minutes - Meeting Minutes dated February 5, 2025

Minutes

Valleywise Community Health Centers Governing Council Meeting
Virginia G. Piper Charitable Trust Pavilion
2609 East Roosevelt Street, Phoenix, AZ 85008
2nd Floor, Auditoriums 1 and 2
February 5, 2025, 5:30 p.m.

DRAFT

Members Present:
Scott Jacobson, Chairman
Eileen Sullivan, Vice Chairman – *participated remotely, then in-person*
Earl Arbuckle, Treasurer
Nelly Clotter-Woods, Member
Chris Hooper, Member
Salina Imam, Member
Norma Muñoz, Member
William O'Neill, Member – *participated remotely*
Essen Otu, Member
Wayne Tormala, Member – *participated remotely*
Jane Wilson, Member – *participated remotely*

Others/Guest Presenters:
Michelle Barker, DHSc, Chief Executive Officer of the Federally Qualified Health Centers
Steve Purves, FACHE, President and Chief Executive Officer – *participated remotely*
Michael D. White, MD, MBA, Chief Clinical Officer – *participated remotely*
Melanie Talbot, Chief Governance Officer; and Clerk of the Board
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer
Matthew Meier, MBA, Vice President, Financial
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety
Sean Stallings, FHC Manager

Recorded by: Denise Tapia, Deputy Clerk of the Board

Call to Order:

Chairman Jacobson called the meeting to order at 5:30 p.m.

Roll Call

Ms. Tapia called roll. Following roll call, she noted nine of the eleven voting members of the Valleywise Community Health Centers Governing Council were present, which represented a quorum. Vice Chairman Sullivan and Mr. Otu arrived after roll call.

For the benefit of all participants, Ms. Tapia announced the Governing Council members participating remotely.

Call to the Public

Chairman Jacobson called for public comment. There were no comments.

NOTE: Mr. Otu arrived at 5:31 p.m.

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda:

   a. Minutes:

      i. Approve Valleywise Community Health Centers Governing Council meeting minutes dated January 2, 2025

   b. Contracts:

      i. Accept amendment #3 to the intergovernmental agreement (IGA) (90-22-167-1-03) between Maricopa County, Ryan White Part A Program and Maricopa County Special Health Care District dba Valleywise Health for the Emergency Relief Project Grant to revise Number 3

   c. Governance:

      i. Approve revisions to Policy - 89104 T Valleywise Community Health Centers Governing Council Members Attendance Expectations

      ii. Appoint the following to the Valleywise Community Health Centers Governing Council's Connecting with the Community Ad Hoc Committee:
         a. Rebecca Birr
         b. Vicki Staples

   d. Medical Staff:

      i. Intentionally Left Blank

MOTION: Mr. Arbuckle moved to approve the consent agenda. Ms. Muñoz seconded.

VOTE: 10 Ayes: Chairman Jacobson, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
1 Absent: Vice Chairman Sullivan
Motion passed.

2. Mission Moment – A Patient Story

Mr. Stallings mentioned the community had come to consider Valleywise Health Center – South Central location as a trusted place to receive healthcare with dignity, without judgment and typically with associated costs that allowed patients to receive care without the fear of not being able to afford it.

The clinic did not provide emergency care, but a teenage boy arrived at the clinic with two missing fingers, with a third nearly missing, resulting from an accident after playing with fireworks. The clinic staff immediately grabbed tourniquets and wrapped his wounds as best as possible, then called 911. Phoenix Fire stabilized the patient and transferred him to the Valleywise Health Emergency Department, where he was treated for his injuries.

The situation encompassed how the patient visualizes the clinic as a trusted resource and a trusted advisor of the community.

General Session, Presentation, Discussion and Action, cont.:

2. Mission Moment – A Patient Story cont.

Ms. Muñoz expressed her gratitude and thanked Mr. Stallings for the care provided to the community.

NOTE: Vice Chairman Sullivan joined at 5:37 p.m.

10. Valleywise Health's President and Chief Executive Officer's Report

Mr. Purves provided an overview of the items staff was monitoring with respect to the new federal administration.

The most significant items were related to the financial impact on Valleywise Health if changes were made to the Medicaid program and if the Safety Net Service Initiative (SNSI) program was not approved.

Another concern was the subsidies for the Affordable Care Act (ACA), noting that removing the subsidies may create more uncompensated care.

Other concerns were related to the immigration policy changes and the impact it had on the community. Valleywise Health had policies in place that outlined the procedures if law enforcement officials showed up at any Valleywise Health facility, stating that Valleywise Health's primary objective was to provide patient care.

Mr. Otu mentioned with the executive orders, there was fear around immigration and the Lesbian, Bisexual, Gay, Transgender, Queer (LGBTQ+) communities with the collection of data, and asked if Valleywise Health leveraged any other community partners to help advocate for some of those concerns.

Mr. Purves stated there was a lot of confusion, but the staff was using all avenues to ensure that people could seek care if they needed it. Valleywise Health was collaborating with the Arizona Alliance for Community Health Center (AACHC).

Dr. Barker noted that she is on a weekly call with the other Federally Qualified Health Care Clinics (FQHCs) and the AACHC to discuss legislative actions. She was confident that nothing was at risk for the services and programs at Valleywise Health.

3. Discuss and Review Federally Qualified Health Centers Press Ganey Patient Experience Data for the Second Quarter of Fiscal Year 2025

Ms. Garcia stated there was a successful transition to the new Press Ganey vendor on October 1, 2024.

NOTE: Vice Chairman Sullivan arrived at 5:57 p.m.

Ms. Garcia outlined how surveys were sent to patients via text message, and if the patient did not have a mobile phone number, it was automatically send to an email. She also explained that they were trying to add a third option, Interactive Voice Response (IVR), to see if the response rates would increase.

She explained that the previous vendor used the net promoter score metrics, and with Press Ganey, they utilized the top box metrics. She outlined the percentile rankings and provided an overview of peer groups and data types.

General Session, Presentation, Discussion and Action, cont.:

3. Discuss and Review Federally Qualified Health Centers Press Ganey Patient Experience Data for the Second Quarter of Fiscal Year 2025 cont.

Ms. Garcia said 3,167 dental services surveys were distributed, with 6.1% of those surveys returned. The average response rate for Press Ganey metrics was 8.8 percent. The Valleywise Health response rate for medical practice was 6.8% with the average response rate being 12.9%. There was some work to be done to reach the average standard.

Mr. Otu asked if the response rates were industry standard.

Ms. Garcia stated the average was based on all the Press Ganey peer groups.

The net promoter score and the top box score were not comparable. For example, the survey question asked about the likelihood of recommending the facility. The goal was 80.8%, and the quarterly results were 78.73% and continued to improve.

She noted that the individual FQHC clinics were doing well, and staff would continue to monitor.

Ms. Garcia outlined the action items, including meetings with the FQHC leadership to help with action plans, emailing comments to all FQHC leadership and medical directors, and working with Press Ganey on survey mode and response rate.

4. Discuss and Review Federally Qualified Health Centers Patient Safety Report for the Second Quarter of Fiscal Year 2025

Ms. Garcia reviewed patient safety events for the second quarter of fiscal year (FY) 2025. Staff entered events into the Continuous Healthcare Evaluation & Quality Improvement Tool (CHEQ-IT), which was used to track any trends to make process improvements based on information received. There were approximately 25,000 visits per month from October through December 2024, with 135 incidents that were reported.

The most frequent class of events reported were safety and security, which included Code White events. A Code White was when a patient, visitor, or staff was in distress and needed medical assistance.

Behavioral health events included, but were not limited to, patients leaving the clinic against medical advice and refusing to seek a higher level of care upon staff's recommendations was the number one event.

Ms. Garcia highlighted specific events for each category and outlined how staff would track and monitor those events to ensure process improvements were implemented.

Vice Chairman Sullivan asked about the safety report that noted a Health Insurance Portability and Accountability Act (HIPPA) complaint.

Ms. Garcia stated when there is a HIPPA violation, it goes to the compliance department and does the requirements that are needed.

Ms. Agnew mentioned that when there is a HIPPA violation, the compliance department investigates and takes it very seriously.

Ms. Garcia reiterated that HIPPA violations go through compliance and are handled according to Valleywise Health policies and regulations.

General Session, Presentation, Discussion and Action, cont.:

5. Discuss and Review Federally Qualified Health Centers Uniform Data System (UDS) Quality Metrics for Calendar Year End 2024

Ms. Garcia provided an overview of the Uniform Data System (UDS) for calendar year end 2024. She mentioned the data was gathered on a calendar year as opposed to the fiscal year. There were no metrics that were negatively outside of the established benchmark. The updated goals were received in August, and Valleywise Health continued to meet the metrics.

The metric related to the control of diabetes completed the year at 29.14%, with the national average at 28.81%, the metric was being met.

Mr. Otu asked for clarification on the trend line for FY 2023 versus FY 2024.

Ms. Garcia stated that there was always a large spike in January, which made the numbers look bad due to the limited number of qualified visits. The comparison for the previous year was shown so staff could see if the trend was to meet the goal.

The benchmark for the blood pressure metric was 58.07%, with the organization meeting the goal ending the year at 60.75 percent.

Depression screening and follow-up met the benchmark of 71.6%, ending the year at 80.39 percent.

Childhood immunization met the benchmark, ending the year at 39.16 percent. She noted the previous issues with the logic in calculating the metric, but it had been corrected.

6. Discuss and Review Federally Qualified Health Centers Financials and Payor Mix for the Second Quarter of Fiscal Year 2025

Mr. Meier presented the financial statements for the FQHCs for the second quarter of FY 2025. Visits at the Community Health Centers were two percent better than budget, total operating revenues were one percent better than budget, and total operating expenses were missed budget by six percent, resulting in a negative operating margin variance of $621,325. An unbudgeted lease for Valleywise Community Health Center–McDowell contributed to the negative operating margin.

Outpatient behavioral health visits were five percent better than budget; total operating revenues were six percent better than budget, and total operating expenses missed budget by 19%, resulting in a negative operating margin variance of $205,842.

The Comprehensive Health Center-Phoenix visits were four percent better than budget; total operating revenues were 10% better than budget; operating expenses missed budget by three percent, resulting in a positive operating margin variance of $156,929.

The Comprehensive Health Center-Peoria visits were five percent better than budget; total operating revenues were two percent better than budget; total operating expenses missed budget by eight percent, resulting in a negative operating margin variance of $108,859.

Dental clinic visits were three percent better than budget, total operating revenues were nine percent better than budget, and total operating expenses missed budget by two percent, resulting in a positive operating margin variance of $41,396.

The Mobile Health Unit visits were 30% better than budget; total operating revenues were 219% better than budget, and total operating expenses were 14% better than budget, resulting in a positive operating margin variance of $72,160.

General Session, Presentation, Discussion and Action, cont.:

6. Discuss and Review Federally Qualified Health Centers Financials and Payor Mix for the Second Quarter of Fiscal Year 2025 cont.

In reviewing the statistics for all clinics combined, Mr. Meier noted visits were three percent better than budget, total operating revenues were four percent better than budget, total operating expenses missed budget by six percent, resulting in a negative operating margin variance of $665,541.

The six-month review of the payor mix showed a 0.8% decrease in Medicaid utilization, a 1.4% increase in commercial utilization, and a 0.7% decrease in self-pay utilization.

When reviewing the four-year trend, Mr. Meier highlighted that self-pay and commercial utilization increased every year.

Mr. Otu asked if the increase in commercial patients compensated for the decrease in Medicaid patients.

Mr. Meier stated the payor mix was continually monitored, noting that while there was an increase in commercial utilization, the reimbursement rate for Medicaid was higher, creating a shortfall.

Ms. Agnew stated that the self-pay patients had doubled compared to other FQHCs in the area and the same size as Valleywise Health. Despite that, there is still a positive variance in the budget. Some work remains on what is being done differently at other FQHCs.

7. Discuss, Review and Approve revision to Valleywise Health Policy: 21531 D - Ambulatory Clinics Management of No-Shows and Late Arrivals

Dr. Barker noted there were a few adjustments to the language from the first draft that was presented to the Governing Council in December 2024. She noted the language was clarified to state that patients would be seen even if they were late for their appointments.

Mr. Otu stated he appreciated the human element by giving grace and accommodations to patients who show up late.

MOTION: Mr. Hooper moved to approve revisions to the Valleywise Health policy: 21531 D - ambulatory clinics management of no-shows and late arrivals. Mr. Otu seconded.

VOTE: 11 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
Motion passed.

8. Discussion and Possible Action on a Charter for the Valleywise Community Health Centers Governing Council's Connecting with the Community Ad Hoc Committee

Dr. Barker stated that the Connecting with the Community Charter outlined the purpose and overall responsibility of the Connecting with the Community Ad Hoc Committee.

Mr. Otu asked If the responsibilities would include the recruitment of more Governing Council Members.

Dr. Barker mentioned the responsibilities of recruitment rely on the current Governing Council.

General Session, Presentation, Discussion and Action, cont.:

8. Discussion and Possible Action on a Charter for the Valleywise Community Health Centers Governing Council's Connecting with the Community Ad Hoc Committee, cont.

MOTION: Mr. Arbuckle moved to approve the charter for the Valleywise Health Centers Governing Council's Connecting with the Community Ad Hoc Committee. Ms. Muñoz seconded.

VOTE: 11 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
Motion passed.

9. Federally Qualified Health Centers' Chief Executive Officer's Report, including Ambulatory Operational Dashboards

Dr. Barker reviewed the Valleywise Health FQHC strategic dashboard for December 2024. She planned on revising the metrics included and would present those metrics to the Governing Council.

She was in the midst of a campaign to recruit new Governing Council members.

She announced Dr. Merima Bucaj, was the interim FQHC medical director, noting Dr. Christina Smarik-Snyder stepped down but would still be involved.

11. Governing Council Member Closing Comments/Announcements.

Chairman Jacobson mentioned he attended the grand opening event for the Mesa Behavioral Health Specialty clinic on January 23, 2025.

Adjourn

MOTION: Mr. Hooper moved to adjourn the February 5, 2025, Valleywise Community Health Centers Governing Council Meeting. Ms. Wilson seconded.

VOTE: 11 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Otu, Mr. Tormala, Ms. Wilson
0 Nays
Motion passed.

Meeting adjourned at 6:52 p.m.

_____
Denise Tapia
Deputy Clerk of the Board

1.b.i Medical Staff

Recommended by Credentials Committee: December 3, 2024
Recommended by Medical Executive Committee: December 7, 2024
Submitted to MSHCDB: January 22, 2025

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
MEDICAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

INITIAL MEDICAL STAFF APPOINTMENT				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
Michael Joseph Christie, M.D.	Courtesy	Obstetrics & Gynecology	2/1/2025 to 1/31/2027	
Victoria Elizabeth Wadman, D.O.	Active	Family & Community Medicine	2/1/2025 to 1/31/2027	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Ahmed Abdel Kerim, M.D.	Internal Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Core privileges.
Rami Abusaleh, M.D.	Internal Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Core privileges.
Daniel Adam Davis, M.D.	Internal Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Core privileges.
Omair Hasan, M.D.	Internal Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Core privileges.
Sandeep Randhawa, M.D.	Pediatrics	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Pediatric & Adolescent Core privileges.
Rex H. Ragsdale, M.D.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for In-Patient Core Adult Cognitive and Adult Procedural privileges.

Recommended by Credentials Committee: December 3, 2024
Recommended by Medical Executive Committee: December 7, 2024
Submitted to MSHCDB: January 22, 2025

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
Linda R. Chambliss, M.D.	Active	Obstetrics & Gynecology	2/1/2025 to 1/31/2027	
Rex H. Ragsdale, M.D.	Active	Family & Community Medicine	2/1/2025 to 1/31/2027	
Sandeep Randhawa, M.D.	Active	Pediatrics	2/1/2025 to 1/31/2027	

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Abhijeet S. Namjoshi, M.D.	Pediatrics	Courtesy to Inactive	Resigned effective November 25, 2024
Kristyn Marie Wendelschafer, D.O.	Family & Community Medicine	Active to Inactive	Resigned effective April 19, 2024

Definitions:

Active	≥ 1,000 hours/year – Active members of the medical staff have voting rights and can serve on medical staff committees
Courtesy	< 1,000 hours/year – Courtesy members do not have voting rights and do not serve on medical staff committees
Reappointments	Renewal of appointment and privileges is for a period of two years unless otherwise specified for a shorter period of time.
FPPE	Focused professional practice evaluation is a process by which the organization validates current clinical competence. This process may also be used when a question arises in practice patterns.

Recommended by Credentials Committee: January 7, 2025
Recommended by Medical Executive Committee: January 14, 2025
Submitted to MSHCDB: January 22, 2025

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
MEDICAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

INITIAL MEDICAL STAFF APPOINTMENT				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
Katherine Brandee Glaser, M.D.	Courtesy	Obstetrics & Gynecology	2/1/2025 to 1/31/2027	
Hardhipriya Sudarsanam, M.D.	Active	Family & Community Medicine	2/1/2025 to 1/31/2027	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Tracy Anne Contant, M.D.	Obstetrics & Gynecology	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Obstetrics Core privileges.

Recommended by Credentials Committee: January 7, 2025
Recommended by Medical Executive Committee: January 14, 2025
Submitted to MSHCDB: January 22, 2025

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
Tracy Anne Contant, M.D.	Active	Obstetrics & Gynecology	2/1/2025 to 1/31/2027	
Fawad Rast, M.D.	Courtesy	Internal Medicine	2/1/2025 to 1/31/2027	
Suhair N. Stipho-Majeed, M.D.	Active	Internal Medicine	2/1/2025 to 1/31/2027	
Bruce A. Takahashi, D.O.	Active	Internal Medicine	2/1/2025 to 1/31/2027	
Thomas Q. Zheng, M.D.	Courtesy	Obstetrics & Gynecology	2/1/2025 to 1/31/2027	

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Nothing to report			

Definitions:

Active	≥ 1,000 hours/year – Active members of the medical staff have voting rights and can serve on medical staff committees
Courtesy	< 1,000 hours/year – Courtesy members do not have voting rights and do not serve on medical staff committees
Reappointments	Renewal of appointment and privileges is for a period of two years unless otherwise specified for a shorter period of time.
FPPE	Focused professional practice evaluation is a process by which the organization validates current clinical competence. This process may also be used when a question arises in practice patterns.

Recommended by Credentials Committee: December 3, 2024
Recommended by Medical Executive Committee: December 7, 2024
Submitted to MSHCDB: January 22, 2025

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Nothing to report				

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Lorna Ann Hill, A.G.N.P.	Internal Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Nurse Practitioner Core privileges.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Georgina Amaya, F.N.P., D.N.P.	Internal Medicine	Practice Prerogatives on file	2/1/2025 to 1/31/2027	

RESIGNATION (Information Only)			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Emily Rose Corazza, C.N.M.	Obstetrics & Gynecology	Allied Health Professional to Inactive	Resigned effective November 19, 2024
Marisa Irene Rebeka, F.N.P.	Internal Medicine	Allied Health Professional to Inactive	Resigned effective January 22, 2025
Brittney Kathleen Whitney, W.H.N.P.	Obstetrics & Gynecology	Allied Health Professional to Inactive	Resigned effective January 09, 2025

CORRECTION TO THE NOVEMBER 26, 2024 VALLEYWISE HEALTH CARE DISTRICT BOARD MEETING ROSTER			
NAME	**DEPARTMENT/SPECIALTY**	**CATEGORY**	**COMMENTS**
Samantha Ari Bianchi, P.A.-C.	Family & Community Medicine	Allied Health Professional	Provider was inadvertently listed for resignation.

Recommended by Credentials Committee: December 3, 2024
Recommended by Medical Executive Committee: December 7, 2024
Submitted to MSHCDB: January 22, 2025

General Definitions:

Advanced Practice Clinician	An Advanced Practice Clinicians (APC) means individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.
Allied Health Professional	An Allied Health Professional (AHP) means individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.
Practice Prerogatives	Scopes of practice summarizing qualifications for the respective category, developed with input from the physician director of the clinical service and the observer/sponsor/responsible party of the AHP, Department Chair, and other representatives of the Medical Staff, Hospital management, and other professionals.

Supervision Definitions:

(1) General Supervision	The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure or provision of the services.
(2) Direct Supervision	The physician must be present in the office suite or on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
(3) Personal Supervision	A physician must be in the room during the performance of the procedure.

Recommended by Credentials Committee: January 7, 2025
Recommended by Medical Executive Committee: January 14, 2025
Submitted to MSHCDB: January 22, 2025

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL STAFF

The credentials of the following individuals including, current licensure, relevant training and experience, malpractice insurance, current competence and the ability to perform the requested privileges have been verified.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Diamond Marie Radivoyevich, F.N.P.	Pediatrics	Practice Prerogatives on file	2/1/2025 to 1/31/2027	
Caitlin Ann Teefy, P.A.-C.	Internal Medicine	Practice Prerogatives on file	2/1/2025 to 1/31/2027	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Nothing to report			

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Yvonne Rae Downs, C.N.M., D.N.P.	Obstetrics & Gynecology	Practice Prerogatives on file	2/1/2025 to 1/31/2027	
Sabina T. Szabala, N.N.P.	Pediatrics	Practice Prerogatives on file	2/1/2025 to 1/31/2027	

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Ashley Nicole Rush, F.N.P.	Obstetrics & Gynecology	Addition: Fetal Monitoring privileges	FPPE

RESIGNATION (Information Only)			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Darna Khav Long, A.G.N.P.	Internal Medicine	Allied Health Professional to Inactive	Provider is no longer contracted with DMG effective December 1, 2024

General Definitions:

Advanced Practice Clinician — An Advanced Practice Clinicians (APC) means individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.

Allied Health Professional — An Allied Health Professional (AHP) means individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.

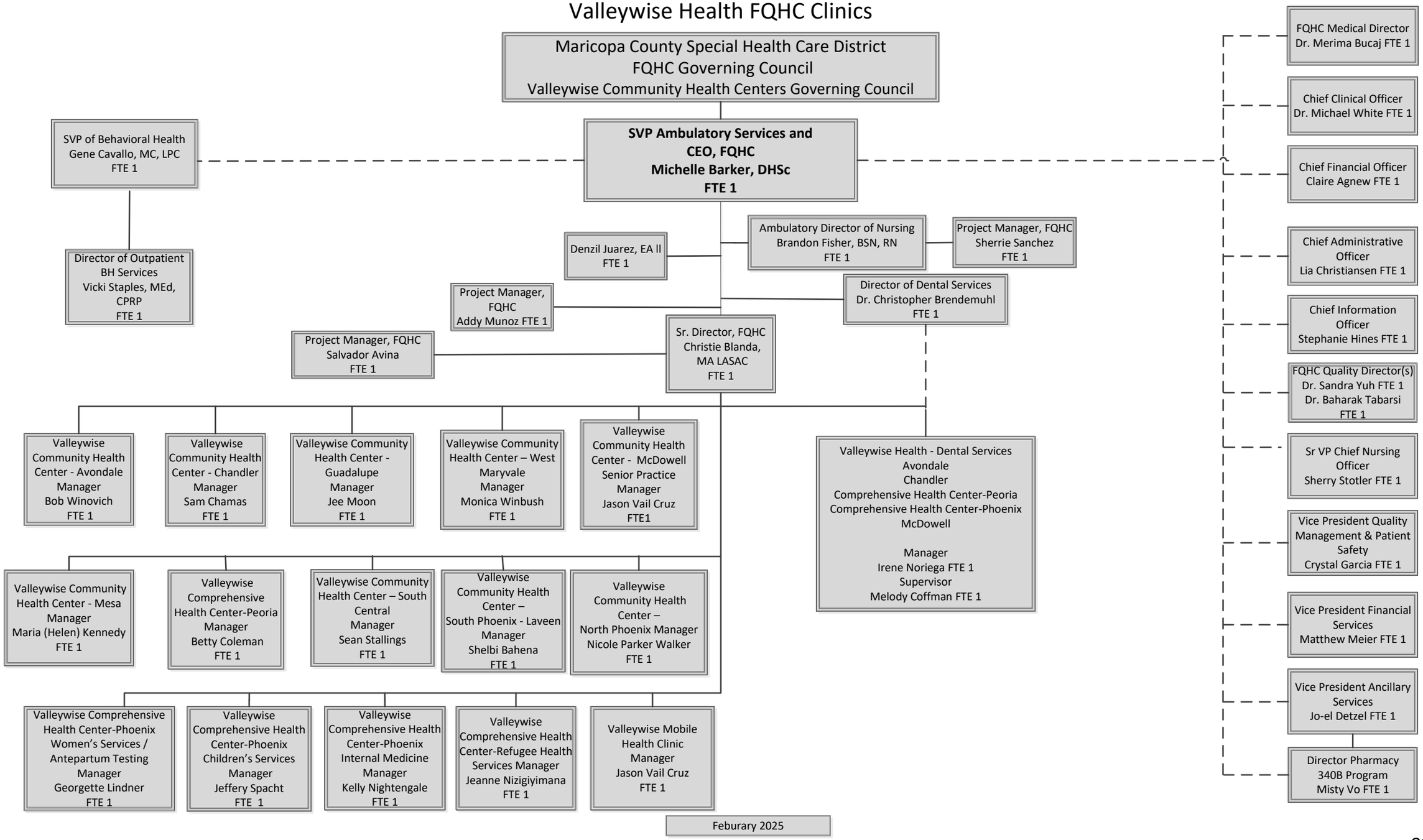
Practice Prerogatives	Scopes of practice summarizing qualifications for the respective category, developed with input from the physician director of the clinical service and the observer/sponsor/responsible party of the AHP, Department Chair, and other representatives of the Medical Staff, Hospital management, and other professionals.

Supervision Definitions:

(1) General Supervision	The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure or provision of the services.
(2) Direct Supervision	The physician must be present in the office suite or on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.
(3) Personal Supervision	A physician must be in the room during the performance of the procedure.

3. FQHC Organizational Chart

Maricopa County Special Health Care District
Valleywise Health FQHC Clinics



4. FQHC Poverty Level Guidelines

202~~4~~5 Federal Poverty Levels

HHS Poverty Guidelines for 202~~4~~5

The 2024 poverty guidelines are in effect as of January 17, 202~~4~~5.

Federal Register :: Annual Update of the HHS Poverty Guidelines

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$15,650~~060~~
2	$2~~1~~0,150~~440~~
3	$2~~6~~5,650~~820~~
4	$3~~2~~1,150~~200~~
5	$3~~7~~6,650~~580~~
6	$4~~3~~1,150~~960~~
7	$4~~8~~7,650~~340~~
8	$5~~4~~2,150~~720~~
For families/households with more than 8 persons, add $5,500~~380~~ for each additional person.	

2025 Federal Poverty Levels

HHS Poverty Guidelines for 2025

The 2024 poverty guidelines are in effect as of January 17, 2025.

Federal Register :: Annual Update of the HHS Poverty Guidelines

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
Persons in family/household	**Poverty guideline**
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

4. FQHC Sliding Fee Discount Program Policy

Valleywise Health Administrative Policy & Procedure

Effective Date: **05/15**

Reviewed Dates: **03/24**

Revision Dates: **01/18, 07/18, 09/18, 10/18, 02/20, 09/21, 08/22, 10/23, 11/23, 05/24, 03/25**

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

Scope:
[ ] District Governance (G)
[ ] System-Wide (S)
[X] Division (D)
[ ] Multi-Division (MD)
[ ] Department (T)
[ ] Multi-Department (MT)
[X] FQHC (F)

Purpose: In accordance with the Health Resources and Services Administration (HRSA) Health Center Program Compliance Manual, Chapter 9: Sliding Fee Discount Program, HRSA Valleywise Health's Federally Qualified Health Centers (FQHCs) established a sliding fee discount program that includes a schedule of fees for services, a schedule of discounts for services, or a sliding fee discount schedule, that minimizes financial barriers to care for patients who meet certain eligibility criteria.
This policy establishes the procedure for those patients who meet eligibility criteria to have access to necessary health care services at Valleywise Health's FQHC designated clinics at costs based on their ability to pay as determined by their gross annual household income and family size.

Definitions:
Advanced Practice Clinicians (APCs): Individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.

Deposit: Initial payment applied toward the total fees due.

FQHC Sliding Fee Discount Program: A program which ensures that Valleywise Health's FQHC Health Center patients have access to all services that are available at the health center. The program seeks to provide its services to eligible patients and minimize financial barriers, all according to the following elements:

+ A schedule of fees for services.

+ A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's family size and income.

+ Board of Director and Valleywise Community Health Centers Governing Council (VCHCGC) approved policies and Valleywise Health's supporting operating policies and procedures, including billing and collections.

Family Size / Household: Immediate family members including head of household, legal guardians, spouse, domestic partners, same gender marriage, and children under the age of 19 will be classified as part of the household. Individuals and family members temporarily living / sharing quarters or foreign visitors, where permanent residence will not be maintained, will not be considered as part of the household. Adults that are living in the household that are self-sufficient and are not included in the "household" are considered individually for eligibility.

Income / Annual Household Income: Gross annual income before deductions include the following: Earnings, unemployment compensation, worker's compensation, social security, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, estates and trusts, educational assistance, alimony and/or child support, financial assistance from outside of the household, and/or other sources of income.

Low Income: Annual income = less than or equal to 200% of the current Federal Poverty Level.

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board of Directors of Valleywise Health. Medical Staff are also referred to as Attendings and for purposes of this policy is synonymous with Provider.

Nominal Fee / Nominal Charge: The amount charged for services to patients at or below 100% of the Federal Poverty Level (FPL). It is designed to help patients invest in their care and minimize the potential for inappropriate utilization of services. The nominal charge is a fixed fee that does not reflect the value of the service(s) provided and is considered nominal from the perspective of the patient. Nominal charges are not "minimum fees," "minimum charges," or "co-pays." The nominal fee must not impede the patient in accessing services due to their ability to pay.

Presumptive Eligibility Screening System: An automated software tool that predicts the likelihood of a patient to qualify for the Sliding Fee Program based on publicly available data sources. The tool provides estimates of the patient's household income and size.

Valleywise Health Clinic Manager: The Valleywise Heath clinic manager is responsible for the supervision, direction, and coordination of the day to day operations of the assigned Valleywise Health clinic.

Policy: A Sliding Fee Discount Schedule (SFDS) is used to determine the nominal fee and /or dollar amount of any given fee which the eligible patient is expected to pay. The SFDS is based on current FPL Guidelines and is adjusted annually based on gross annual household income and family size in the household. Under this policy, the

patient is responsible for one hundred percent (100%) of the fees charged for the services rendered. However, the SFDS offers to the patient a method of satisfying the debt when the patient's resources are limited.

Valleywise Health recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Valleywise Health utilizes an automated, predictive scoring tool provided by our third-party vendor to assess patients for financial need. This screening process utilizes public record data and includes estimates for income and household size.

Procedure:

I. Eligibility

A. Valleywise Health will inform patients about the availability of the Sliding Fee Discount Program through signage, personal reminders and other methods of communication. As part of the preregistration or registration process, the Valleywise Health eligibility specialist or other front office staff will inform patients that are not informed of the SFDS.

B. Patients whose income exceeds 200% of the FPL Guidelines are not eligible for discounts on the Sliding Fee Discount Program. (Appendix A)

C. Valleywise Health uses two types of screening to determine eligibility for the Sliding Fee Discount Program: Presumptive and Traditional.
+ Presumptive screening is the initial process used to determine a patient's eligibility for the Sliding Fee Discount Program.
+ Traditional screening is completed for patients who disagree with the Sliding Fee level assigned by the Presumptive Eligibility Screening System.

D. Patients applying via the Traditional screening for the Sliding Fee Discount Program must provide written verification of monthly income (see Appendix A).
Examples include:
+ Previous year federal tax returns.
+ Paycheck stubs for each adult working in the household.
+ A signed statement from the patient's employer stating rate of pay, average number of hours worked weekly and hire date.
+ Quarterly tax statement for those self-employed.
+ Unemployment benefit letter.
+ Benefit letter from Social Security showing monthly payment received for each person in the household.
+ Documentation of child support and/or alimony (divorce paperwork, etc.)
+ Copy of pension / retirement benefits.
+ Copy of Veterans benefits.
+ Full time unemployed students: Provide proof of student status.
+ Federal or State support: Example: Food stamps, the packet received with approval is required, this includes start and stop dates and Food Stamp Summary page.

E. Valleywise Health will verify patient eligibility, at minimum, on an annual basis.

F. Patients unable or unwilling to provide verification may be eligible for self-declaration of income which will be used in special circumstances. Patients

unable to provide written verification of income must provide a signed statement of income, and why he / she are unable to provide independent verification. This written statement is subject to management review and final determination as to the sliding fee category eligibility. Self–declaration applies to one visit only within a 12-month period and the patient must provide the required written verification of income of the items in Appendix A, within 30 days following the one time visit in order to remain eligible to participate in the Sliding Fee Discount Program. The assigned category will be retroactive for 30 days. (Appendix B)

G. Patients applying for the Sliding Fee Discount Program will be informed that they will need to contact Valleywise Health if their income or household status changes.

H. Situational waivers can be approved based on catastrophic situations or significant changes in guarantor income.
   + If during the process of discussing an outstanding balance with a patient or reviewing payment plan options a situation or change is brought up that would impact the ability to pay, a request will be forwarded to the Director of Patient Financial Services for review.
   + After review of a guarantor's significant change in ability to pay an approval may be granted for a waiver of all or some of the guarantor's outstanding balance.
   + Activities related to the review for waiver and approval, or declination will be documented in the patient accounting system.

II. Sliding Fee Discount Schedule

A. The Sliding Fee Discount Schedule and corresponding rates and policies for administration of the Sliding Fee Discount Program will be reviewed and updated annually.

B. The updated FPL income guidelines will be obtained from the Federal Register annually. The Poverty Guidelines document and corresponding systems will be updated promptly following the federal update.

C. Services covered by Sliding Fee Discount Program must be medically necessary, as determined by the health care provider. If additional services or tests are desired by the patient, including immunizations, they must be paid for in advance. Similarly, certain high cost procedures, elective procedures and lab tests with less expensive options are exempted from sliding fee discounts.

III. Billing and Collection Schedules

A. The patient will be advised that the applicable fee, including the nominal fee, is expected at the time of service. In the event the patient is unable to pay at the time of service, the patient will be informed that they will be billed. Patients are expected to make payment in full within 90 days or establish a payment plan, including making payment(s) on their outstanding bill, with a Valleywise Health financial counselor.

B. An inability to pay will not impede access to care. Payment arrangements may be made through Patient Financial Services in accordance with policy #09003 S Revenue Cycle/Business Office: Payment Plans. This will be determined on an individual basis. Factors that may be considered in making this determination include large outstanding medical bills which place a client under extreme

financial duress. Despite current income, staff are asked to apprise the clinic manager of the circumstances so that further discounts may be offered to the patient to facilitate his / her receipt of medically necessary services.

C. Refusal to pay will not impede access to care. Patients refusing to pay the nominal fee will not be denied care. Payment and/or payment arrangements may be made through Patient Financial Services in accordance with applicable policies.
D. Insured patients qualifying for Sliding Fee after insurance will be billed for the lessor of the copay/co-insurance assigned by their insurance company or the Sliding Fee Discount amount.

IV. Governing Body Oversight

A. Updates to the Sliding Fee Discount Program and proposed policy changes will be presented every 3 years to the by Valleywise Health Governing Council and the District's Board of Directors for approval.

B. The Sliding Fee Discount Schedule will be presented annually to the Valleywise Health Governing Council and the District's Board of Directors for approval.

C. Sliding Fee Level Utilization information will be reviewed and discussed annually to ensure no barriers to care exist.

References: HRSA Health Center Program Compliance Manual, released August 2018
CHC & FHC Internal and External Referrals Policy # 20006 S

Valleywise Health Policy & Procedure – Approval Sheet
(**Before submitting, fill out COMPLETELY**.)

POLICY RESPONSIBLE PARTY: Valleywise Health Vice President of Revenue Cycle
DEVELOPMENT TEAM(S): Patient Financial Services, Valleywise Community Health Centers Administration, and Revenue Integrity Management
Policy #: 23624 D
Policy Title: FQHC Sliding Fee Discount Program
e-Signers: Amanda De Los Reyes, VP Revenue Cycle
Place an X on the right side of applicable description:
New –
Retire – Reviewed –
Revised with Minor Changes – X
Revised with Major Changes –
Please list revisions made below: (Other than grammatical changes or name and date changes)
Reviewed and Approved by in Addition to Responsible Party and E-Signer(s):
Required Approval: Valleywise Community Health Centers Governing Council **035/254**
Required Approval: Maricopa County Special Health Care District Board of Directors **05/24**
Required Approval: Michelle Barker, Sr VP Ambulatory Services and CEO FQHC Clinics **033/254**
Required Approval: Vanessa Couch-Laguana, Director Patient Financial Services **033/254**
Committee:
Other:

Appendix A

VALLEYWISE HEALTH FINANCIAL/DISCOUNTED POLICIES

Sliding Fee- Free Pregnancy Test- Prenatal Care-Maternity Agreements, Healthy (E)
AHCCCS Applications- Family Planning Program for Women
Thank you for your interest in Valleywise Health's medical programs. To assist you better please provide the following information at the time of your interview. Please provide documents from each of the following categories.

Proof of income for the past 30 days from interview date for EVERYONE in the household

- ✓ Current award letter from DES if receiving cash assistance or food stamps
- ✓ Paycheck stubs (4) if paid weekly, (2) if paid bi-weekly
- ✓ Employer statements on letterhead / business card or notarized.
- ✓ Unemployment income
- ✓ Social Security award letter or copy of check for all household members
- ✓ Veteran's Benefits
- ✓ Pensions
- ✓ Workman's Compensation
- ✓ Child support/Alimony
- ✓ Record of earnings from self-employment or odd jobs (Income calendar if paid in cash)
- ✓ Grants, scholarships or educational benefit letters
- ✓ Current bank statements, **checking and savings** for all household members
- ✓ Statement of support from person **providing** support

Self Employed Clients 30 days from interview date

- ✓ Bank statements
- ✓ Check stubs
- ✓ Income vouchers or receipts
- ✓ Income statement from person/company paying for the services rendered
- ✓ Income calendar or any other documentation
- ✓ Statements/calendars must display dates and total amount of payment and current tax returns
- ✓ All business expenses

Proof of Address/Monthly Household Monthly Expenses within 30 days from the interview date
(All that applies)

- ✓ Rent or lease agreement/mortgage payment
- ✓ Utility receipt electric, gas, water, phone, cable, internet, car insurance, bank statement
- ✓ Letter from Landlord or a neighbor if utility bills under someone else's name
- ✓ Current registration for school aged children

Proof of dependents/relationship

- ✓ Children's birth or baptismal certificates **(Even if child is already insured)**
- ✓ Marriage License
- ✓ Proof of Pregnancy (if applicable)
- ✓ Receipt from social security administration

Proof of Identity (Not required and inability to provide will not disqualify for Sliding Fee)

- ✓ Birth or Baptismal Certificate
- ✓ Naturalization/Citizenship Certificate
- ✓ Driver's license/Photo ID for everyone over 18 years of age
- ✓ Lawful Permanent Resident Card

- ✓ Employment Authorization Card
- ✓ Passport Visa
- ✓ Passport-INS-194

Appendix A

PÓLIZAS FINANCIERAS/DE DESCUENTOS DE VALLEYWISE HEALTH

Programa de Descuento - Pruebas de embarazo sin costo - Cuidado prenatal - Acuerdos de maternidad - Solicitudes para Healthy (E) AHCCCS - Programa de planificación familiar para mujeres

Gracias por su interes en los programas medicos de Valleywise Health. Para asistirle mejor, por favor traiga la siguiente información el día de su entrevista. Por favor proporcione documentos para cada una de las siguientes categorías.

Comprobante de ingresos de los últimos 30 días antes de la fecha de su entrevista de TODOS los que viven en la casa.

- ✓ Carta más reciente del Departamento de Servicios Económicos (DES) si recibe asistencia económica en efectivo, o estampillas de comida
- ✓ Talones de cheque (4) si el pago es semanal, (2) si el pago es cada dos semanas
- ✓ Una declaración por escrito del empleador en papel con el membrete/tarjeta del negocio o notariada
- ✓ Información sobre ingresos de desempleo
- ✓ Carta de aceptación o copia de cheques del Seguro Social para todos los que viven en su casa
- ✓ Beneficios de veterano
- ✓ Pensiones
- ✓ Información de ingresos del seguro de compensación laboral
- ✓ Manutención de hijos/pensión alimenticia
- ✓ Registro de ingresos de trabajo por cuenta propia/o trabajos ocasionales
- ✓ Cartas de subsidios, becas u otros beneficios educacionales
- ✓ Estados actuales de cuenta bancaria, de ahorros y cheques para todos los que viven en su casa
- ✓ Carta de apoyo de la persona que lo mantiene

Clientes con Trabajo por Cuenta Propia Comprobante de los 30 días antes de la Entrevista

- ✓ Estados de cuenta bancaria
- ✓ Talones de cheque
- ✓ Vales o recibos de ingresos
- ✓ Declaración de ingresos de la persona/compañía que paga por los servicios proporcionados
- ✓ Calendario de ingresos o cualquier otro documento
- ✓ Las/los declaraciones/calendarios deben mostrar fechas y cantidad total del pago y devoluciones de impuestos actuales
- ✓ Todos los gastos del negocio

Comprobante de domicilio/gastos mensuales del hogar: Debe incluir los gastos dentro de los 30 días antes de la fecha de la entrevista (todo lo que corresponda).

- ✓ Recibo de pago o contrato de renta/hipoteca
- ✓ Recibos de luz, gas, agua, teléfono, cable, Internet, seguro del carro, cuenta de banco.
- ✓ Carta del arrendador o de un vecino si los recibos de servicios públicos están a nombre de alguien más
- ✓ Comprobante de la inscripción escolar actual de los niños

Comprobante de dependientes/parentesco

- ✓ Acta de nacimiento o certificado de bautismo de los niños (incluso si el menor ya tiene Seguro medico)
- ✓ Acta de matrimonio
- ✓ Prueba de embarazo (si corresponde)

Prueba de identidad (No es obligatorio y si no puede proporcionarlo, no será descalificado de los programas de descuento)

- ✓ Acta de nacimiento o certificado de bautismo
- ✓ Certificado de naturalización/ciudadanía
- ✓ Licencia para manejar o identificación con foto de todas las personas mayores de 18 años
- ✓ Tarjeta de residencia permanente legal
- ✓ Tarjeta de permiso para trabajar
- ✓ Pasaporte visado
- ✓ Pasaporte-INS-194

Si tiene alguna pregunta acerca de los documentos indicados anteriormente, por favor llame a 602-344-2550

Appendix B

MRN:

SELF-DECLARATION/DECLARACION: DATE/FECHA: _____

SIGNATURE/FIRMA: _____

Revised 02/2012

Appendix C

Valleywise Health

Federally Qualified Health Center Sliding Fee Discount Schedule

Effective 05/15 Reviewed/Revised 0~~3~~5/25~~3~~4

Valleywise Health
Federally Qualified Health Center Sliding Fee Discount Schedule

Effective 05/15 Reviewed/Revised 03/25

Medical

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5	
Federal Poverty Level Scale	0-100%	101-138%	139-150%	151-200%	>201% FPL	>251% FPL
Primary Care	$20 Nominal Charge	$30 Flat Fee	$40 Flat Fee	$50 Flat Fee	No Discount	
Immunization for Flu*	$20	$20	$20	$20	$20	
Immunization for Covid*	100% cost	100% cost + $12	115% cost + $13	125% cost + $14	150% cost + $15	
Family Planning Services - Maryvale Clinic Only	$0	$20	$30	$40	201-250% FPL $50	>251% FPL No Discount
FQHC Specialty Visits (Example - Cardiology)	$50 Nominal Charge	$70 Flat Fee	$80 Flat Fee	$90 Flat Fee	No Discount	
Outpatient Ancillary Services (Lab)	$10 Nominal Charge	25% of Medicare rate - 50% due prior to service ($20 minimum)	50% of Medicare rate - 50% due prior to service ($30 Minimum)	75% of Medicare rate - 50% due prior to service ($40 minimum)	No Discount	
Outpatient Ancillary Services (Imaging)	$30 Nominal Charge	25% of Medicare rate - 50% due prior to service ($40 minimum)	50% of Medicare rate - 50% due prior to service ($50 Minimum)	75% of Medicare rate - 50% due prior to service ($60 minimum)	No Discount	

*Unless covered by another source, such as a grant

Dental

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	0-100%	101-138%	139-150%	151-200%	>201% FPL
Diagnostic Dental Services	$10 Nominal Charge	$15 Flat Fee	$20 Flat Fee	$25 Flat Fee	$30 Flat Fee
Restorative Dental Services *See Grid Below	$50 Nominal Charge + Cost of Supplies	75% of Delta Dental allowable rates	80% of Delta Dental allowable rates	85% of Delta Dental allowable rates	100% of Delta Dental allowable rates
Dental Lab Services	$50 Nominal Charge + Cost of Supplies	85% of Delta Dental allowable rates	90% of Delta Dental allowable rates	95% of Delta Dental allowable rates	100% of Delta Dental allowable rates

Restorative Grid	Category 1	Category 2	Category 3	Category 4	Category 5
Filling	$25.00	$35.00	$50.00	$75.00	$80.00
Crowns Simple	$75.00	$100.00	$125.00	$150.00	$175.00
Crowns	$250.00	$400.00	$450.00	$475.00	$500.00
Dentures - Temporary	$100.00	$200.00	$250.00	$300.00	$350.00
Dentures - partial	$300.00	$350.00	$400.00	$450.00	$500.00
Dentures - complete	$350.00	$795.00	$842.00	$865.00	$900.00
Bridges - Temporary	$50.00	$100.00	$150.00	$200.00	$225.00
Bridges	$200.00	$250.00	$300.00	$350.00	$375.00
Extractions - simple	$50.00	$62.00	$66.00	$70.00	$83.00
Extractions - complex	$100.00	$110.00	$125.00	$135.00	$145.00

** Please note all payments will be requested prior to service.*

Valleywise Health Protocol – Tracking Form (Not Part Of Policy)
(Before submitting, fill out COMPLETELY.)

POLICY RESPONSIBLE PARTY: Valleywise Health Vice President of Revenue Cycle

DEVELOPMENT TEAM(S): Patient Financial Services, Valleywise Community Health Centers Administration, and Revenue Integrity Management

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

e-Signers: Amanda De Los Reyes, VP Revenue Cycle

Place an X on the right side of applicable description:

New -

Retire - **Reviewed -**

Revised with Minor Changes - X

Revised with Major Changes -

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Required Approval: Michelle Barker, Sr VP Ambulatory Services and CEO FQHC Clinics **03/25**

Required Approval: Vanessa Couch-Laguana, Director Patient Financial Services **03/25**

Committee:

Other:

Valleywise Health Administrative Policy & Procedure

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Reviewed Dates: **03/24**

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+ A schedule of fees for services.

+ A corresponding schedule of discounts for eligible patients that is adjusted based on the patient's family size and income.

+ Board of Director and Valleywise Community Health Centers Governing Council (VCHCGC) approved policies and Valleywise Health's supporting operating policies and procedures, including billing and collections.

Family Size / Household: Immediate family members including head of household, legal guardians, spouse, domestic partners, same gender marriage, and children under the age of 19 will be classified as part of the household. Individuals and family members temporarily living / sharing quarters or foreign visitors, where permanent residence will not be maintained, will not be considered as part of the household. Adults that are living in the household that are self-sufficient and are not included in the "household" are considered individually for eligibility.

Income / Annual Household Income: Gross annual income before deductions include the following: Earnings, unemployment compensation, worker's compensation, social security, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, estates and trusts, educational assistance, alimony and/or child support, financial assistance from outside of the household, and/or other sources of income.

Low Income: Annual income = less than or equal to 200% of the current Federal Poverty Level.

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board of Directors of Valleywise Health. Medical Staff are also referred to as Attendings and for purposes of this policy is synonymous with Provider.

Nominal Fee / Nominal Charge: The amount charged for services to patients at or below 100% of the Federal Poverty Level (FPL). It is designed to help patients invest in their care and minimize the potential for inappropriate utilization of services. The nominal charge is a fixed fee that does not reflect the value of the service(s) provided and is considered nominal from the perspective of the patient. Nominal charges are not "minimum fees," "minimum charges," or "co-pays." The nominal fee must not impede the patient in accessing services due to their ability to pay.

Presumptive Eligibility Screening System: An automated software tool that predicts the likelihood of a patient to qualify for the Sliding Fee Program based on publicly available data sources. The tool provides estimates of the patient's household income and size.

Valleywise Health Clinic Manager: The Valleywise Heath clinic manager is responsible for the supervision, direction, and coordination of the day to day operations of the assigned Valleywise Health clinic.

Policy: A Sliding Fee Discount Schedule (SFDS) is used to determine the nominal fee and /or dollar amount of any given fee which the eligible patient is expected to pay. The SFDS is based on current FPL Guidelines and is adjusted annually based on gross annual household income and family size in the household. Under this policy, the

patient is responsible for one hundred percent (100%) of the fees charged for the services rendered. However, the SFDS offers to the patient a method of satisfying the debt when the patient's resources are limited.

Valleywise Health recognizes that a portion of the uninsured or underinsured patient population may not engage in the traditional financial assistance application process. If the required information is not provided by the patient, Valleywise Health utilizes an automated, predictive scoring tool provided by our third-party vendor to assess patients for financial need. This screening process utilizes public record data and includes estimates for income and household size.

Procedure:

I. Eligibility

A. Valleywise Health will inform patients about the availability of the Sliding Fee Discount Program through signage, personal reminders and other methods of communication. As part of the preregistration or registration process, the Valleywise Health eligibility specialist or other front office staff will inform patients that are not informed of the SFDS.

B. Patients whose income exceeds 200% of the FPL Guidelines are not eligible for discounts on the Sliding Fee Discount Program. (Appendix A)

C. Valleywise Health uses two types of screening to determine eligibility for the Sliding Fee Discount Program: Presumptive and Traditional.
+ Presumptive screening is the initial process used to determine a patient's eligibility for the Sliding Fee Discount Program.
+ Traditional screening is completed for patients who disagree with the Sliding Fee level assigned by the Presumptive Eligibility Screening System.

D. Patients applying via the Traditional screening for the Sliding Fee Discount Program must provide written verification of monthly income (see Appendix A).
Examples include:
+ Previous year federal tax returns.
+ Paycheck stubs for each adult working in the household.
+ A signed statement from the patient's employer stating rate of pay, average number of hours worked weekly and hire date.
+ Quarterly tax statement for those self-employed.
+ Unemployment benefit letter.
+ Benefit letter from Social Security showing monthly payment received for each person in the household.
+ Documentation of child support and/or alimony (divorce paperwork, etc.)
+ Copy of pension / retirement benefits.
+ Copy of Veterans benefits.
+ Full time unemployed students: Provide proof of student status.
+ Federal or State support: Example: Food stamps, the packet received with approval is required, this includes start and stop dates and Food Stamp Summary page.

E. Valleywise Health will verify patient eligibility, at minimum, on an annual basis.

F. Patients unable or unwilling to provide verification may be eligible for self-declaration of income which will be used in special circumstances. Patients

unable to provide written verification of income must provide a signed statement of income, and why he / she are unable to provide independent verification. This written statement is subject to management review and final determination as to the sliding fee category eligibility. Self–declaration applies to one visit only within a 12-month period and the patient must provide the required written verification of income of the items in Appendix A, within 30 days following the one time visit in order to remain eligible to participate in the Sliding Fee Discount Program. The assigned category will be retroactive for 30 days. (Appendix B)

G. Patients applying for the Sliding Fee Discount Program will be informed that they will need to contact Valleywise Health if their income or household status changes.

H. Situational waivers can be approved based on catastrophic situations or significant changes in guarantor income.
   + If during the process of discussing an outstanding balance with a patient or reviewing payment plan options a situation or change is brought up that would impact the ability to pay, a request will be forwarded to the Director of Patient Financial Services for review.
   + After review of a guarantor's significant change in ability to pay an approval may be granted for a waiver of all or some of the guarantor's outstanding balance.
   + Activities related to the review for waiver and approval, or declination will be documented in the patient accounting system.

II. Sliding Fee Discount Schedule

A. The Sliding Fee Discount Schedule and corresponding rates and policies for administration of the Sliding Fee Discount Program will be reviewed and updated annually.

B. The updated FPL income guidelines will be obtained from the Federal Register annually. The Poverty Guidelines document and corresponding systems will be updated promptly following the federal update.

C. Services covered by Sliding Fee Discount Program must be medically necessary, as determined by the health care provider. If additional services or tests are desired by the patient, including immunizations, they must be paid for in advance. Similarly, certain high cost procedures, elective procedures and lab tests with less expensive options are exempted from sliding fee discounts.

III. Billing and Collection Schedules

A. The patient will be advised that the applicable fee, including the nominal fee, is expected at the time of service. In the event the patient is unable to pay at the time of service, the patient will be informed that they will be billed. Patients are expected to make payment in full within 90 days or establish a payment plan, including making payment(s) on their outstanding bill, with a Valleywise Health financial counselor.

B. An inability to pay will not impede access to care. Payment arrangements may be made through Patient Financial Services in accordance with policy #09003 S Revenue Cycle/Business Office: Payment Plans. This will be determined on an individual basis. Factors that may be considered in making this determination include large outstanding medical bills which place a client under extreme

financial duress. Despite current income, staff are asked to apprise the clinic manager of the circumstances so that further discounts may be offered to the patient to facilitate his / her receipt of medically necessary services.

C. Refusal to pay will not impede access to care. Patients refusing to pay the nominal fee will not be denied care. Payment and/or payment arrangements may be made through Patient Financial Services in accordance with applicable policies.
D. Insured patients qualifying for Sliding Fee after insurance will be billed for the lessor of the copay/co-insurance assigned by their insurance company or the Sliding Fee Discount amount.

IV. Governing Body Oversight

A. Updates to the Sliding Fee Discount Program and proposed policy changes will be presented every 3 years to the by Valleywise Health Governing Council and the District's Board of Directors for approval.

B. The Sliding Fee Discount Schedule will be presented annually to the Valleywise Health Governing Council and the District's Board of Directors for approval.

C. Sliding Fee Level Utilization information will be reviewed and discussed annually to ensure no barriers to care exist.

References: HRSA Health Center Program Compliance Manual, released August 2018
CHC & FHC Internal and External Referrals Policy # 20006 S

Appendix A

VALLEYWISE HEALTH FINANCIAL/DISCOUNTED POLICIES

Sliding Fee- Free Pregnancy Test- Prenatal Care-Maternity Agreements, Healthy (E) AHCCCS Applications- Family Planning Program for Women
Thank you for your interest in Valleywise Health's medical programs. To assist you better please provide the following information at the time of your interview. Please provide documents from each of the following categories.

Proof of income for the past 30 days from interview date for EVERYONE in the household

- ✓ Current award letter from DES if receiving cash assistance or food stamps
- ✓ Paycheck stubs (4) if paid weekly, (2) if paid bi-weekly
- ✓ Employer statements on letterhead / business card or notarized.
- ✓ Unemployment income
- ✓ Social Security award letter or copy of check for all household members
- ✓ Veteran's Benefits
- ✓ Pensions
- ✓ Workman's Compensation
- ✓ Child support/Alimony
- ✓ Record of earnings from self-employment or odd jobs (Income calendar if paid in cash)
- ✓ Grants, scholarships or educational benefit letters
- ✓ Current bank statements, **checking and savings** for all household members
- ✓ Statement of support from person **providing** support

Self Employed Clients 30 days from interview date

- ✓ Bank statements
- ✓ Check stubs
- ✓ Income vouchers or receipts
- ✓ Income statement from person/company paying for the services rendered
- ✓ Income calendar or any other documentation
- ✓ Statements/calendars must display dates and total amount of payment and current tax returns
- ✓ All business expenses

Proof of Address/Monthly Household Monthly Expenses within 30 days from the interview date
(All that applies)

- ✓ Rent or lease agreement/mortgage payment
- ✓ Utility receipt electric, gas, water, phone, cable, internet, car insurance, bank statement
- ✓ Letter from Landlord or a neighbor if utility bills under someone else's name
- ✓ Current registration for school aged children

Proof of dependents/relationship

- ✓ Children's birth or baptismal certificates **(Even if child is already insured)**
- ✓ Marriage License
- ✓ Proof of Pregnancy (if applicable)
- ✓ Receipt from social security administration

Proof of Identity (Not required and inability to provide will not disqualify for Sliding Fee)

- ✓ Birth or Baptismal Certificate
- ✓ Naturalization/Citizenship Certificate
- ✓ Driver's license/Photo ID for everyone over 18 years of age
- ✓ Lawful Permanent Resident Card

- ✓ Employment Authorization Card
- ✓ Passport Visa
- ✓ Passport-INS-194

Appendix A

PÓLIZAS FINANCIERAS/DE DESCUENTOS DE VALLEYWISE HEALTH

Programa de Descuento - Pruebas de embarazo sin costo - Cuidado prenatal - Acuerdos de maternidad - Solicitudes para Healthy (E) AHCCCS - Programa de planificación familiar para mujeres

Gracias por su interes en los programas medicos de Valleywise Health. Para asistirle mejor, por favor traiga la siguiente información el día de su entrevista. Por favor proporcione documentos para cada una de las siguientes categorías.

Comprobante de ingresos de los últimos 30 días antes de la fecha de su entrevista de TODOS los que viven en la casa.

- ✓ Carta más reciente del Departamento de Servicios Económicos (DES) si recibe asistencia económica en efectivo, o estampillas de comida
- ✓ Talones de cheque (4) si el pago es semanal, (2) si el pago es cada dos semanas
- ✓ Una declaración por escrito del empleador en papel con el membrete/tarjeta del negocio o notariada
- ✓ Información sobre ingresos de desempleo
- ✓ Carta de aceptación o copia de cheques del Seguro Social para todos los que viven en su casa
- ✓ Beneficios de veterano
- ✓ Pensiones
- ✓ Información de ingresos del seguro de compensación laboral
- ✓ Manutención de hijos/pensión alimenticia
- ✓ Registro de ingresos de trabajo por cuenta propia/o trabajos ocasionales
- ✓ Cartas de subsidios, becas u otros beneficios educacionales
- ✓ Estados actuales de cuenta bancaria, de ahorros y cheques para todos los que viven en su casa
- ✓ Carta de apoyo de la persona que lo mantiene

Clientes con Trabajo por Cuenta Propia Comprobante de los 30 días antes de la Entrevista

- ✓ Estados de cuenta bancaria
- ✓ Talones de cheque
- ✓ Vales o recibos de ingresos
- ✓ Declaración de ingresos de la persona/compañía que paga por los servicios proporcionados
- ✓ Calendario de ingresos o cualquier otro documento
- ✓ Las/los declaraciones/calendarios deben mostrar fechas y cantidad total del pago y devoluciones de impuestos actuales
- ✓ Todos los gastos del negocio

Comprobante de domicilio/gastos mensuales del hogar: Debe incluir los gastos dentro de los 30 días antes de la fecha de la entrevista (todo lo que corresponda).

- ✓ Recibo de pago o contrato de renta/hipoteca
- ✓ Recibos de luz, gas, agua, teléfono, cable, Internet, seguro del carro, cuenta de banco.
- ✓ Carta del arrendador o de un vecino si los recibos de servicios públicos están a nombre de alguien más
- ✓ Comprobante de la inscripción escolar actual de los niños

Comprobante de dependientes/parentesco

- ✓ Acta de nacimiento o certificado de bautismo de los niños (incluso si el menor ya tiene Seguro medico)
- ✓ Acta de matrimonio
- ✓ Prueba de embarazo (si corresponde)

Prueba de identidad (No es obligatorio y si no puede proporcionarlo, no será descalificado de los programas de descuento)

- ✓ Acta de nacimiento o certificado de bautismo
- ✓ Certificado de naturalización/ciudadanía
- ✓ Licencia para manejar o identificación con foto de todas las personas mayores de 18 años
- ✓ Tarjeta de residencia permanente legal
- ✓ Tarjeta de permiso para trabajar
- ✓ Pasaporte visado
- ✓ Pasaporte-INS-194

Si tiene alguna pregunta acerca de los documentos indicados anteriormente, por favor llame a 602-344-2550

Appendix B

MRN:
SELF-DECLARATION/DECLARACION: DATE/FECHA: _____

SIGNATURE/FIRMA: _____
Revised 02/2012

Appendix C

Valleywise Health

Federally Qualified Health Center Sliding Fee Discount Schedule

Effective 05/15 Reviewed/Revised 03/25

Valleywise Health
Federally Qualified Health Center Sliding Fee Discount Schedule

Effective 05/15 Reviewed/Revised 03/25

Medical

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5	
Federal Poverty Level Scale	0-100%	101-138%	139-150%	151-200%	>201% FPL	>251% FPL
Primary Care	$20 Nominal Charge	$30 Flat Fee	$40 Flat Fee	$50 Flat Fee	No Discount	
Immunization for Flu*	$20	$20	$20	$20	$20	
Immunization for Covid*	100% cost	100% cost + $12	115% cost + $13	125% cost + $14	150% cost + $15	
Family Planning Services - Maryvale Clinic Only	$0	$20	$30	$40	201-250% FPL $50	>251% FPL No Discount
FQHC Specialty Visits (Example - Cardiology)	$50 Nominal Charge	$70 Flat Fee	$80 Flat Fee	$90 Flat Fee	No Discount	
Outpatient Ancillary Services (Lab)	$10 Nominal Charge	25% of Medicare rate - 50% due prior to service ($20 minimum)	50% of Medicare rate - 50% due prior to service ($30 Minimum)	75% of Medicare rate - 50% due prior to service ($40 minimum)	No Discount	
Outpatient Ancillary Services (Imaging)	$30 Nominal Charge	25% of Medicare rate - 50% due prior to service ($40 minimum)	50% of Medicare rate - 50% due prior to service ($50 Minimum)	75% of Medicare rate - 50% due prior to service ($60 minimum)	No Discount	

*Unless covered by another source, such as a grant

Dental

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	0-100%	101-138%	139-150%	151-200%	>201% FPL
Diagnostic Dental Services	$10 Nominal Charge	$15 Flat Fee	$20 Flat Fee	$25 Flat Fee	$30 Flat Fee
Restorative Dental Services *See Grid Below	$50 Nominal Charge + Cost of Supplies	75% of Delta Dental allowable rates	80% of Delta Dental allowable rates	85% of Delta Dental allowable rates	100% of Delta Dental allowable rates
Dental Lab Services	$50 Nominal Charge + Cost of Supplies	85% of Delta Dental allowable rates	90% of Delta Dental allowable rates	95% of Delta Dental allowable rates	100% of Delta Dental allowable rates

Restorative Grid	Category 1	Category 2	Category 3	Category 4	Category 5
Filling	$25.00	$35.00	$50.00	$75.00	$80.00
Crowns Simple	$75.00	$100.00	$125.00	$150.00	$175.00
Crowns	$250.00	$400.00	$450.00	$475.00	$500.00
Dentures - Temporary	$100.00	$200.00	$250.00	$300.00	$350.00
Dentures - partial	$300.00	$350.00	$400.00	$450.00	$500.00
Dentures - complete	$350.00	$795.00	$842.00	$865.00	$900.00
Bridges - Temporary	$50.00	$100.00	$150.00	$200.00	$225.00
Bridges	$200.00	$250.00	$300.00	$350.00	$375.00
Extractions - simple	$50.00	$62.00	$66.00	$70.00	$83.00
Extractions - complex	$100.00	$110.00	$125.00	$135.00	$145.00

** Please note all payments will be requested prior to service.*

Valleywise Health Protocol – Tracking Form (Not Part Of Policy)
(**Before submitting, fill out COMPLETELY**.)

POLICY RESPONSIBLE PARTY: Valleywise Health Vice President of Revenue Cycle

DEVELOPMENT TEAM(S): Patient Financial Services, Valleywise Community Health Centers Administration, and Revenue Integrity Management

Policy #: 23624 D

Policy Title: FQHC Sliding Fee Discount Program

e-Signers: Amanda De Los Reyes, VP Revenue Cycle

Place an X on the right side of applicable description:

New -

Retire - **Reviewed -**

Revised with Minor Changes - X

Revised with Major Changes -

Please list revisions made below: (Other than grammatical changes or name and date changes)

Reviewed and Approved by in Addition to Responsible Party and E-Signer(s):

Required Approval: Valleywise Community Health Centers Governing Council **03/25**

Required Approval: Maricopa County Special Health Care District Board of Directors **05/24**

Required Approval: Michelle Barker, Sr VP Ambulatory Services and CEO FQHC Clinics **03/25**

Required Approval: Vanessa Couch-Laguana, Director Patient Financial Services **03/25**

Committee:

Other:

4. FQHC Program Utilization

Valleywise Health

SLIDING FEES UTILIZATION - ANNUAL

2024 ($)

Plan Id	Plan Name	Visit Count	Unique Patient Count	Average Visits / Year	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	108,721	15,334	7.1	188,464,054	183,371,975	3,432,290	1,659,790
602	SLIDING FEE CAT 2	32,186	5,236	6.1	53,777,212	51,141,201	1,554,507	1,081,504
603	SLIDING FEE CAT 3	6,591	1,180	5.6	10,257,661	9,485,803	423,085	348,774
604	SLIDING FEE CAT 4	11,999	2,293	5.2	20,851,677	18,629,546	921,424	1,300,707
605	SLIDING FEE CAT 5	60,187	25,991	2.3	207,979,002	170,732,054	4,426,373	32,820,575

2024 (%)

Plan Id	Plan Name	Visit Count	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	49.5%	39.2%	42.3%	31.9%	4.5%
602	SLIDING FEE CAT 2	14.7%	11.2%	11.8%	14.5%	2.9%
603	SLIDING FEE CAT 3	3.0%	2.1%	2.2%	3.9%	0.9%
604	SLIDING FEE CAT 4	5.5%	4.3%	4.3%	8.6%	3.5%
605	SLIDING FEE CAT 5	27.4%	43.2%	39.4%	41.1%	88.2%

2023 ($)

Plan Id	Plan Name	Visit Count	Unique Patient Count	Average Visits / Year	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	100,680	14,660	6.9	174,669,358	170,589,989	3,221,583	857,786
602	SLIDING FEE CAT 2	30,971	5,581	5.5	52,109,060	49,634,865	1,524,266	949,929
603	SLIDING FEE CAT 3	5,641	1,146	4.9	9,429,952	8,769,544	394,918	265,490
604	SLIDING FEE CAT 4	10,202	2,203	4.6	19,877,989	17,876,177	865,090	1,136,722
605	SLIDING FEE CAT 5	49,110	20,650	2.4	150,470,893	126,017,782	3,524,929	20,928,183

2023 (%)

Plan Id	Plan Name	Visit Count	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	51.2%	43.0%	45.7%	33.8%	3.6%
602	SLIDING FEE CAT 2	15.8%	12.8%	13.3%	16.0%	3.9%
603	SLIDING FEE CAT 3	2.9%	2.3%	2.4%	4.1%	1.1%
604	SLIDING FEE CAT 4	5.2%	4.9%	4.8%	9.1%	4.7%
605	SLIDING FEE CAT 5	25.0%	37.0%	33.8%	37.0%	86.7%

2024 vs. 2023 ($)

Plan Id	Plan Name	Visit Count	Unique Patient Count	Average Visits / Year	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	8,041	674	0.2	13,794,697	12,781,986	210,707	802,004
602	SLIDING FEE CAT 2	1,215	(345)	0.6	1,668,152	1,506,336	30,240	131,576
603	SLIDING FEE CAT 3	950	34	0.7	827,709	716,258	28,167	83,284
604	SLIDING FEE CAT 4	1,797	90	0.6	973,688	753,369	56,334	163,984
605	SLIDING FEE CAT 5	11,077	5,341	(0.1)	57,508,109	44,714,272	901,444	11,892,393

2024 vs. 2023 (%)

Plan Id	Plan Name	Visit Count	T_Charges	T_Adjust	T_Pmt_Amts	T_Bal_Amts
601	SLIDING FEE CAT 1	8.0%	7.9%	7.5%	6.5%	93.5%
602	SLIDING FEE CAT 2	3.9%	3.2%	3.0%	2.0%	13.9%
603	SLIDING FEE CAT 3	16.8%	8.8%	8.2%	7.1%	31.4%
604	SLIDING FEE CAT 4	17.6%	4.9%	4.2%	6.5%	14.4%
605	SLIDING FEE CAT 5	22.6%	38.2%	35.5%	25.6%	56.8%

4. FQHC Sliding Fee Discount Schedule

Valleywise Health
Federally Qualified Health Center Sliding Fee Discount Schedule
Effective 05/15 Reviewed/Revised 03/25

Medical

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5	
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***Unless covered by another source, such as a grant**

Dental

Plan Levels	Category 1	Category 2	Category 3	Category 4	Category 5
Federal Poverty Level Scale	**0-100%**	**101-138%**	**139-150%**	**151-200%**	**>201% FPL**
Diagnostic Dental Services	$10 Nominal Charge	$15 Flat Fee	$20 Flat Fee	$25 Flat Fee	$30 Flat Fee
Restorative Dental Services ***See Grid Below**	$50 Nominal Charge + Cost of Supplies	75% of Delta Dental allowable rates	80% of Delta Dental allowable rates	85% of Delta Dental allowable rates	100% of Delta Dental allowable rates
Dental Lab Services	$50 Nominal Charge + Cost of Supplies	85% of Delta Dental allowable rates	90% of Delta Dental allowable rates	95% of Delta Dental allowable rates	100% of Delta Dental allowable rates

Restorative Grid	Category 1	Category 2	Category 3	Category 4	Category 5
Filling	$25.00	$35.00	$50.00	$75.00	$80.00
Crowns Simple	$75.00	$100.00	$125.00	$150.00	$175.00
Crowns	$250.00	$400.00	$450.00	$475.00	$500.00
Dentures - Temporary	$100.00	$200.00	$250.00	$300.00	$350.00
Dentures - partial	$300.00	$350.00	$400.00	$450.00	$500.00
Dentures - complete	$350.00	$795.00	$842.00	$865.00	$900.00
Bridges - Temporary	$50.00	$100.00	$150.00	$200.00	$225.00
Bridges	$200.00	$250.00	$300.00	$350.00	$375.00
Extractions - simple	$50.00	$62.00	$66.00	$70.00	$83.00
Extractions - complex	$100.00	$110.00	$125.00	$135.00	$145.00

Please note all payments will be requested prior to service.

5. FQHC Semiannual Compliance and Internal Audit Work Plans and Ethics Line Report

FY2025 (Q1 & Q2) FQHC Compliance and Internal Audit Work Plan Update - Valleywise Health Community Health Center Governing Council

Valleywise Health

Reporting Group: Compliance and Internal Audit
Person Reporting:
L.T. Slaughter, Jr., CPA, CGMA, CHC, CISSP, CISA, MBA
or Elena Landeros, Privacy Specialist
Reporting period: FY2025 (Q1 & Q2)
Chief Compliance Officer/Privacy Officer

FY2025 (Q1 & Q2) Compliance and Internal Audit Work Plan Update – FQHC

- 1.0 –FY2025 (Q1 & Q2) Compliance Work Plan - FQHC
- 2.0 –FY2025 (Q1 & Q2) Internal Audit Work Plan - FQHC
- 3.0 –FY2025 (Q1 & Q2) Ethics Line Reports - FQHC

1.0 – FY2025 (Q1 & Q2) Compliance Work Plans – FQHC

1.0 Data Dictionary for the Compliance and Internal Audit Work Plan

AHCCCS – Arizona Healthcare Cost Containment System – State of Arizona's name for the Medicaid state plan.
E&M – Evaluation and Management – Physician professional services.
patients with emergency medical conditions.
HIPAA – The Health Information Portability and Accountability Act – Healthcare privacy, IT security and transaction code set rules.
Prop 480 (Care-Reimagined) – Referendum passed by the voters of Maricopa County to fund the re-construction of Maricopa County Special Health Care District d/b/a Valleywise Health.
Uniform Guidance (UG) – Uniform Administrative, Cost Principles and Audit requirements for Federal Awards (grants).

1.1 Q1-Q2 FY2025 Compliance Work Plan

The FY2025 compliance projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of compliance with regulations, as well as the identification of value-added recommendations. The FY2025 compliance work plan represents compliance activities based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1						
CQ1.1 Adolescent Consenting Review and Training	Q1	100 Hours	Policies were updated.	On-going	5	2
CQ1.2 Evaluation and Management (E&M) Coding Review and Training	Q1	150 Hours	Coding training implemented.	Completed	5	3
Risk Re-assessment and Selection Q2						
CQ2.1 Residence in the Clinic Setting	Q2	150 Hours	Reviewed required signage and documentation process.	On-going	5	2
CQ2.2 HIPAA IT Security and Privacy Reviews	Q2	100 Hours	IT security review completed. Employee break the glass implemented.	Completed	5	3

2.0 – FY2025 (Q1 & Q2) Internal Audit Work Plans – FQHC

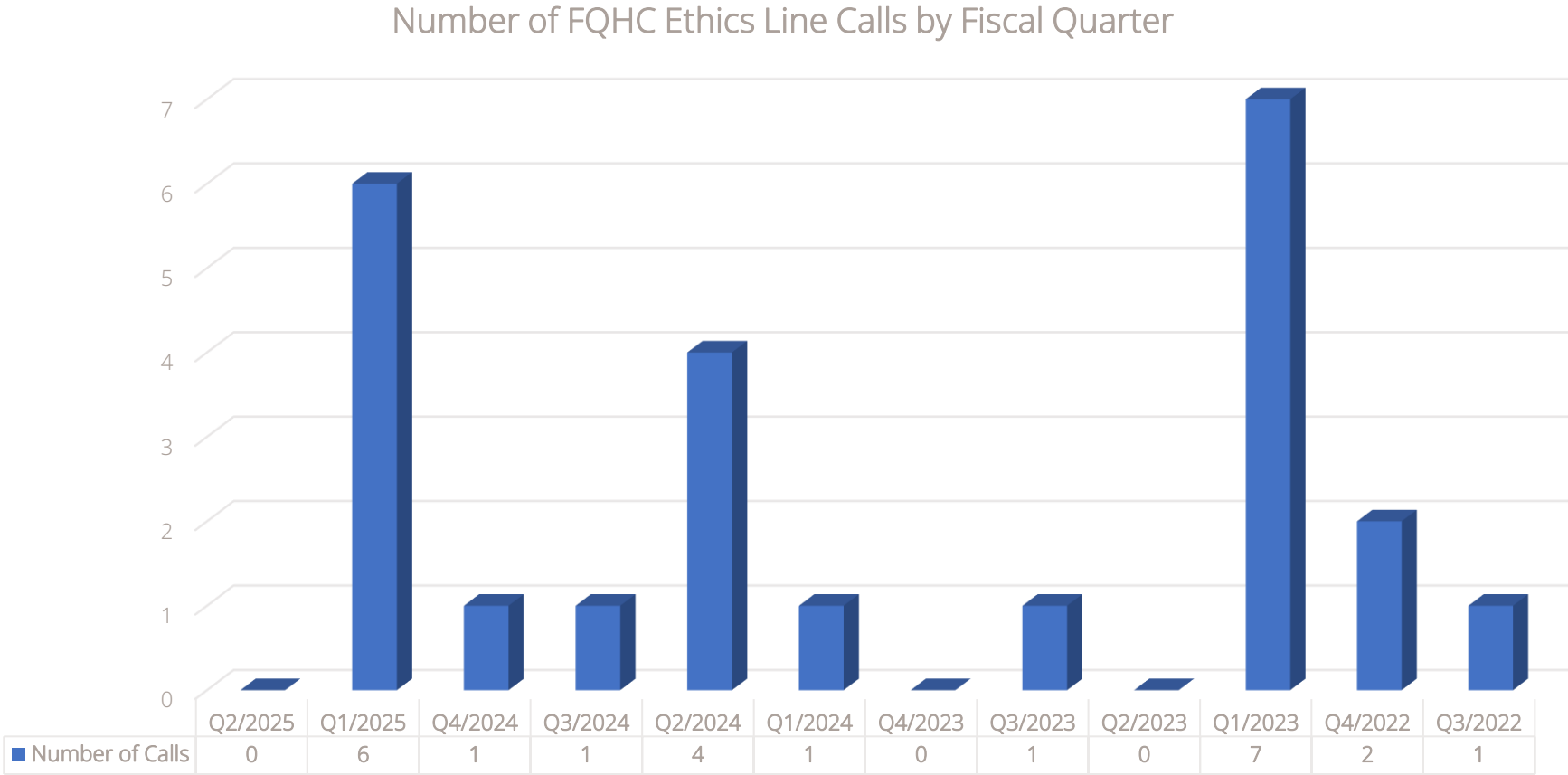
2.1 Q1-Q2 FY2025 Internal Audit Work Plan

The FY2025 internal audit projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of internal controls as well as the identification of value-added recommendations. The FY2025 audit plan represents audits based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1 (Current State Assessment)						
IQ1.1 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q1	100 Hours	Monitoring expenditures.	On-going	5	2
IQ1.2 HR Benefits and Payroll Review	Q1	150 Hours	Phase I (interviews) was completed.	Completed	5	4
IQ1.3 FQHC Uniform Guidance Grants Reviews	Q1	100 Hours	Uniform Guidance monitoring.	On-going	5	2
Risk Re-assessment and Selection Q2						
IQ2.1 FQHC Physical Security and HIPAA Walkthroughs	Q2	200 Hours	CHC walkthroughs completed.	On-going	5	2
IQ2.2 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q2	100 Hours	Monitoring expenditures.	On-going	5	2

3.0 –FY2025 (Q1 & Q2) Ethics Line Reports (07/01/2024 thru 12/31/2024) – FQHC Only

3.1 – FQHC Ethics Line Report (Three-Year Trending by Quarter)



Average of 2 Calls per Quarter

3.2 –FY2025 (Q1) Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Column Labels	
Row Labels	Green	Grand Total
Disclosure of Confidential Information	1	1
Harassment - Sexual	1	1
Harassment - Workplace	1	1
Inappropriate Behavior	1	1
Unfair Employment Practices	2	2
Grand Total	**6**	**6**

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization
(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization
(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization
(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

3.2 FY2025 (Q1) Relevant Issue Definitions

Disclosure of Confidential Information - The unauthorized or illegal disclosure, copying, duplication, misuse or release of confidential or personal data including but not limited to employment, financial, medical and health, customer lists, contracts, business plans, personnel records or other property marked or generally regarded as confidential or trade secrets.

Harassment (Sexual) - Statements or actions expressing unwelcome sexual advances, requests for sexual favors, unsolicited physical contact or propositions, unwelcome flirtations, or offensive verbal or visual expressions or physical conduct of a sexual nature.

Harassment (Workplace) - Persistent statements, conduct or actions that are uninvited, degrading, offensive, humiliating or intimidating and create an unpleasant or hostile environment.

Inappropriate Behavior - Statements or actions that are not harassing in nature, but are believed to be unsuitable for the workplace.

Unfair Employment Practices - Employment decisions, practices or disciplinary actions that are believed to be unfair regardless of whether they are the result of job performance, changes in business needs or other business-related decisions.

3.3 –FY2025 (Q2) Issue Type, Alert Status and Primary Outcome Report

No FQHC Cases Reported in Q2 FY2025

3.4 –FY2025 Q1 & Q2 (FQHC Only) Average Days to Close
(Cases Closed - Same Quarter & Two Previous Years)

Benchmark:
Average Days to Close Benchmark = 30 days or less

Q1 Results:
Q1 FY2025 Average Days to Close = 21
Q1 FY2024 Average Days to Close = 26
Q1 FY2023 Average Days to Close = 32

Q2 Results:
Q2 FY2025 Average Days to Close = 0
Q2 FY2024 Average Days to Close = 12
Q2 FY2023 Average Days to Close = 36

Previous Quarter’s Indicators (Supplemental Data)

FY2024 (Q4) Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Column Labels	
Row Labels	**Green**	**Grand Total**
Inappropriate Behavior	1	1
Grand Total	**1**	**1**

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

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Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

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Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization

(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

FY2024 (Q3) Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Column Labels	
Row Labels	Green	Grand Total
Misconduct Behavior	1	1
Grand Total	**1**	**1**

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization

(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization

(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization

(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

FY2024 (Q1-Q2) Issue Type, Alert Status and Primary Outcome Report

Q1 FY2024

Count of Primary Case Outcome	Column Labels	
Row Labels	Green	Grand Total
HIPAA, Privacy, Security	1	1
Grand Total	**1**	**1**

Q2 FY2024

Count of Primary Case Outcome	Colu	Labels
Row Labels	Green	Grand Total
Discrimination	1	1
Health Insurance Portability and Accountability Act (HIPAA)	1	1
Patient Care	1	1
Unfair Employment Practices	1	1
Grand Total	**4**	**4**

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

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6. FQHC Compliance Training

FY2025 Valleywise Health Community Health Centers Governing Council Compliance Training

Reporting Group: Compliance and Internal Audit
Person Reporting:
L.T. Slaughter, Jr., CPA, CGMA, CHC, CISSP, CISA, MBA
Reporting period: FY2025
Chief Compliance Officer/Privacy Officer

Three Compliance Words for 2025:

- **Celebrate:** Acknowledge a significant achievement in a social gathering
- **Risk Management:** Continued process of identifying, analyzing and responding to potential threat and uncertainties that could impact the organization.
- **Excellence** (see the next slide).

What is Excellence?

Definition: "the quality of being outstanding or extremely good"

Our Excellence Value:

We are committed to delivering breakthrough quality and service that exceeds expectations, improves outcomes and provides exceptional patient care.

What is Compliance?

- Compliance is adhering to the laws, rules, regulations, policies and procedures that govern the job we perform.
- It is the responsibility of ***all the employees*** of the organization.

Excellence and Compliance produce the best results!

Healthcare companies with an effective compliance program, effective quality program and strong internal controls have these attributes:

- Significantly less errors;
- Significantly less rework;
- Higher patient quality scores;
- Higher employee and patient satisfactions; and
- Are more profitable!

Expectations for Board Oversight of Compliance Program Functions

- A Board must act in good faith in the exercise of its oversight responsibility for its organization, including making inquiries to ensure: (1) a corporate information and reporting system exists and (2) the reporting system is adequate to assure the Board that appropriate information relating to compliance with applicable laws will come to its attention timely and as a matter of course.

Expectations for Board Oversight of Compliance Program Functions

- The existence of a corporate reporting system is a key compliance program element, which not only keeps the Board informed of the activities of the organization, but also enables an organization to evaluate and respond to issues of potentially illegal or otherwise inappropriate activity.

OBJECTIVES

In this training, you will learn about our approach:

- Understand the Your Business - Overview of Valleywise Health (including the FQHC Structure)
- Understand the Healthcare Environment - Key Regulations and Trends
- Risk Assessment Process - Identification and Prioritization of Risks
- Risk Mitigation Process - Board Oversight, Conflict of Interest, Management Oversight, FAC Committee, Compliance Program, Internal Audit, Revenue Cycle, Performance Excellence, etc.

METHODOLOGY AND APPROACH

Our Methodology and Approach

1 *Understand the Business*

- Conducted interviews with various members of Valleywise Health Management and Healthcare Industry leaders;
- Considered whether any key initiatives or changes to Valleywise Health' strategic plan may impact the risk profile of the organization;
- Reviewed the audit and compliance work plans and priorities of other health systems to determine current areas of focus by others in the industry.

2 *Risk Assessment*

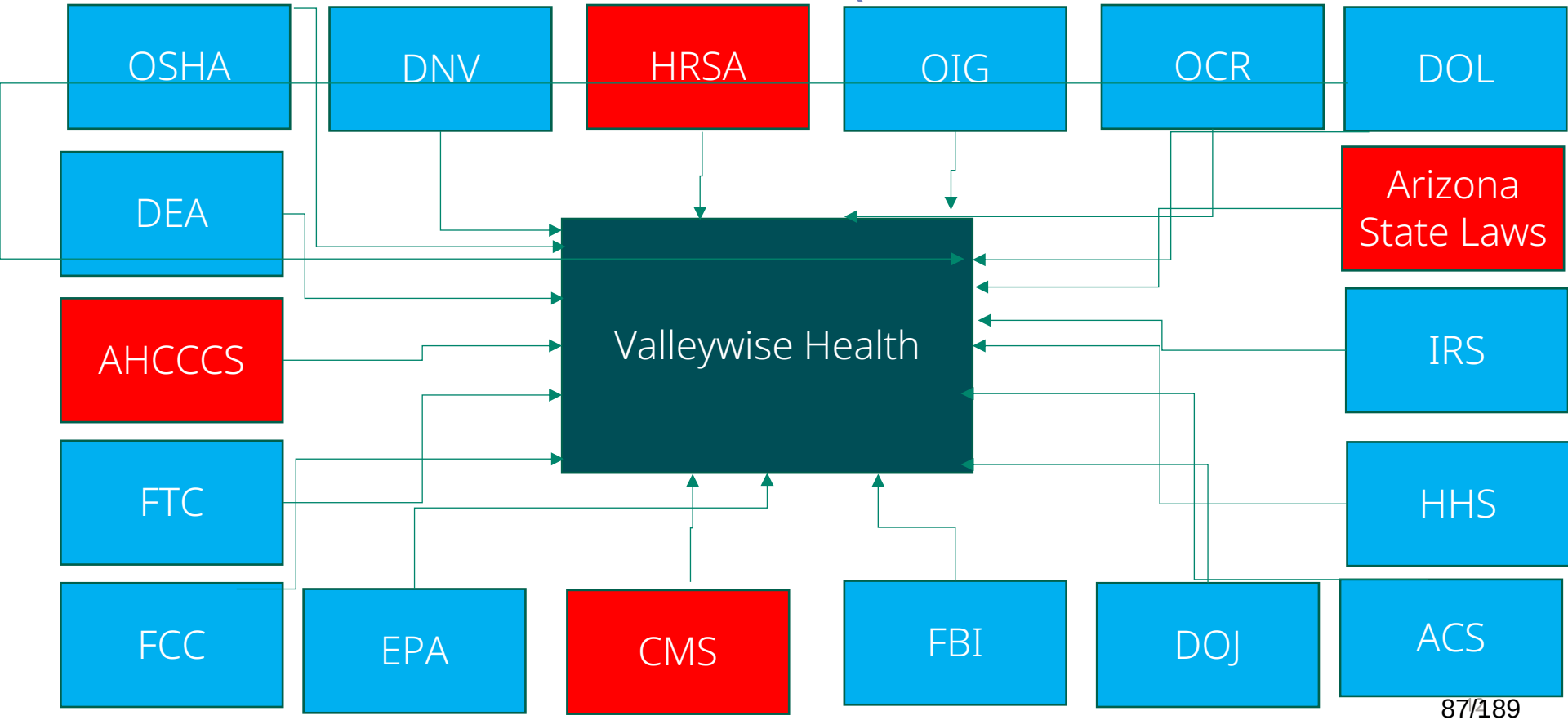
- Prioritized risks and areas of concern based on the importance to business performance, impact to the organization and the likelihood of control /process issues;
- Considered the prior year risk assessments and work completed in FY23 & FY24 and the findings from previous internal audit and compliance activities.

3 *Prioritized Internal Audit and Compliance Plan*

- Proposed a list of compliance and internal audit projects focused on the risks identified and areas of concern to be completed in FY2025. These will be reassessed quarterly.

UNDERSTAND THE HEALTHCARE ENVIRONMENT

Healthcare Regulation/Quality Oversight Bodies for FQHCs



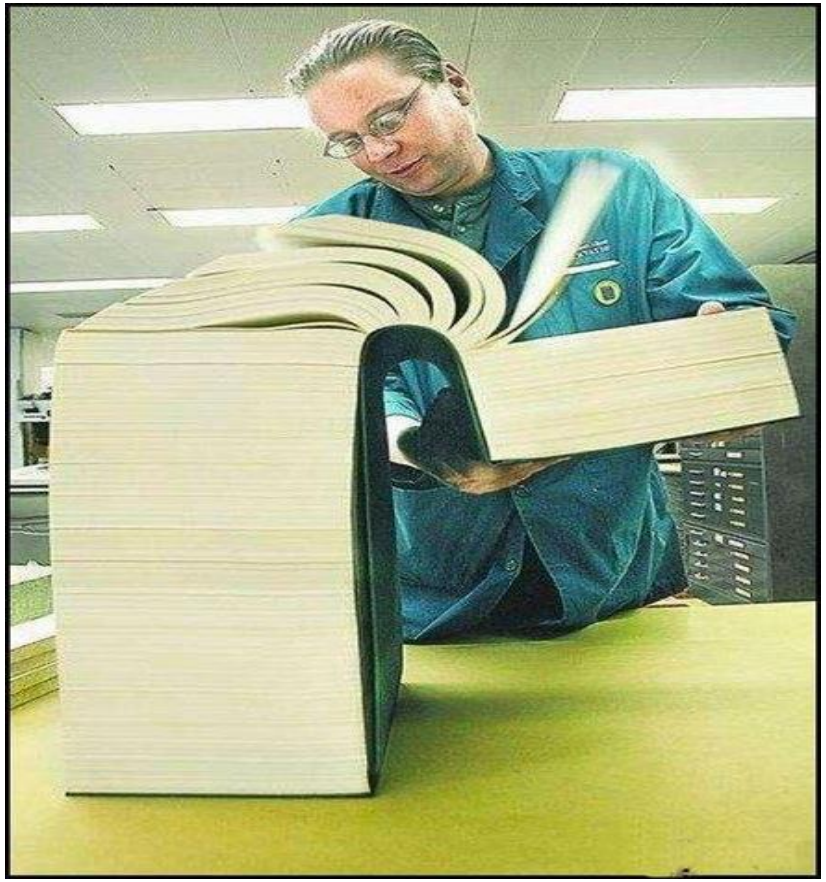
Healthcare Regulation Oversight Bodies

- Arizona Healthcare Cost Containment System (AHCCCS)
- Center for Medicare and Medicaid Services (CMS)
- Health Resources and Services Administration (HRSA)
- United States Department of Justice (DOJ)
- Office of Inspector General (OIG)
- Office for Civil Rights (OCR)
- Valleywise Health District policies
- Internal Revenue Service (IRS)
- Food and Drug Administration (FDA)
- Many Others (OSHA, FCC, DEA, etc.)

Top Risks Changes for Valleywise Health in 2025

1. Artificial Intelligence (AI) Impacts on Healthcare (Increased)
2. Cybersecurity (Increased)
3. Changes in Regulations/Legislation (Increased)
4. Kronos to ADP Implementation (Increased)
5. Disaster Recovery and Business Continuity (Increased)
6. Rising Costs and Inflation (Increased)
7. Price Transparency/Machine Readable Information (Increased)
8. Behavioral Health Services (Increased)
9. Patient Violence (Increased)
10. Speed of Data Being Sent to Patients (Increased)
11. Third-party Vendor Management (Increased)
12. DMG Contracting (Same as previous year)
13. Grant Audits (Same as previous year)
14. Patient Safety (Same as previous year)
15. Case Management (Same as previous year)

And many more!



Changes to current healthcare regulations (Example: HIPAA and Reproductive Health Care Services)

Below are some risks that may affect how you do your oversight

Valleywise Health

1. AHCCCS State Medicaid Plan
2. HRSA (Regulates Federally Qualified Health Center (FQHC))
3. Affordable Care Act (MACRA)
4. Anti-Kickback Statutes
5. Emergency Medical Treatment and Active Labor Act (EMTALA)
6. HIPAA (Health Insurance Portability and Accountability Act) and HITECH.
7. Medicare Rules – Condition of Participation
8. Care Re-imagined
9. False Claims Act and the Federal Sentencing Guidelines
10. Deficit Reduction Act of 2005
11. OSHA, FDA, and EPA Laws (DNV, Occupational Safety and Health Administration, Food and Drug Administration, Environmental Protection Agency).
12. Others (Arizona State Regulations, LEP 1557, Payment Suspensions, 60 Day Rule, etc.)

UNDERSTAND THE BUSINESS

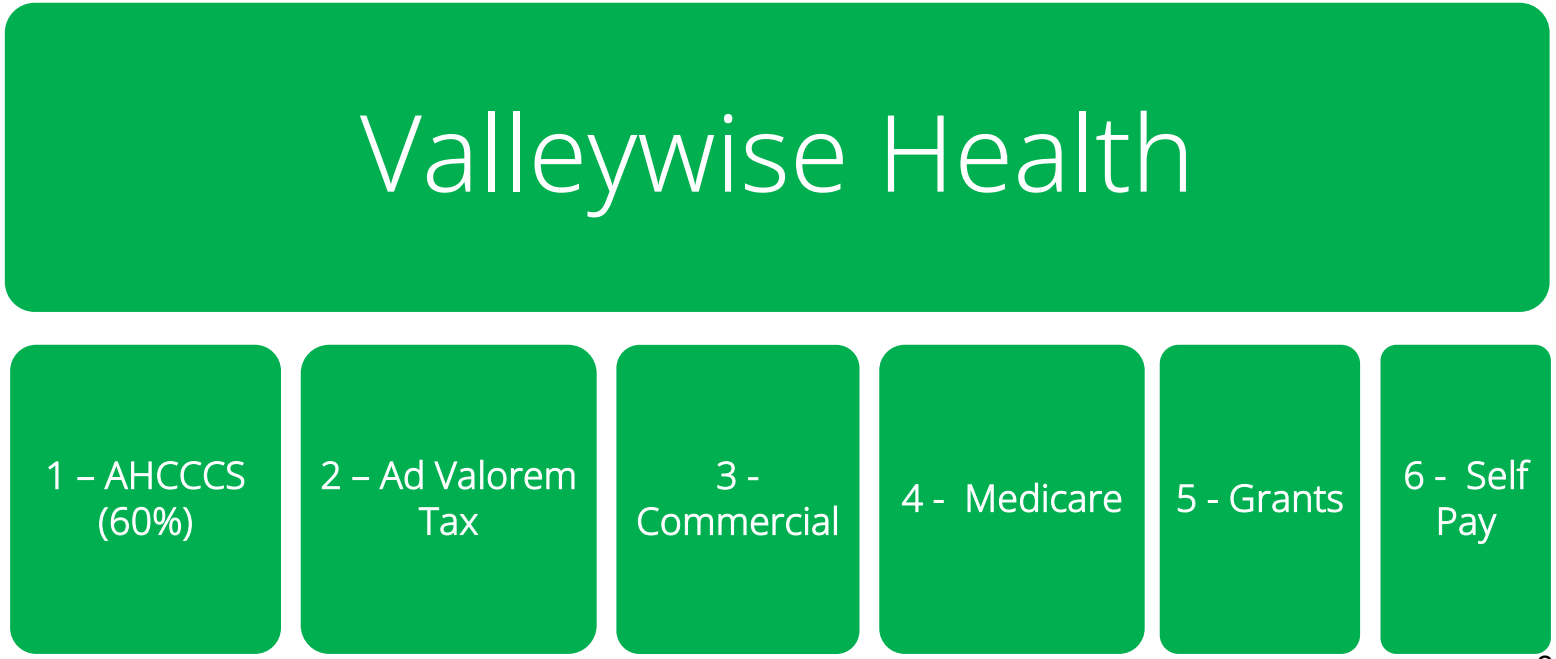
Understand the Business – Valleywise Health's Main Business Units

Valleywise Health

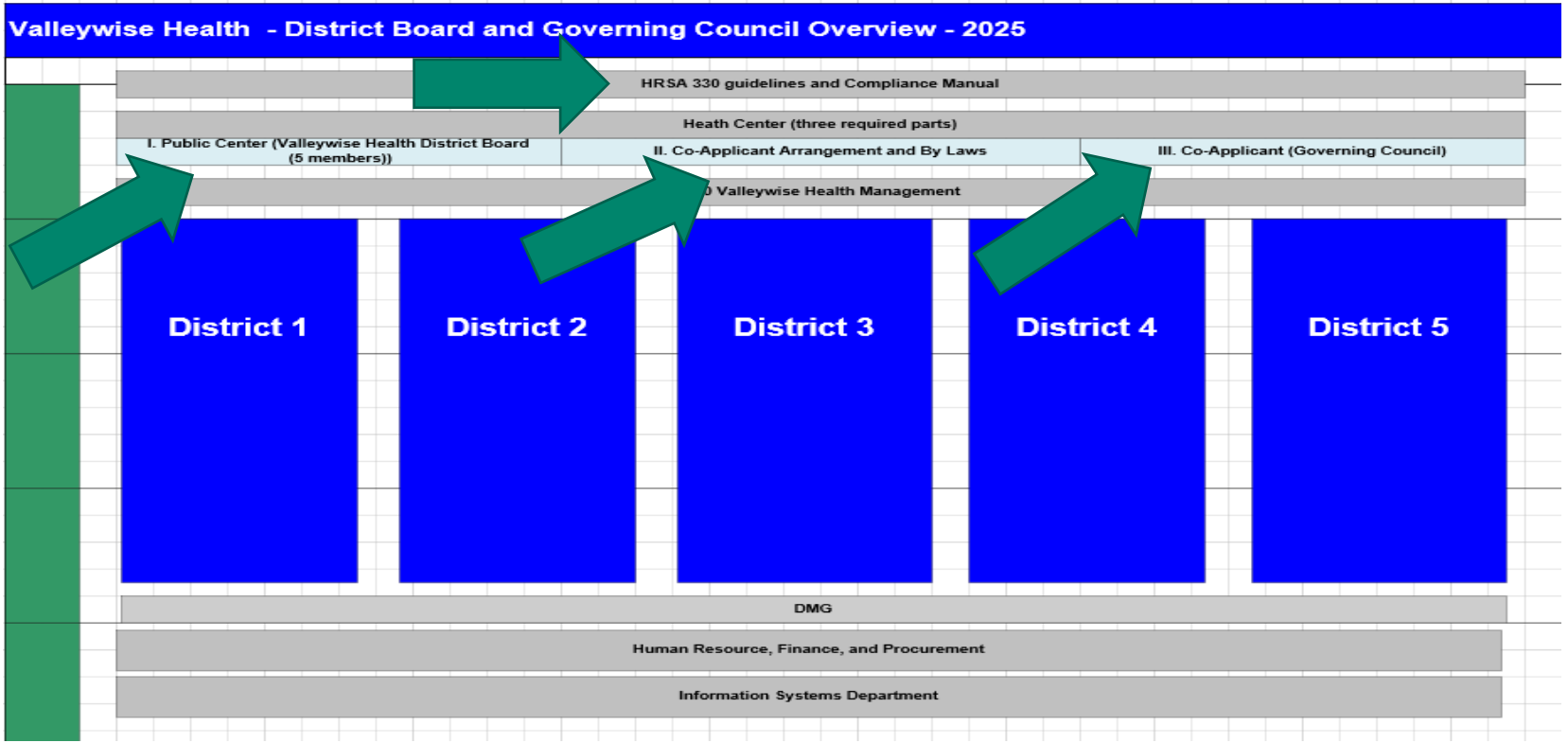
Valleywise Health

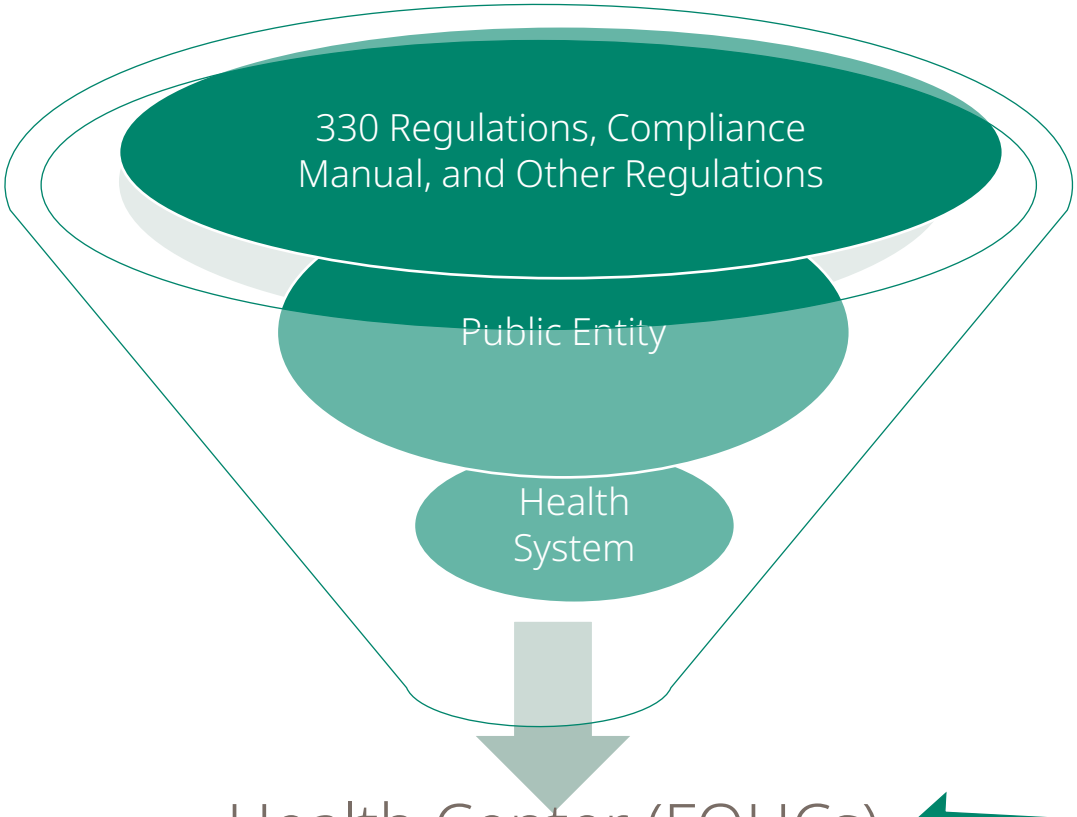
- A - Acute Care Hospital
- B – Creighton Alliance (Residency Program)
- C - FQHC
- D - CHC
- E - Behavioral Health
- F - DMG (District Medical Group)
- G - ACO (ACN)
- H – Grants and Research
- I – Care Re-imagined

Understand the Business – Valleywise Health's Major Payers/Revenue



Understand the Business – Valleywise Health's FQHC Structure

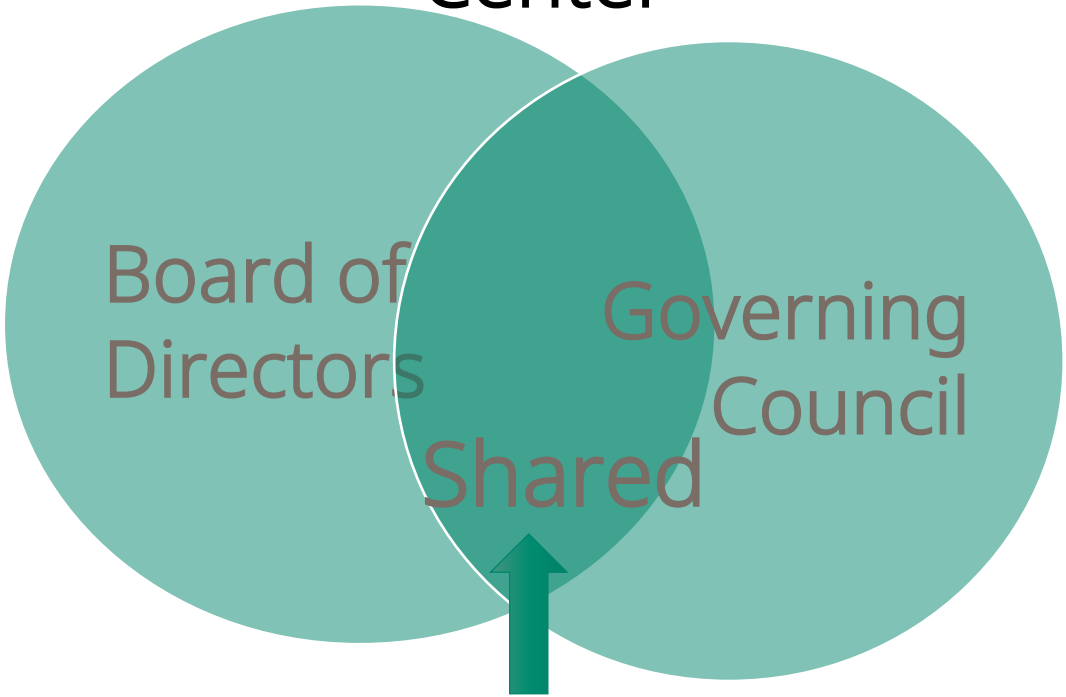




Health Center (FQHCs)

(Board of Directors and Governing Council)

Responsibilities of the Health Center



CO-APPLICANT OPERATIONAL ARRANGEMENT
Between the
MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
and the
VALLEYWISE COMMUNITY HEALTH CENTERS GOVERNING COUNCIL

See Co-Applicant Arrangement

Health Center Program Compliance Manual Overview and Operational Site Visit (OSV) Guidance

The Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) is responsible for effective and efficient oversight of the Health Center Program. This includes ensuring that health centers comply with applicable statutory and regulatory requirements for the Health Center Program. The Health Center Program Compliance Manual serves as a streamlined and consolidated resource to assist health centers in understanding and demonstrating compliance with Health Center Program and Federal Torts Claims Act program requirements.

FQHC TIMELINE:

10/2018 - **First** site visit in nine years was a successful… achieving 90/93 Elements (97%)

9/2019 - We received full FQHC status in September 2019.

2/2020 - Technical Assistance Review

8/2021 – Operational Site Visit (OSV) – 100%!!

11/2023 – Operational Site Visit (OSV) – 100%!!

**Next OSV is in 2026. OSVs are conducted every three years.

RISK ASSESSMENT

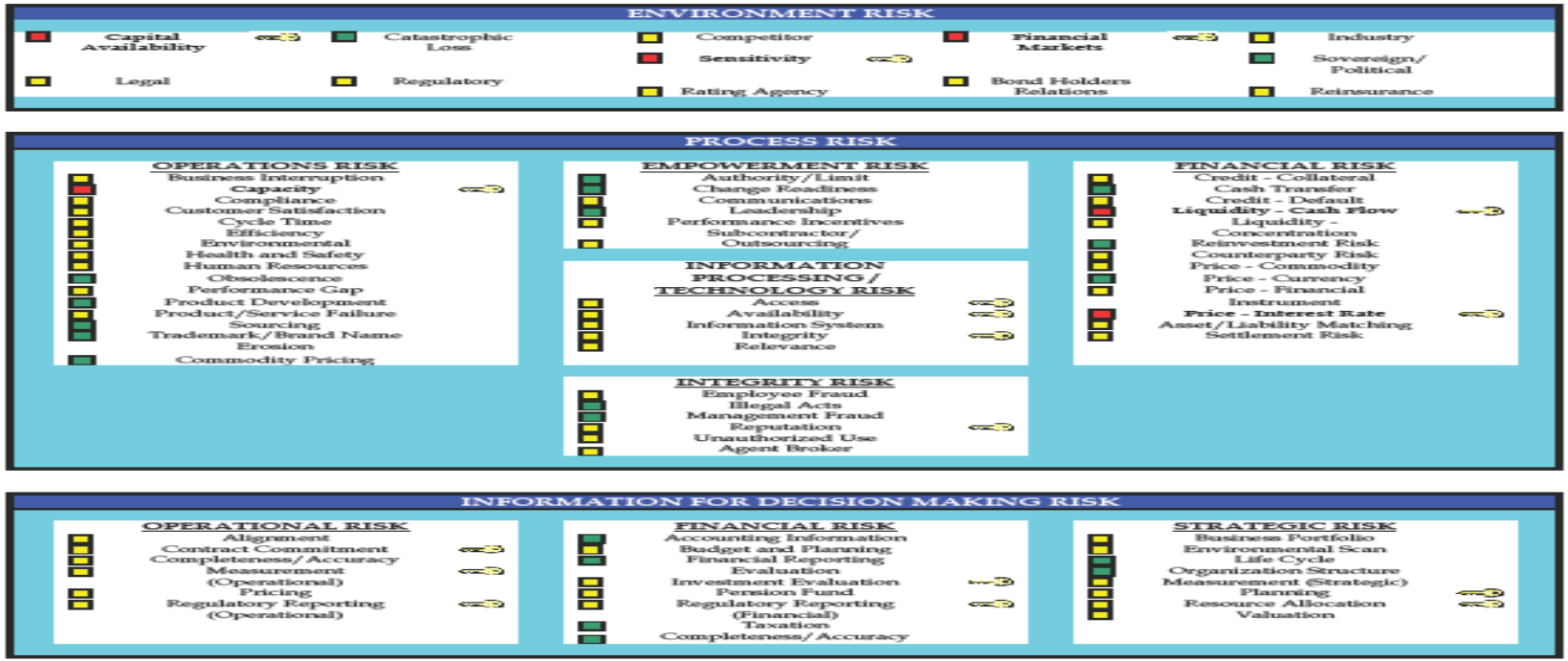
The Enterprise Risk Management Process

The ERM process includes the following major components:

- Risk identification
- Prioritization and scoring of risks
- Risk response - This involves developing and implementing an action plan to avoid, accept, reduce or finance risks

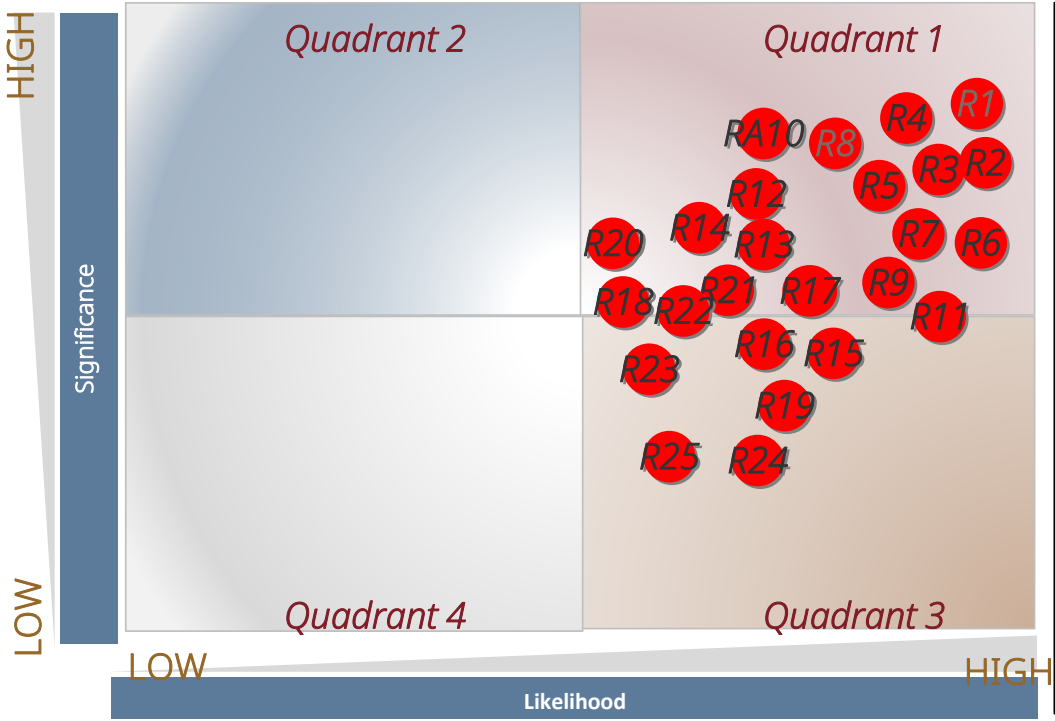
Valleywise Health

Enterprise Risk Management
Prepared By L.T. Slaughter



Risk Assessment Process– Prioritization Map

The map below depicts the highest rated risks based on feedback from interviews and other data gathering. The risks are plotted based on their individual significance to the business along with the likelihood that issues and / or improvement opportunities currently exist. The highest risk areas are shown in Quadrant 1 and generally include those risks that are inherently high for the industry or are a known concern to Valleywise Health.



FY2025 Top 25 Risk Factors

R1 Workforce/Physician Recruitment and Retention (Gaps in services and coverage)

R2 Care-Reimagined Projects (Prop 480)/New Hospital Opening and Operations/Old Hospital Decommissioning and Close Out/Future Operating Costs and Warranties

R3 Level One Trauma – America College of Surgeons (ACS) Verification/AZ State Certification/Process Improvement Activities (New Grey Book - Very Stringent Requirements) More than Three Type II findings and you fail the ACS Verification

R4 Human Resources, Benefits, ADP Implementations (Timekeeper and Recruiter) and Payroll Controls

R5 Privacy (Media/External Provider) and IT Security (Cyber Threats) of Protected Health Information/ Hospital Move/Information Blocking (Cures Act) – Audio and Video Controls in the new tower/Medical Devices

R6 IT Disaster Recovery and Business Continuity (SAFER Guidelines)

R7 .Revenue Cycle - (A/R Valuation, Burn Cases, Telemedicine, Patient Access Center (PAC), External Referrals, Leakage of Patients)

R8 DMG Contract Compliance/Payment Reconciliation/Other physician contracts

R9 Compliance with Medicare and AHCCCS Medicaid Regulations (increase AHCCCS review of behavioral health (Cost report, Bad Debt, etc.)/Direct Payments/340b Compliance

R10 Patient Violence/Active Shooter/Infant Abduction/FQHC Clinic and SDI Office Physician Security

R11 Behavioral Health (BH) – Title 36 – Timed-Out Patients/Physical structure/ Discharge Risks/IMD Exclusion Compliance/Electronic filing with Court/42 Part 2 Substance abuse

R12 Physician Documentation/ Clinical Validation/ Coding/ Professional fee EPIC billing system/observation patients/Dragon Statements

R13 EPIC Rebasing /Key IT Staffing and Turnover/Remote Workforce Monitoring

R14 Contracting Process – Approval Matrix and Contracting Process

R15 Grant and Research Department (uniform guidance) – SOAR and Capital Expenditure

R16 EMTALA/Dedicated Emergency Departments/New Tower

R17 Artificial Intelligence(AI) Impacts on Healthcare

R18 Hospital Accreditation (DNV) and FQHC Licensure (HRSA)/ Quality and Internal and External Score Rating/Patient Harm Events

R19 GME and Resident Supervision/Medical Students and Controls (Creighton Alliance)/Credentialing

R20 Public Information Requests

R21 Charge Master/Charge Capture/Work Queues/Charge Reconciliations

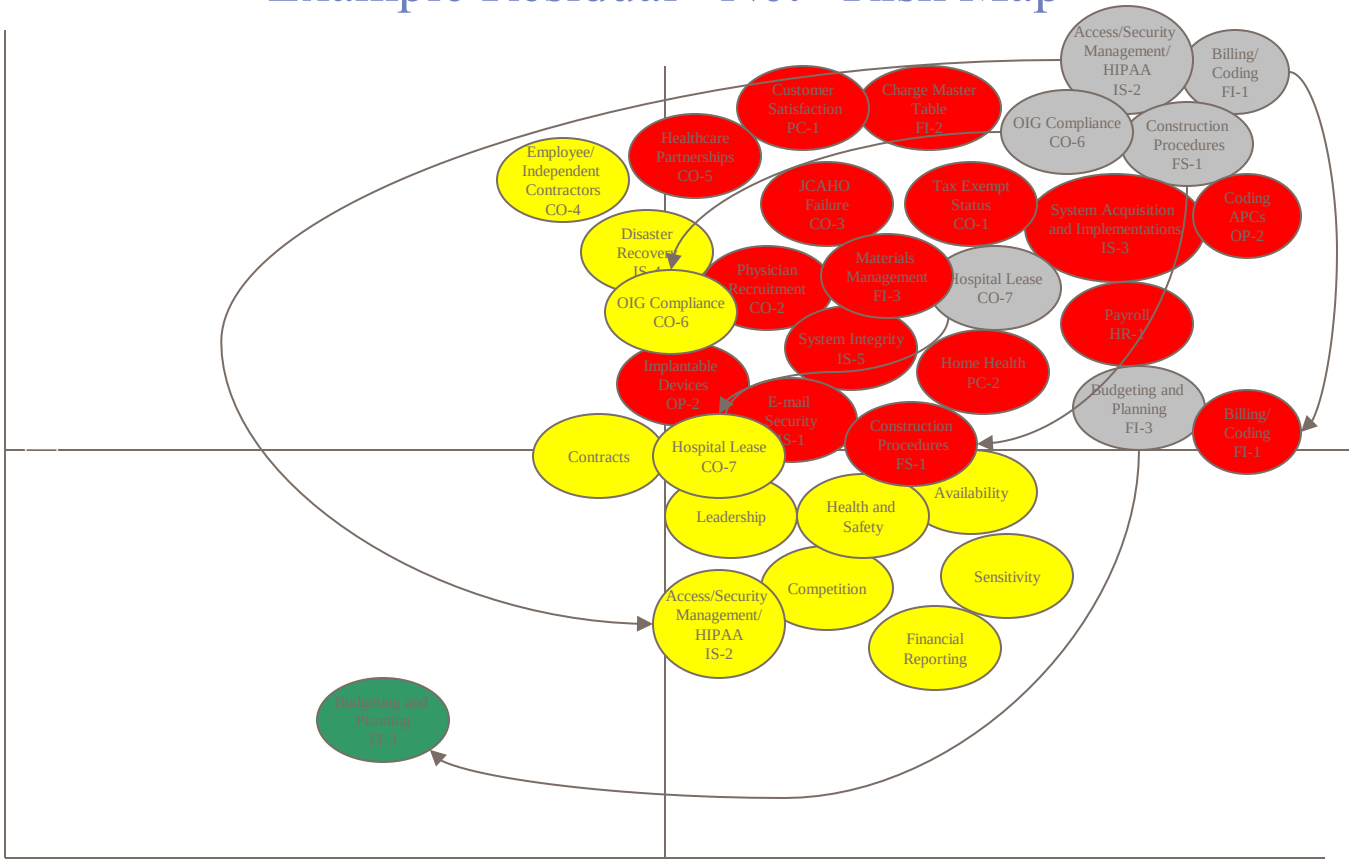
R22 Larger District Board Turnover Possibility in 2025 (

R23 Supply Chain - Procurement Process/Value Analysis/OP Time Interface/ GPO Contract Expiration

R24 Information Blocking/Price Transparency/No Surprise Act

R25 Managed Care Contracts/Differential Adjustment Payments (DAP)/Payer Contract Management/ Denied Reimbursement/Credentialling Physicians

Example Residual "Net" Risk Map



Internal Audit

Internal Control

- In 2013, the Committee of Sponsoring Organizations of the Treadway Commission (COSO) updated their model for evaluating internal controls.
- This model has been adopted as the generally accepted framework for internal control.
- The COSO model defines internal control as: a process, effected by an entity's board of directors, management and other personnel, designed to provide "reasonable assurance" regarding the achievement of objectives in the following categories:
  - Effectiveness and efficiency of operations
  - Reliability of financial reporting
  - Compliance with applicable laws and regulations

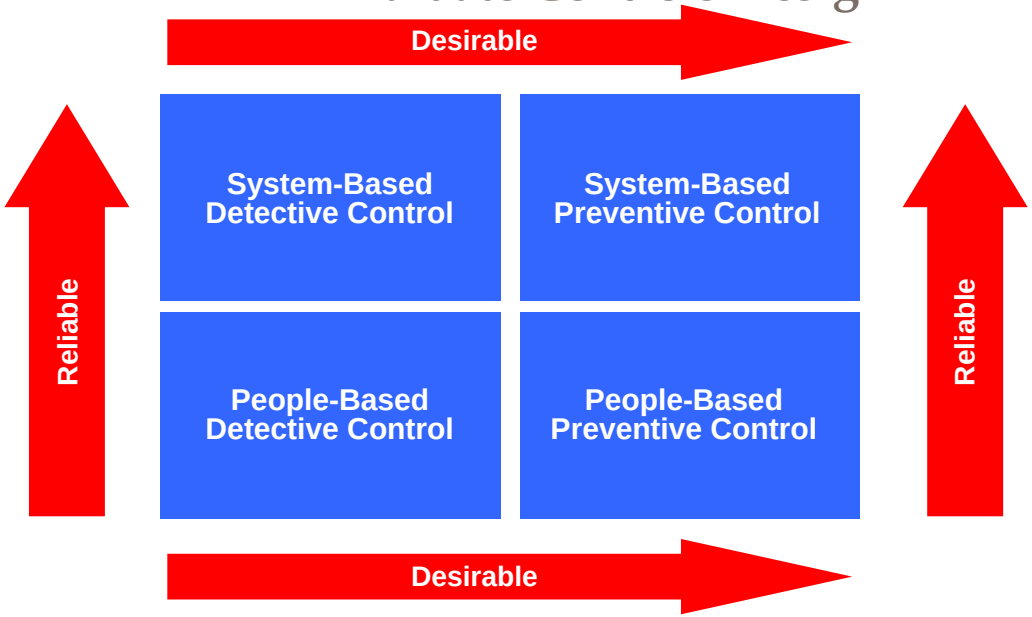
Types of Internal Controls

- **Preventive** - controls that prevent the loss or harmful event from occurring.
  - Segregation of duties minimizes the chance an employee can issue fraudulent payments (i.e. one person submits a payment request, but a second person must authorize it).
- **Detective** - controls that monitor activity to identify instances where practices or procedures were not followed.
  - An exception report that detects and lists incorrect or invalid entries or transactions.
- **Corrective** - controls that restore the system or process back to the state prior to a harmful event.
  - A full restoration of a system from backup tapes after evidence is found that someone has improperly altered the payment data.

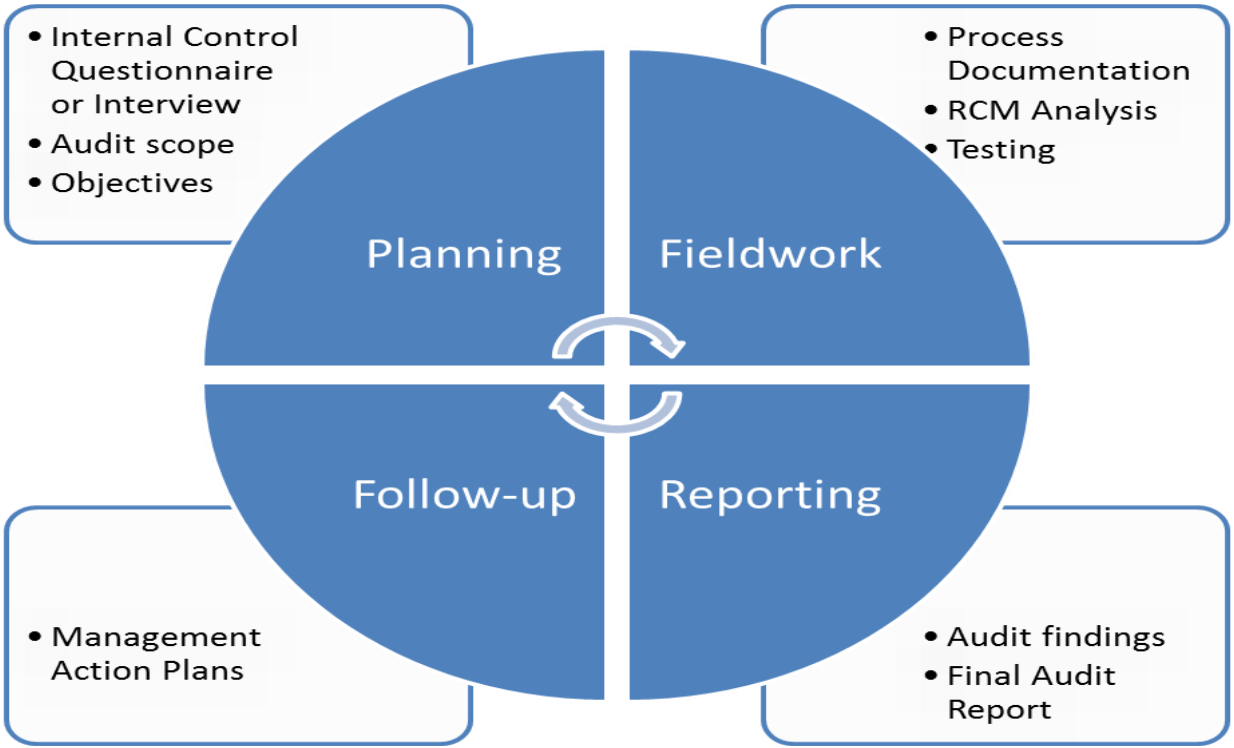
Determine Controls that Mitigate Risks

CONTROL / kun-'trol *(noun):* to reduce the incidence or severity of, especially to innocuous levels.

Control Types
Evaluate Controls Design



The Internal Audit Process

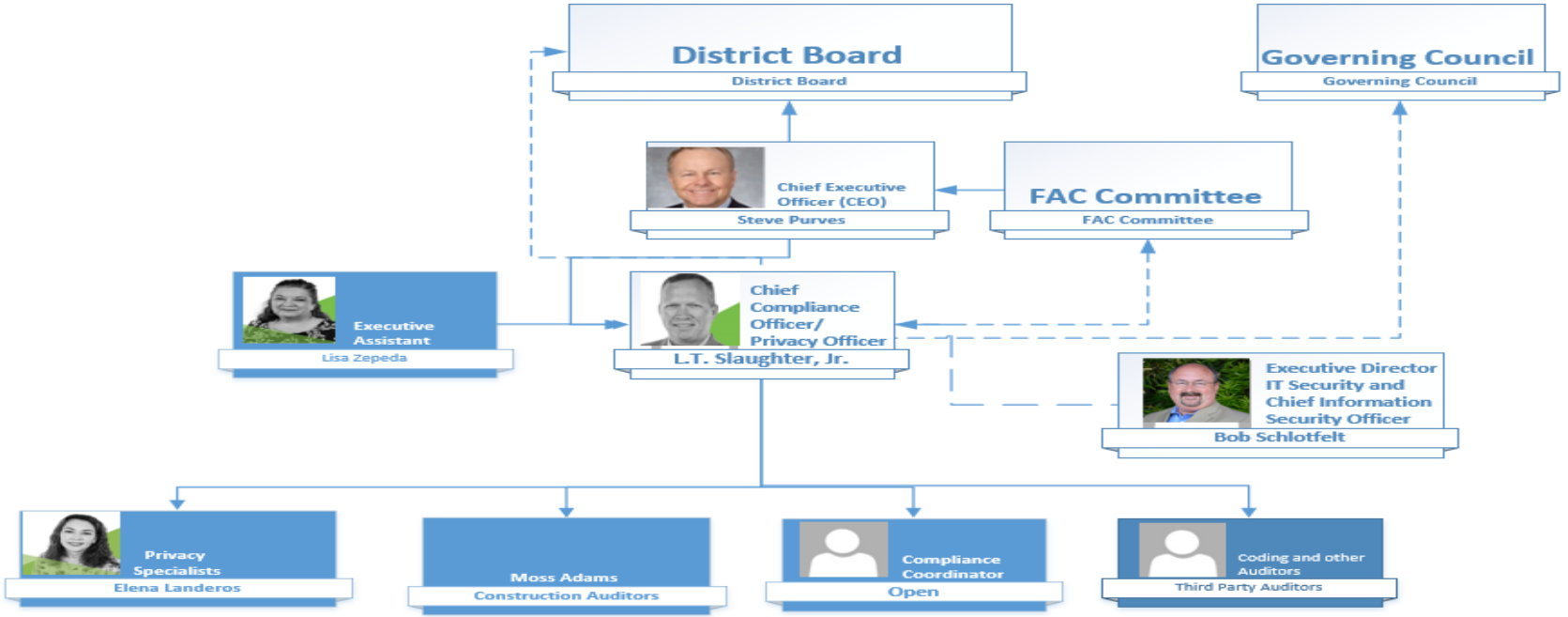


Compliance Program and Code of Conduct and Ethics

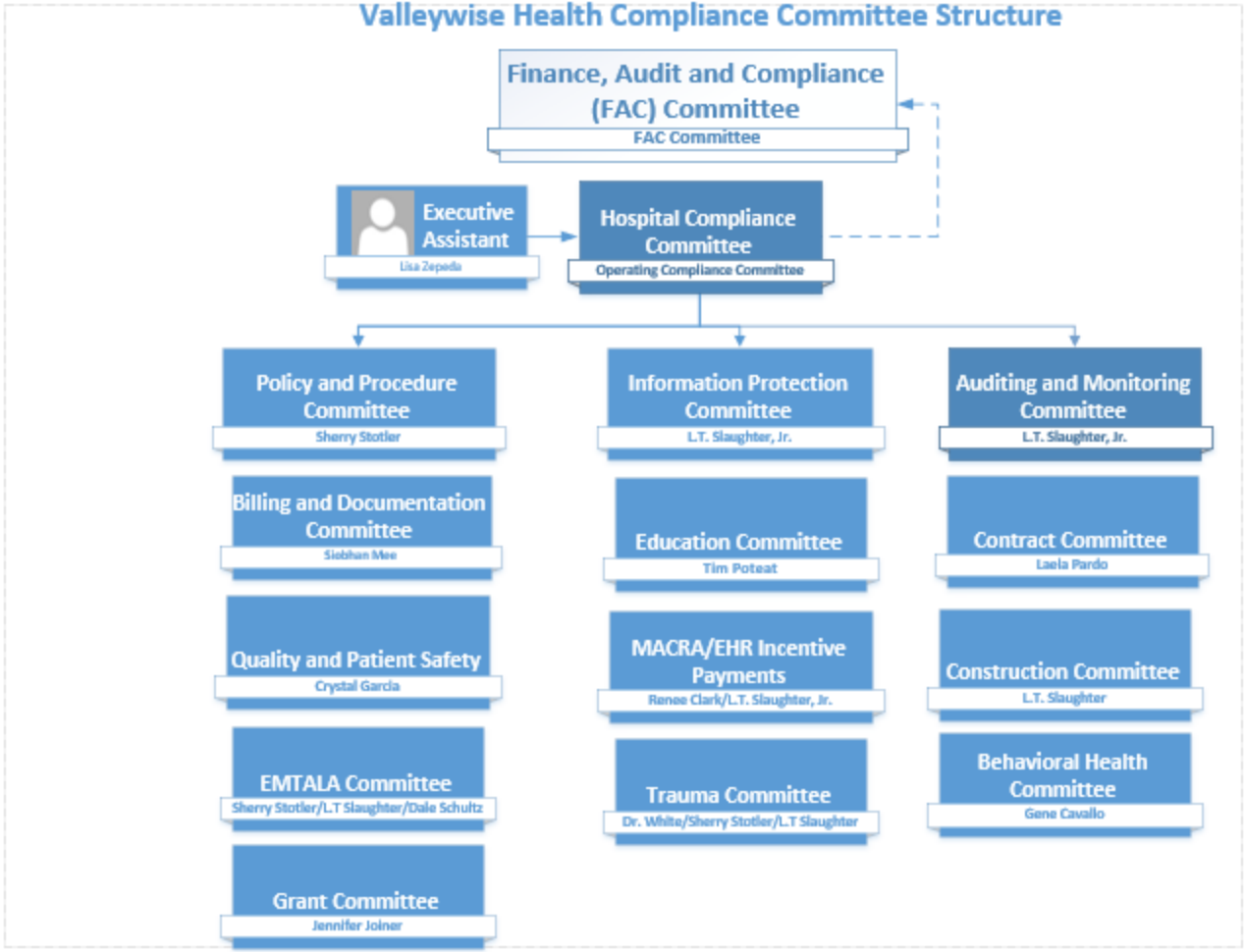
Valleywise Health's Compliance Plan

To help the organization follow rules and be ethical, the Office of Inspector General (OIG) has listed seven elements that facilities should include in their corporate compliance plan. Valleywise Health has used the OIG's guideline as a model, and it is the responsibility of all employees to understand ours

Valleywise Health Compliance Department
Organization Chart and Reporting Structure



Valleywise Health Compliance Committee Structure



Element One: Code of Conduct and Ethics ("The Code") and Policies and Procedures

THE CODE

This Code of Conduct and Ethics ("The Code") has been adopted by the Maricopa County Special Health Care District, d/b/a Valleywise Health ("Valleywise Health"), Board of Directors ("District Board") to provide standards by which the District Board, Valleywise Community Health Centers Governing Council ("Governing Council"), Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members will conduct themselves to protect and promote organization-wide integrity and to enhance Valleywise Health's ability to achieve its organizational mission.

Policies and Procedures

All policies and procedures are located on the Vine and ar
(our online policy and procedure management system).

Compliance 360° Policies/Forms

Valleywise Health

Maricopa County Special Health Care District

Code of Conduct and Ethics

November 26, 2024

Please sign here:_____ Date: _____

Please print your name:_____ Dept. _____

*We are requesting that you sign this today

Standards of Conduct and Ethics – "THE CODE"

T - Treat all Patients with respect and dignity – Providing High Quality Services

H - Healthcare Legal and Regulatory Compliance – Full Compliance with applicable laws.

E - Evaluate Conflict of Interests – See Policy 99305 G.

C - Relationships with Payers and Government - Satisfy the Conditions of Payment Required to Payers

O – Oversight of Relationships with Physicians and other Providers

D - Respect for Our Culture – Recognize our Diverse workforce

E – Electronic Information Systems – Information is used appropriately and safeguarded zealously.

E EVALUATE CONFLICT OF INTERESTS

Valleywise Health has adopted the Conflict of Interest and Gift Policy – 01291 S.

Conflict of Interest and Gift Policy

Valleywise Health Administrative Policy & Procedure

Effective Date: 08/10, 11/17

Reviewed Dates: 03/15, 11/17, 05/19

Revision Dates: 08/12, 11/17, 12/19, 12/21, 12/23

Policy #: 01291 S

Policy Title: Compliance: Conflicts of Interest and Gift Policy

Scope:
- [ ] District Governance (G)
- [X] System-Wide (S)
- [ ] Division (D)
- [ ] Multi-Division (MD)
- [ ] Department (T)
- [ ] Multi-Department (MT)
- [ ] FQHC (F)

Conflict of Interest

3. **Gifts**: Workforce Members may accept Gifts of Nominal Value (under $25); however, Workforce Members may not accept any Gift in the form of cash or cash equivalents (including gift cards or gift certificates) from Vendors, Contractors or patients. The total value of Nominal Value Gifts accepted in any 12-month period from a single individual or entity may not exceed $250.

Conflict of Interest Form - 44239

Valleywise Health
Conflict of Interest Disclosure Form

Prior to completion of this form, you should be familiar with Valleywise Health's Conflict of Interest Policy which defines many terms used within this disclosure form. You should disclose all actual and potential conflicts of interest. In the event you have questions, please consult the Conflict of Interest Policy or contact the Valleywise Health Chief Compliance Officer, at (602) 344-5915.

Element Two: Oversight & Accountability - Chief Compliance Officer

Valleywise Health has designated L.T. Slaughter, Jr. to be the Chief Compliance Officer. You can reach him directly at (602) 344-5915 or submit a questions through the Vine at “ask the Compliance Officer”.

Element Three: Effective Training

We provide all new hires and existing employees as well as medical staff, residents, contractor and other agents APEX computerized training for the annual requirement. We will also be issuing awareness trainings that will cover compliance, privacy and IT security topics. Lastly, we have developed specific resources, tools and reference materials that are available in the Compliance page of the Vine.

What if training is not completed?

If the required training is not completed by year-end, then there are disciplinary policies and procedures for employees, medical staff, residents, contractor and other agents.

We achieved 98% to 99% completion rate in FY2017 through FY2024 (all physicians, courtesy, residents, agents and employees ….over 4,100 individuals)

Element Four: Lines of Communication

The Compliance Hot Line (Ethics Line) is intended to supplement existing internal communication channels. It is not intended to replace your management team, senior management or other corporate resources. The Compliance Hot Line (Ethics Line) is available when you believe that you have exhausted normal Valleywise Health channels or feel uncomfortable about bringing an issue to your supervisor or a higher-level supervisor.

The Compliance Hot Line (Ethics Line) is available 24 hours a day, seven days a week.

1-866-333-6447

Element Five: Policies, Procedures and Disciplinary Guidelines

We have a progressive disciplinary policy provided by Human Resources. This policy is available on the Vine and in Compliance 360 our online policy and procedure portal.

"We have a zero tolerance for non-compliance".

Steve Purves President and CEO

L.T. Slaughter, Jr., Chief Compliance Officer

Element Six: Auditing and Monitoring

We utilize a risk-based auditing and monitoring approach. We focus on the highest risks and also implement monitoring tools throughout the organization to provide a span on controls and to identify issues as quickly as possible.

Element Seven: Corrective Actions

When an issue has been identified, the Compliance Department will work closely with management to recommend corrective action and may assist with the implementation of the plan and future monitoring for effectiveness.

Element Eight: Monitoring Effectiveness of the Plan

The Finance, Audit and Compliance (FAC) Committee monitors the effectiveness of the internal audit and compliance program. They report their findings to the CEO quarterly and this get reported to the Board of Directors.

Audit and Compliance Plan Examples

FY2025 Compliance Work Plan – Example

The FY2025 compliance projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of compliance with regulations, as well as the identification of value-added recommendations. The FY 2025 compliance work plan represents compliance activities based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1						
CQ1.1 Level One Trauma - American College of Surgeons (ACS) Grey Book Review Part 1 (R3)	Q1	150 Hours			5	
CQ1.2 Grants (Uniform Guidance) and Research Reviews (R15)	Q1	100 Hours			5	
CQ1.3 Privacy and Security - New Tower and Audio and Visual Controls, Infant Abduction (R5)(R10)	Q1	100 Hours			5	
CQ1.4 Public Information Requests Training (R20)	Q1	75 Hours			5	
Risk Re-assessment and Selection Q2						
CQ2.1 Level One Trauma - ACS Grey Book Review Part 2 (R3)	Q2	150 Hours			5	
CQ2.2 Physician Documentation, Attestations and Observation Status and Charge Reconciliations (R12)(R21)	Q2	100 Hours			5	
CQ2.3 EMTALA and Dedicated Emergency Departments (R16)	Q2	100 Hours			5	

Data Dictionary for the Compliance and Internal Audit Work Plan

ACS – American College of Surgeons - Entity that verifies level one trauma center's processes and quality.
AHCCCS – Arizona Healthcare Cost Containment System – State of Arizona's name for the Medicaid state plan.
DNV – (Det Norske Veritas. Inc.) Acute care Medicare accreditation organization.
EMTALA – Emergency Medical Treatment and Labor Act – Log, Screen and Stabilize patients that present to a dedicated emergency department.
EPIC – Electronic medical record system used by Valleywise.
FQHC – Federally Qualified Health Centers – Primary care entities that are granted this status by HRSA.
GME – Graduate Medical Education – is a formal hospital-based training program for individuals that have completed medical school.
HRSA – Health Resources & Services Administration – Governmental entity that regulates 340b, Ryan White and FQHCs.
Information Blocking – Cures Act regulation requiring medical information systems to communicate with other systems.
Medicare PPS – Medicare Prospective Payment System – A fixed based Medicare payment model.
No Surprise Act – Regulation that establishes federal prohibitions against certain surprise medical bills.
Observe Smart – Behavioral health patient rounding monitoring system.
Price Transparency Rules – Rules that help Americans know the cost of covered medical services.
Prop 480 (Care-Reimagined) – Referendum passed by the voters of Maricopa County to fund the re-construction of Maricopa County Special Health Care District d/b/a Valleywise Health.
PHE - Public Health Emergency – U.S. Department of Health and Human Services can declare a public health emergency under Section 319 of the Public Services Act.
SAFER Guidelines – A set of self-assessment tools aimed at helping healthcare organizations evaluate their electronic health record safety practices, identify potential risks and mitigate those risks.
Uniform Guidance – A government-wide framework for grant management, rules and requirements.
340b – A HRSA sponsored discount drug program (797 is compounding regulations).

FY2025 Internal Audit Work Plan - Example

The FY2025 internal audit projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of internal controls as well as the identification of value-added recommendations. The FY2025 audit plan represents audits based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

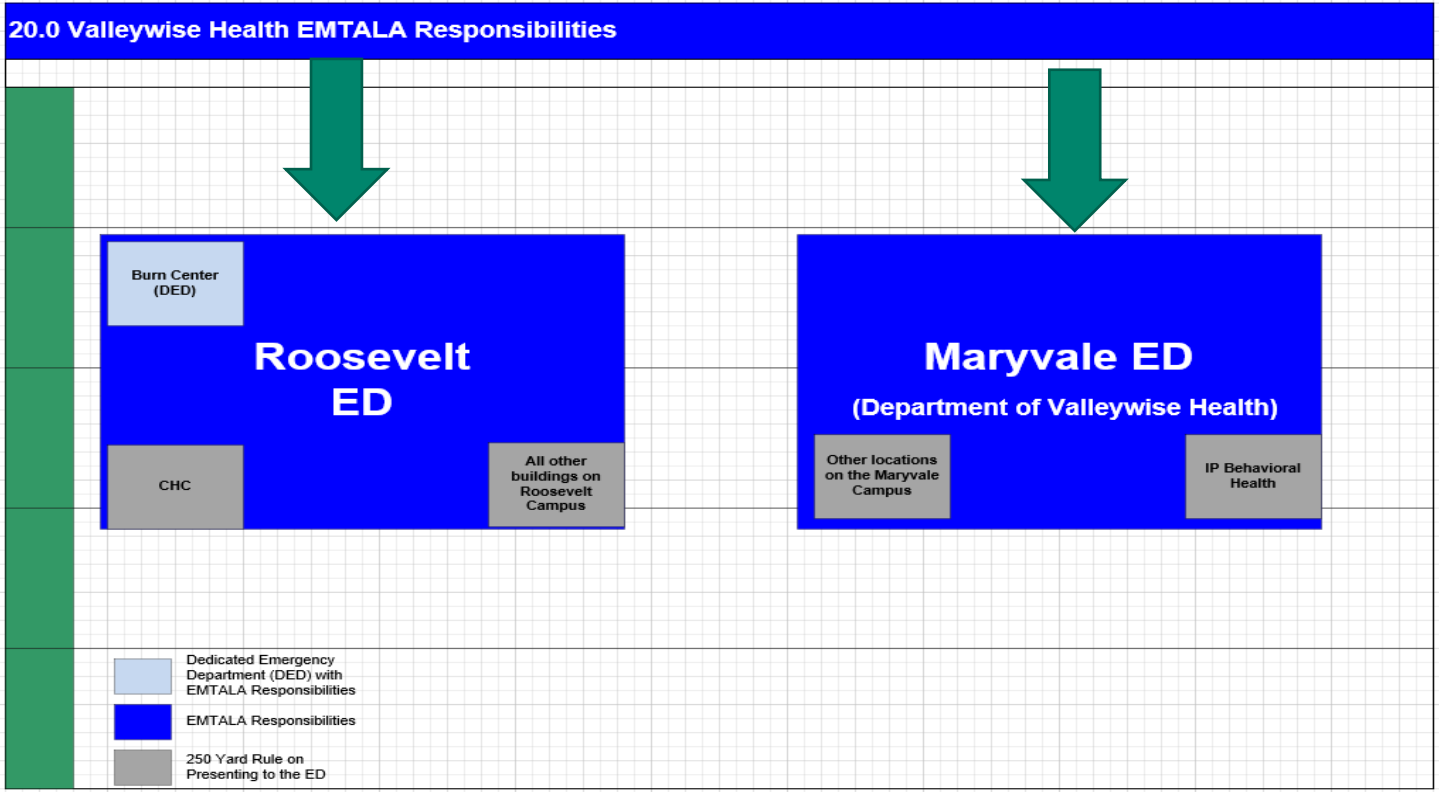
Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1 (Current State Assessment)						
IQ1.1 Care Re-Imagined (Prop 480) Controls and Monitoring Review (R2)	Q1	100 Hours			5	
IQ1.2 Human Resources, Benefits, and Payroll Controls Part 1 (R1), (R4)	Q1	150 Hours			5	
IQ1.3 Contracting Process - Approval Matrix and Contract Flows (R8) ($14)	Q1	150 Hours			5	
Risk Re-assessment and Selection Q2						
IQ2.1 Medicare and AHCCCS Medicaid Direct Payments (R9)(R25)	Q2	200 Hours			5	
IQ2.2 Care Re-Imagined (Prop 480) Controls and Monitoring Review (R2)	Q2	100 Hours			5	
IQ2.3 Human Resources, Benefits, and Payroll Controls ADP Implementation Part 2 (R1), (R4)	Q2	150 Hours			5	
IQ2.4 IT Disaster Recovery/Business Continuity Assessment and SAFER Guidelines (R6)	Q2	100 Hours			5	

Compliance Regulations and Other Key Issues

The Emergency Medical Treatment and Labor Act (EMTALA), is also known as the Patient Anti-Dumping Law.

- ❑All clinical facilities must meet or exceed the requirements of the Emergency Medical Treatment and Labor Act (EMTALA) in providing emergency medical treatment to all patients
- ❑When an individual arrives alone or with another person at a clinical facility, and a request is made on the individual's behalf for a medical examination or for treatment, a clinical facility must provide for an appropriate medical screening examination within the capability of the facility's emergency department, to determine whether an emergency medical condition exists, or with respect to a pregnant woman having contractions, whether the woman is in labor.
- ❑The facility must not delay an examination or treatment to inquire about the method of payment or the individual's insurance status
- ❑If a medical emergency exists, or a woman is in labor, the clinical facility must treat and stabilize the patient before transferring to another facility.

The Emergency Medical Treatment And Labor Act (EMTALA), is also known as the Patient Anti-Dumping Law.



Emergency Medical Treatment and Labor Act (EMTALA)

- **The Emergency Medical Treatment and Labor Act (EMTALA) is triggered when one of two events occur:**

1. **Patient Presents:** Individual comes to the 1) **Maryvale ED** 2) **Roosevelt ED or to our Dedicated Emergency Departments (DED) at Roosevelt Campus (i.e., Burn ED)** or 3) **on the either campus/property** and a request is made for examination/treatment for an emergency medical condition ("EMC") (or based on appearance, prudent layperson observer would believe individual needs an exam); or

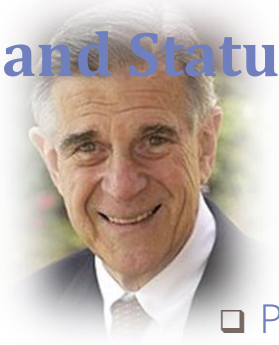
2. **Transfer Requested:** A transfer request is made for an unstable ED patient where the transferring hospital lacks specialized capability or capacity to treat individual at the time of the request and the recipient hospital has capability and capacity to treat at the time of the request.

Emergency Medical Treatment and Labor Act (EMTALA)

- **1) INDIVIDUAL PRESENTS:**
- **1.1) LOG**
- **1.2) SCREEN**
- **1.3) STABILIZE**
- **(EVERY INDIVIDUAL EVERY TIME)**

Fraud, Waste and Abuse:

Laws and Statutes



Pete Stark –
CA Congressman

Stark Law – known as "Physician Self Referral Law"

Enacted 1992

- Physician may not make a referral to an entity for which Medicare payment may be made if the physician or an immediate family member that has a financial relationship with the entity
- Can be liable for civil penalties of up to $15,000
- 3 X, the amount of improper payment received from the Medicare program;
- Exclusion from the Medicare / Medicaid programs
- Payment of civil penalties of up to $100,000 for each circumvention scheme.

Laws and Statutes

Valleywise Health

The Anti-Kickback Statute – Enacted 1987

- Prohibits making or accepting payment to induce or reward for referring, recommending or arranging for the purchase of any item for which payment may be made under a federally-funded health care program.
- Prohibits outright bribes, offering inurement or remuneration when its purpose is the inducement of a physician to refer patients for services or Research Studies that will be reimbursed by a federal healthcare program.
- Both sides of an impermissible kickback relationship are liable
- Violations can lead to criminal and civil penalties.

False Claims Act (Lincoln's Law)

Valleywise Health

Enforcement

Imposes liability on persons and companies who defraud government programs

- ❑ Results in both criminal and civil liabilities
- ❑ 7 types of misconduct
- ❑ Knowledge requirement
- ❑ "Deliberate Ignorance", and "Reckless Disregard", increased civil fines, increased rewards for whistleblowers, employment protection.

Examples of False Claims

- ❑ Billing for a service that was not medically necessary
- ❑ Billing and inflating costs in order to be reimbursed
- ❑ Billing for services that are research-only services
- ❑ Billing Medicare or Medicaid for services that are paid for by the Study Sponsor

FCA Implications

What could be the impact on the hospital?

- Criminal & Civil Liability*
- Cost associated with investigating the alleged fraud
- Impact to revenue
- Damaged reputation
- Corporate Integrity Agreement

An agreement usually for 5 years with strict audit, reporting and compliance program activities must be conducted – strictly monitored by Office of Inspector General

*Any person knowingly submits false claims is liable for treble damages and penalties per claim from $5,000 to $11, 000

Deficit Reduction Act (DRA)

Deficit Reduction Act of 2005 (signed 2006) and the Employee Whistleblower Protection 2013

- Requires we teach about whistleblowing, includes employees may not be demoted, discriminated against or discharged for disclosing information.
- The DRA is driven by amount of Medicaid dollars.
- **5 million dollars** or more in a given period in a calendar year
- Requires whistleblower to have followed internal reporting process

Deficit Reduction Act Policy 01111S

We were audited by AHCCCS in 2019, 2021 and 2024 and achieved a 100% compliance rating.

Valleywise Health Administrative Policy & Procedure

Effective Date: 10/06

Reviewed Dates: 11/11, 11/17, 09/18, 01/20

Revision Dates: 02/08, 01/10, 06/15, 09/15, 11/17, 12/21, 12/23, 03/24

Policy #: 01111 S

Policy Title: Compliance: False Claims Act

Scope:
- [ ] District Governance (G)
- [X] System-Wide (S)
- [ ] Division (D)
- [ ] Multi-Division (MD)
- [ ] Department (T)
- [ ] Multi-Department (MT)
- [ ] FQHC (F)

HIPAA Privacy and Security

Privacy vs Security

The privacy rules identify what information is protected. They also define when and how that information may be used or disclosed. The security rules identify steps to take to secure PHI that is in electronic format. These rules help to make sure processes are in place to protect the information covered by the privacy rules.

Respect of the Patient's Health Information (PHI)

Eight main areas to watch out for at Valleywise Health:

1. E-MAILS and TEXTING – E-mailing or texting unencrypted PHI or clicking inappropriate links.
2. PHI ON DEVICES - Unencrypted Devices with PHI – Loss of thumb drives, computers, cell phones, etc.
3. PICTURES AND VIDEOS- Taking Pictures of PHI with a non-Valleywise Health camera.
4. SOCIAL NETWORKS – Posting information on social networks.
5. FAXES (make sure you verify the number).
6. TRASH (do not throw away IV bags, stickers, etc. with patient identifiers on them).
7. DISCUSSION WITH PEERS or PATIENTS (Peers - Dining Room, elevators, home, etc. – Patients - Inappropriate Setting.)
8. MAILING/PROVIDING CORRESPONDENCE - Providing patients with paperwork related to their care.

Breach and Obligations

Where a covered entity knows of a material breach or violation by the business associate of the contract or agreement, the covered entity is required to take reasonable steps to cure the breach or end the violation, and if such steps are unsuccessful, to terminate the contract or arrangement.

If termination of the contract or agreement is not feasible, a covered entity is required to report the problem to the Department of Health and Human Services (HHS) Office for Civil Rights (OCR)

VALLEYWISE HEALTH'S PROACTIVE RESPONSE:

- ✓ Implemented a Compliance Program (Seven Elements)
- ✓ Push!
- ✓ Risk Management Plan (Risk Assessment)
- ✓ Compliance and Internal Audits
- ✓ Policies and Procedures Reviews
- ✓ Education Training General and Specific
- ✓ Designate a Compliance Officer, Privacy Officer and Information Security Officer
- ✓ Discipline and Corrective Actions
- ✓ Communication and Team Work
- ✓ Expect to be Excellent!

Questions?

Maricopa County Special Health Care District
Code of Conduct and Ethics
November 26, 2024

Summary of Approvals

Approval Signatures:

Chairman, District Board
Maricopa County Special Health Care District

November 26, 2024
Date

President and Chief Executive Officer
Valleywise Health

November 26, 2024
Date

Chief Compliance Officer
Valleywise Health

November 26, 2024
Date

Code of Conduct and Ethics
Effective November 26, 2024

I. PURPOSE

This Code of Conduct and Ethics ("Code") has been adopted by the Maricopa County Special Health Care District, d/b/a Valleywise Health ("Valleywise Health"), Board of Directors ("District Board") to provide standards by which the District Board, Valleywise Community Health Centers Governing Council ("Governing Council"), Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members will conduct themselves to protect and promote organization-wide integrity and to enhance Valleywise Health's ability to achieve its organizational mission. The Code is intended to serve as a guide to assist the District Board, Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members to make sound decisions in carrying out their day-to-day responsibilities.

II. RESPONSIBILITIES UNDER THE CODE OF CONDUCT and ETHICS

Who must comply with the District's Code of Conduct and Ethics?

The Code applies to *all* members of the District Board, Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors, and other Valleywise Health committee members. Valleywise Health recognizes the different missions and services that each of these entities provide in developing policies and procedures to achieve the standards and goals set forth in the Code while maintaining each of their unique missions and services.

Definitions:

Administration: Executive leadership (including President and Chief Executive Officer, Executive Vice Presidents, and Senior Leadership including Senior Vice Presidents and Vice Presidents, and Chief Compliance Officer) of Valleywise Health.

Advanced Practice Clinicians (APCs): Individuals other than Medical Staff members or AHPs who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.

Allied Health Professionals (AHPs): Individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.

Board of Directors – The five publicly elected officials that serve on the Maricopa County Special Health Care District, d/b/a Valleywise Health, for Maricopa County, Arizona.

Clinical Privileges or Privileges: The authorization granted by the District Board to render specific patient care services, for which the Medical Staff leaders and the District Board have developed eligibility and other privileging criteria and focused and ongoing professional practice evaluation standards.

Contractors: A person or entity who is not employed by Valleywise Health and who is performing specific services as defined in their contract.

Finance, Audit and Compliance Committee (FACC): An advisory committee to assist Valleywise Health's President and Chief Executive Officer ("CEO") with oversight responsibilities related to compliance and financial matters, and internal and external audit functions.

Governing Council: Governing body that maintains oversight of the Federal Qualified Health Center (FQHC).

House Staff: Includes residents, fellows, and individuals licensed as appropriate, who are graduates of medical, allopathic and osteopathic, dental, or podiatric schools; who are appointed to a hospital's professional graduate training program that is approved by a nationally recognized accrediting body; and who participate in patient care under the direction of a member of the Medical Staff of the pertinent clinical disciplines with appropriate clinical privileges in the hospital.

Management: – Valleywise Health Employees who provide supervision to other Valleywise Health Employees.

Medical Staff: All physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the District Board.

Provider: A Medical Staff member with Clinical Privileges, a House Staff member, an Advanced Practice Clinician, or an Allied Health Professional.

Vendor: Any person or entity under contract with Valleywise Health to provide goods.

Workforce Member: Governing Council members, Valleywise Health Employees, Providers, Agents, and other Valleywise Health committee members whether or not they are paid by Valleywise Health.

What are your responsibilities as a Valleywise Health employee with regard to the Code?

Foster and support an atmosphere of compliance by:

- Reading the Standards of Conduct and Ethics contained in the Code and think about their application to your work. You should have a basic understanding of issues covered by each Standard and the supplemental compliance policies that apply to your job function.

- Seeking guidance from your supervisor(s), Administration, Management, the Chief Compliance Officer or other Valleywise Health leadership resources when you have questions about the application of the standards and other Valleywise Health policies related to your work.

- Understanding the options that Valleywise Health makes available to you for conduct or ethical concerns and promptly raise such concerns with your immediate supervisor or Valleywise Health's Chief Compliance Officer or General Counsel. If you prefer to raise your concerns anonymously, call the Valleywise Health Compliance Hotline Line 1-866-333-6447 and/or you can file a concern on the Valleywise Health internal website (i.e., The Vine) under "Report a Compliance Concern".

- Cooperating in Valleywise Health's investigations concerning potential violations of the law, government payer regulations and rules, the Code, the Valleywise Health Compliance Program and Valleywise Health's policies and procedures.

- Completing all required compliance training.

- Understanding that accessing a patient's personal health information (PHI), where you are not involved in their care, would be a violation of Valleywise Health's privacy policies. Employees should only use MyChart to access their own PHI. Additionally, Employees should not access their relatives or anyone else's PHI where they are not involved in their care (See Policy 01261 S). Taking pictures with a personal camera or cell phone (especially in a treatment area) is a violation of Valleywise Health's policies and will result in immediate disciplinary actions.

What are your responsibilities as Valleywise Health's Administration and Management?

Build and maintain a culture of compliance by:

- Leading by example, using your own behavior as a model for all Employees.
- Knowing, understanding, and following the federal, state, and local statutes, rules and regulations that govern your area(s) of responsibility.
- Encouraging Employees to raise conduct and ethical questions and concerns.
- Ensuring that all Workforce Members (within your areas of responsibility) complete all required annual compliance training.

Prevent compliance problems by:

- Identifying potential compliance risks and proposing appropriate policies, procedures, and actions to address such risks.
- Identifying Workforce Member's whose activities have compliance risks and that are covered by Valleywise Health's policies and procedures.
- Providing education, role playing and counseling to assist Workforce Members to understand the Code, Valleywise Health policies and procedures, applicable laws, and government payer regulations and rules.

Detect compliance problems by:

- Maintaining appropriate controls to monitor compliance and mechanisms that foster the effective reporting of potential compliance issues.
- Promoting an environment that permits Workforce Members to raise concerns without fear of retaliation.
- Arranging periodic compliance reviews that are conducted with the assistance of Valleywise Health's Chief Compliance Officer to assess the effectiveness of Valleywise Health's Compliance Program and related policies and procedures, and to identify methods of improving them.

Respond to compliance problems by:

- Pursuing prompt corrective action to address weaknesses in internal controls.

- Applying corrective action(s) and disciplinary plans when necessary.

- Consulting with Valleywise Health's Chief Compliance Officer to ensure compliance issues are promptly and effectively addressed.

What are your responsibilities as the District's Board of Directors

Build and maintain a culture of compliance by:

- Reading the Standards of Conduct and Ethics contained in the Code, thinking about them and their application to your role.

- Leading by example, using your own behavior as a model for others.

- Making decisions that are in the best interest of Valleywise Health and that are not affected by conflicts of interest (See the District Board Conflicts of Interest and Gift Policy - 99305 G).

- Being knowledgeable about the Valleywise Health Compliance Program (as taught in the new District Board member training and in the annual compliance training) and exercise governance and oversight over it.

- Requiring appropriate reports from Administration concerning the status of the Valleywise Health Compliance Program, the resources required to maintain its vitality and Valleywise Health's response to identified compliance deficiencies.

- Receiving and acting on compliance issues, upon advice from Valleywise Health's President and Chief Executive Officer, District Board Counsel, General Counsel, and/or Chief Compliance Officer.

- Assuring that the Compliance Program is free from undue restraints and influences through direct reporting by the Chief Compliance Officer regarding compliance issues that promote the integrity of the Compliance Program and raising any concerns with the Chief Compliance Officer, District Board Counsel and General Counsel.

- Maintaining the confidentiality of all compliance-related information provided to you, subject to the requirements of applicable law.

- Complete required compliance training.

What are your responsibilities as Provider?

Assist Valleywise Health to foster an atmosphere of compliance by:

- Reading the Standards of Conduct and Ethics contained in the Code and think about their application to your work. You should have a basic understanding of issues covered by each Standard and the supplemental compliance policies that apply to the services you furnish to Valleywise Health and our patients.

- Actively participating in compliance activities as requested by Valleywise Health.

- Maintaining the confidentiality of information provided to you relating to compliance issues subject to applicable laws.

- Assisting Valleywise Health in identifying potential compliance issues and in developing possible solutions to address issues identified.

- Understanding the options that Valleywise Health makes available for you to report ethical concerns and to promptly raise such concerns with Valleywise Health's Chief Compliance Officer or General Counsel. If you prefer to raise your concerns anonymously, call the Valleywise Health Compliance Hotline 1-866- 333-6447 and/or you can file a concern on the Valleywise Health's internal website (i.e., The Vine) under "Report a Compliance Concern."

- Cooperating in Valleywise Health investigations concerning potential violations of the law, government payer regulations and rules, the Code, the Valleywise Health Compliance Program and Valleywise Health's policies and procedures.

- Completing required compliance training.

- Understanding that accessing a patient's personal health information (PHI), where you are not involved in their care, would be a violation of Valleywise Health's privacy policies. Providers should only use MyChart to access their own PHI. Additionally, Providers should not access their relatives or anyone else's PHI where they are not involved in their care (See Policy 01261 S). Taking pictures with a personal camera or cell phone (especially in a treatment area) is a violation of Valleywise Health's policies and will result in immediate disciplinary action.

What are your responsibilities as Governing Council Member, Agents, Contractors, Vendors or other Valleywise Health committee member (e.g., FACC member)?

Governing Council Members, Agents, Contractors, Vendors and other Valleywise Health committee members are responsible to participate in the Valleywise Health compliance program by:

- Understanding and applying the Standards of Conduct and Ethics contained in the Code and think about their application to the services you furnish to Valleywise Health. You should have an understanding of issues covered by each Standard and the supplemental compliance policies that apply to the services you furnish to Valleywise Health.

- Actively participating in compliance activities, such as education, role playing and training, as requested by Valleywise Health or have equivalent requirements in their contract.

- Understanding the various options that Valleywise Health makes available for raising conduct or ethical concerns and promptly raise such concerns. You should raise such concerns with Valleywise Health's Chief Compliance Officer or General Counsel. If you prefer to raise your concerns anonymously, call the Valleywise Health Compliance Hotline 1-866-333-6447 and/or you can file a concern on the Valleywise Health's internal website (i.e., The Vine) under "Report a Compliance Concern".

- Cooperating in Valleywise Health's investigations concerning potential violations of law, government payer regulations and rules, the Code, the Valleywise Health Compliance Program and Valleywise Health's policies and procedures.

- Completing required compliance training.

How May the Code Be Revised?

This Code may be amended, modified only after a review by the FACC, Chief Executive Officer and the approval of the District Board.

How Frequently will the Code and Compliance Program Be Reviewed?

The Code will be reviewed annually by the FACC and District Board to foster its effectiveness and at such times when changes to it are necessitated by changes in laws and regulations applicable to Valleywise Health. Suggested changes to the Valleywise Health Compliance Program will be presented to the District Board for approval, as necessary.

III. STANDARDS OF CONDUCT AND ETHICS (THE STANDARDS)

Patient Relationships: Valleywise Health (We) through our Administration, Clinical Departments, Providers and Quality Department (and other departments as needed) are committed to providing a high quality of healthcare and services to our patients, their families, visitors, and the community. We treat all patients with respect and dignity and provide care that is necessary and appropriate.

Principles:

- We will recognize the right of our patients to receive quality and appropriate services provided by competent individuals in an efficient, cost effective and safe manner.
- We will continually monitor the clinical quality of the services we provide and will endeavor to improve the quality of the services provided.
- We will support every patient's right to be free from all types of abuse and will not tolerate patient abuse in any form.
- We will apply our admission, treatment, transfer, and discharge policies equally to all patients based upon identified patient needs and regardless of a patient's ability to pay.
- We will listen to our patients, families, and visitors to understand any concerns or complaints and will involve patients in the decision-making process about their care.
- We will demonstrate our commitment to patient safety by continuously reviewing systems, processes and policies to detect and prevent medical errors.
- We will provide treatment and medical services in accordance with the state and federal laws which provide that an individual shall not be excluded from participation in, be denied the benefits of, or subjected to discrimination on prohibited grounds, such as age, disability, genetic information, national origin, pregnancy, race/color, religion, sex, sexual orientation and gender identity.
- We will remain sensitive to our position as a regional leader in tertiary and specialty care and research, and to our consequent obligation as a health care leader to all segments of our community.

- We will maintain policies and procedures (e.g., Emergency Medical Treatment and Labor Act (EMTALA) policies) to complete logging in the central log, performing a medical screening exam and stabilizing all patients presenting to our Emergency Department (ED) [e.g., Roosevelt Campus (including trauma) and Maryvale Campus] and at our Dedicated Emergency Departments (DED) [e.g., Burn, Labor and Delivery].

- We will fully and fairly evaluate requests to transfer patients to our care from our colleagues and providers in outlying areas and will accept such transfers as clinically appropriate (i.e., EMTALA transfers-in). Additionally, we will fully and fairly transfer patients to external entities (i.e., EMTALA transfers-out) as clinically appropriate as directed by our Medical Staff.

- We will maintain licensure and credentialing standards to further the provision of clinical services by properly trained and experienced practitioners.

- We will perform background checks of existing and potential Governing Council members, other Valleywise Health committee members (as appropriate), Employees, Providers, Agents, and Contractors. We will also assess whether such individuals and entities (including Vendors) have ever been excluded from participation in any of the federal or state health care programs, including the Medicare, Medicaid, and Arizona Health Care Cost Containment System (AHCCCS) programs.

- We will respect the privacy of our patients, and we will treat all patient information with confidentiality, in accordance with all applicable laws, regulations and professional standards.

General Legal and Regulatory Compliance: Valleywise Health (We) through our Legal Department, Regulatory Department, Compliance Department and Administration (and other departments as needed) will continuously and vigorously promote full compliance with applicable laws.

Principles:

- We will continuously study our legal obligations and create policies and procedures that facilitate compliance by educating the District Board, Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members of their legal obligations.

- We will recognize the critical role of research in improving the health status of our community, and we are committed to conducting all research activities in compliance with the highest ethical, moral, and legal standards.

- We will engage in open and fair competition and marketing practices, based on the needs of our community and consistent with the furtherance of our mission.

- We will treat our Employees with respect and will engage in human relations practices that promote the personal and professional advancement of each employee.

- We will recognize that our Employees work in a variety of situations and with a variety of materials, some of which may pose a risk of injury. We are committed to providing a safe work environment and will maintain and monitor policies and procedures for workplace safety that are designed to comply with federal and state safety laws, regulations, and workplace safety directives.

- We will recognize that the provision of health care may in some instances produce hazardous waste products or other risks involving environmental impact. We are committed to compliance with applicable environmental laws and regulations and will follow proper procedures with respect to handling and disposing of hazardous and bio-hazardous waste.

- We will assist our District Board, Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors, and other Valleywise Health Committee members with understanding the basic legal obligations that pertain to their individual job functions or services they furnish to Valleywise Health and our patients. We will also encourage them to make certain that their decisions and actions are conducted in conformity with such laws, regulations, policies, and procedures.

- We will support educational and other training sessions to teach the District Board, Governing Council members, Employees, Administration, Agents, and Providers and, as warranted, Contractors and Vendors, about the impact of the law on their duties and to promote compliance with our collective legal obligations.

- We will support and maintain multiple resources for the District Board, Governing Council members, Employees, Administration, Providers, Agents, Contractors, and Vendors to voice any questions about the proper interpretation of a particular law, regulation, policy, or procedure while performing services for Valleywise Health.

Avoidance of Conflicts of Interest for the Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members.

Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members maintain a duty of loyalty to Valleywise Health and to all of the citizens of Maricopa County and, as a result, must avoid any activities that may involve (or may appear to involve) a conflict of interest or that may influence or appear to influence the ability of the, Governing Council member, employee, Administration, Providers, agent, Contractors, Vendors and other Valleywise Health committee members to render objective decisions in the course of their job responsibilities, or other services they furnish to Valleywise Health (See the Valleywise Health Conflict of Interest and Gift Policy (See 01291 S)**.**

Principles:

Valleywise Health (We) through Administration and the Compliance Department (and other departments as needed) will maintain policies and procedures that make clear when an individual's private interests may inappropriately interfere with Valleywise Health's interests; and will provide support through which the Governing Council members, Employees, Administration, Providers, Agents, Contractors, and Vendors, and other Valleywise Health committee members (See the Valleywise Health Conflict of Interest and Gift Policy (See 01291 S) may disclose and have an evaluation about whether a particular activity or relationship could be construed as a conflict of interest or otherwise improper.

- We will provide examples of the conduct that must be demonstrated by the Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members (See 01291 S) in the performance of services for Valleywise Health and will require that such individuals to evaluate and report conflicts of interest in the performance of their responsibilities and services to Valleywise Health.

- We will educate the Governing Council members, Employees, management, Administration, Providers, Agents, Contractors, Vendors, and other Valleywise Health committee members (See 01291 S about informing Valleywise Health of personal business ventures and other arrangements that could be perceived as conflicts of interest and will provide for policies and procedures for doing so.

- We will educate the Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members (See 01291 S) about the use any proprietary or non-public information acquired as a result of a relationship with Valleywise Health for person gain or for the benefit of another business opportunity.

- We will educate the Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members about the purchase of outside goods based on the Vendor's ability to best satisfy Valleywise Health's needs and not based on personal relationships.

- We will educate the Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members about the purchase of outside services based on the Contractor's ability to best satisfy Valleywise Health's needs and not based on personal relationships.

- The Governing Council members, Employees, Administration, Providers, Agents, Contractors, Vendors and other Valleywise Health committee members (See 01291 S) shall not use their official position for personal gain. Public influence and confidential or "inside" information must never be used for personal advantage. Conflict of interest laws, A.R.S. § 38-501 *et. seq.* must be scrupulously observed. The conflict-of-interest laws prohibit participation by public officers, elected officials, Management, Administration or Employees in a decision or contract in which they have a direct or indirect pecuniary or proprietary interest, as required by A.R.S. §38-502.

Avoidance of Conflicts of Interest for the District Board

Principles

Valleywise Health (We) through the District Clerk's Office, the Legal Department and the Compliance Department (and other departments as needed), will maintain policies and procedures that make clear when a District Board members private interests may inappropriately interfere with Valleywise Health's interests; and will provide support through which the District Board (See the District Board Conflicts of Interest and Gift Policy (See 99305 G),) may disclose and have an evaluation about whether a particular activity or relationship could be construed as a conflict of interest or otherwise improper.

- The District Board Conflicts of Interest and Gift Policy (See 99305 G) (hereafter "See 99305 G") establishes the policy and procedure for the District Board and defines a Gift as well as District Board conflicts of interest and will require that District Board members to evaluate and report conflicts of interest in the performance of their responsibilities and services to Valleywise Health.

- We will educate the District Board (See 99305 G) about informing Valleywise Health of personal business ventures and other arrangements that could be perceived as conflicts of interest and will provide for policies and procedures for doing so.

- We will educate the District Board (See 99305 G) about the use any proprietary or non-public information acquired as a result of a relationship with Valleywise Health for person gain or for the benefit of another business opportunity.

- We will educate the District Board (See 99305 G) about the purchase of outside goods based on the Vendor's ability to best satisfy Valleywise Health's needs and not based on personal relationships.

- We will educate the District Board (See 99305 G) about the purchase of outside services based on the Contractor's ability to best satisfy Valleywise Health's needs and not based on personal relationships.

- The District Board (See 99305 G) shall not use their official position for personal gain. Public influence and confidential or "inside" information must never be used for personal advantage. Conflict of interest laws, A.R.S. § 38-501 *et. seq.* must be scrupulously observed. The conflict-of-interest laws prohibit participation by public officers, elected officials, Management, Administration or Employees in a decision or contract in which they have a direct or indirect pecuniary or proprietary interest, as required by A.R.S. §38-502.

Relationship with Payers: Valleywise Health (We) through our Health Management Information (HIM), Revenue Cycle, Compliance Providers and Clinical Departments (and other departments as needed) will consistently strive to satisfy the conditions of payment required by the payers with which Valleywise Health transacts business.

- We will promote compliance with laws governing the submission and review of bills for our services and will deal with billing inquiries in an honest and forthright manner.

- We will maintain reasonable measures to prevent the submission or filing of inaccurate, false, or fraudulent claims to payers.

- We will utilize systematic methods for analyzing the payments we receive and will reconcile inaccurate payments in a timely manner after discovery and review.

- We will investigate potential or reported inaccurate billings and payments to determine whether changes to current protocol or other remedial steps are necessary.

- We will maintain documentation systems sufficient to create and maintain complete and accurate documentation of services provided.

- We will review cost reports to be filed with the federal and state health care programs to determine whether such reports accurately and completely reflect the operations and services provided to beneficiaries and to confirm that such reports are completed in accordance with applicable federal and state regulations and Valleywise Health's policies and procedures.

- We will, as necessary, rely on internal and external sources to help improve Valleywise Health's billing and coding protocol and to identify potential areas of noncompliance.

- We will notify impacted plan administrators and third parties within a reasonable time (including but not limited to, Medicare Part C entities) of any detected fraud, waste or abuse activities or other violations (including HIPAA privacy or security, etc.), advise of actions taken, and will work with them if necessary to implement or adjust timely corrective actions.

- We will maintain all Medicare Part C documentation (including training, exclusion checks, and other compliance documentation for at least 10 years).

- We will compensate billing and coding staff and billing/coding consultants for services rendered, in a manner that is permitted under law and will not compensate such persons in any way related to collections or maximization of revenues.

Relationship with Providers: Valleywise Health (We) through our Administration, Management, Compliance and Legal Department (and other departments as needed) will monitor its business dealings to structure relationships in ways that satisfy the needs of the community.

- We will maintain relationships with Providers based only on the needs of our community and consistent with our mission.

- We will treat referral sources fairly and consistently, and will not provide remuneration that could be considered payment for referrals, including:
    - Free or below-market rents; Administrative or staff services at no- or below-cost;
    - Grants in excess of amounts for *bona fide* research or other services rendered;
    - Interest-free loans; or
    - Gifts (See 01291 S) or other payments intended to induce referrals.

- We will maintain policies, procedures and other protocol which require fair market value determinations for services rendered by referral sources and for services rendered by Valleywise Health. (See policies 01111 S False Claims and 01119 S Anti-Kickback Statue)

- We will maintain procedures to require all agreements with referral sources to be reduced to writing and reviewed and approved as appropriate under law and Valleywise Health's policies and procedures. (See policies 01111 S False Claims and 01119 S Anti-Kickback Statue)

- We will train the appropriate personnel on the primary laws and regulations governing the referral of patients and other legal restrictions on the manner in which Valleywise Health transacts business, including the penalties that may result for violations of such laws.

Respect for Our Culture: Valleywise Health (We) through our Human Resources Department, Administration, and Management (and other departments as needed) recognize that a diverse workforce enriches the life experience of all Employees and our community and will promote diversity.

- We will provide equal employment opportunities to Employees and applicants for employment without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, marital status, political belief, age, veteran status, or disability, in accordance with applicable law.

- We will maintain policies and procedures that promote compliance with laws governing nondiscrimination in personnel actions, including recruiting, hiring, training, evaluation, transfer, workforce reduction, termination, compensation, counseling, discipline, and promotion of Employees.

- We will promote diversity with respect to individuals with disabilities and will make reasonable accommodations to any individual as required by law.

- We will recognize the right of our Employees to a workplace free of violence and harassment and will not tolerate any form of harassment or violence toward our Employees.

- We will maintain policies and procedures that promote appropriate conduct in the workplace and prohibit unwanted or hostile interaction, including degrading or humiliating jokes, physical or verbal intimidation, slurs, or other harassing conduct.

- We will not tolerate any form of sexual harassment, either overt, such as request for sexual favors in return for promotions, or less obvious forms of harassment, such as sexual comments.

- We will maintain policies and procedures prohibiting workplace violence, including robbery, stalking, assault, terrorism, hate crimes, or violence against any Employees.

- We will maintain policies, procedures, and practices prohibiting retaliation in any form for reporting.

Information Systems: Valleywise Health (We) recognize that the provision of healthcare services generates business, financial, and patient-related information that requires special protection. We will establish systems that ensure such information is used appropriately and safeguarded zealously.

- We are committed to the privacy, security and integrity of documents and records in our possession, and will develop systems, policies, and procedures sufficient to safeguard the privacy, security and integrity of our documents and records, including systems, policies, and procedures to:

  - Establish retention periods and protocols for business, financial, and patient records in the Valleywise Health system. We will maintain required documentation to meet all record retention standards, including but not limited to Medicare Parts A, B, C (i.e., ten years), D and Medicaid.

  - Prevent the altering, removal, or destruction of records or documents except according to Valleywise Health's records retention policy and applicable ethical and legal standards.

  - Promote the accurate, thorough, detailed, and complete documentation of all business, financial, and patient transactions.

  - Control and monitor access to Valleywise Health's information system, communications systems, electronic mail, internet access, and voicemail to ensure that such systems are accessed appropriately and used in accordance with Valleywise Health's policies and procedures.

  - Protect the privacy and security of patient medical, billing, and claims information by maintaining sufficient physical, systemic, and administrative measures to prevent unauthorized access to or use of patient information, and to track disclosures of such information as required by law.

  - Provide access to medical, billing, and claims information for our patients and their legal representatives as required by law.

- Safeguard the personal and human resources information of our Employees, including salary, benefits, medical, and other information retained within the human resources system as required by law.

IV. VIOLATIONS OF THE CODE OF CONDUCT AND ETHICS

Valleywise Health is committed to providing the District Board, Governing Council members, Employees, Administration, Providers, Contractors, Vendors, Agents, and other Valleywise Health committee members with a means of raising questions and concerns and reporting any conduct that is suspected to be in violation of this Code. District Board members, Governing Council members, Employees, management, Administration, Providers, Contractors, Vendors, Agents, and other Valleywise Health committee members are expected and required to communicate any suspected, detected or reported violations of the Code to a direct supervisor, the Chief Compliance Officer, Human Resources or General Counsel, as applicable. If you prefer, you can anonymously call the Valleywise Health Compliance Hotline 1-866-333-6447 and/or you can file a concern on the Valleywise Health's internal website (i.e., The Vine) under "Report a Compliance Concern". The Chief Compliance Officer will maintain primary responsibility for investigating reports received on this hotline.

The following list, while not exhaustive, describes the type of concerns and questions that you should raise with your supervisor, the Chief Compliance Officer, Human Resources, General Counsel or through the Valleywise Health Compliance Hotline:

- Allegations, discrimination, or retaliation.
- The possible submission of false, inaccurate, or questionable claims to Medicare, Medicaid, AHCCCS or any other payer.
- The provision or acceptance of payments, discounts, or gifts (See 01291 S) in exchange for referrals of patients.
- The utilization of improper physician recruitment techniques under applicable law.
- Situations that could raise conflict-of- interest concerns.
- Potential breaches of confidentiality or privacy.

CERTIFICATION

I acknowledge and certify that I have received and read the Maricopa County Special Health Care District d/b/a Valleywise Health's Code of Conduct and Ethics.

I agree to comply with the Maricopa County Special Health Care District d/b/a Valleywise Health's Code of Conduct and Ethics.

Maricopa County Special Health Care District - District Board

Initials: _____

Governing Council

Initials: _____

Administration, Management and Employees: I understand that compliance with this Code is a condition of my continued employment. I further understand that violation of the Code may result in disciplinary action up to and including termination.

Initials: _____

Providers: I understand that compliance with this Code is a condition to my ability to practice my profession at Valleywise Health. I further understand that violation of the Code may result in disciplinary action as provided in the Bylaws of the Medical Staff/Providers.

Initials: _____

Agents, Contractors, Vendors and Other Valleywise Health Committee Members (including FACC): I understand that compliance with this Code is a condition of my continued ability to furnish services to Valleywise Health. I further understand that violation of the Code may result in a termination by Valleywise Health of any relationship I have with Valleywise Health.

Initials: _____

Please sign here: _____ Date: _____

Please print your name: _____ Dept: _____

Valleywise Health Administrative Policy & Procedure

Effective Date: **08/10, 11/17**

Reviewed Dates: **03/15, 11/17, 05/19**

Revision Dates: **08/12, 11/17, 12/19, 12/21, 12/23**

Policy #: 01291 S

Policy Title: Compliance: Conflicts of Interest and Gift Policy

Scope:
- **[ ] District Governance (G)**
- **[X] System-Wide (S)**
- **[ ] Division (D)**
- **[ ] Multi-Division (MD)**
- **[ ] Department (T)**
- **[ ] Multi-Department (MT)**
- **[ ] FQHC (F)**

Definitions:

Administration: Executive leadership (including Chief Executive Officer and President, executive vice presidents, senior vice presidents and vice presidents) of Valleywise Health.

Advanced Practice Clinicians (APCs): Individuals other than Medical Staff members who are licensed healthcare professionals who are board certified and have at least a master's degree. APCs are trained to practice medicine and prescribe within the scope of their training as outlined by their specific scope of practice and are authorized by law and by the Hospital to provide patient care services.

Allied Health Professionals (AHPs): Individuals other than Medical Staff members or APCs who are qualified by training, experience, and current competence in a discipline permitted to practice in the hospital and are authorized by law and by the Hospital to provide patient care services.

Board of Directors – The five publicly elected officials that serve on the Maricopa County Special Health Care District, d/b/a Valleywise Health, Board of Directors for Maricopa County, Arizona.

Clinical Privileges or Privileges: The authorization granted by the District Board to render specific patient care services, for which the Medical Staff leaders and the District Board have developed eligibility and other privileging criteria and focused and ongoing professional practice evaluation standards.

Finance, Audit and Compliance Committee (FACC): An advisory committee to assist Valleywise Health's President and Chief Executive Officer ("CEO") with oversight responsibilities related to compliance and financial matters, and internal and external audit functions.

Gift: Any payment, distribution, expenditure, advance, deposit or donation of money, any intangible personal property or any kind of tangible personal or real property including travel and dinners.

Governing Council: Governing body that maintains oversight of the Federal Qualified Health Center (FQHC).

Management – Valleywise Health employees that provide supervision to other Valleywise Health employees.

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the District Board.

Provider: A Medical Staff member with Clinical Privileges, a House Staff member, an Advanced Practice Clinician or an Allied Health Professional.

House Staff: Includes residents, fellows, and individuals licensed as appropriate, who are graduates of medical, allopathic and osteopathic, dental, or podiatric schools; who are appointed to a hospital's professional graduate training program that is approved by a nationally recognized accrediting body; and who participate in patient care under the direction of a member of the Medical Staff of the pertinent clinical disciplines with appropriate clinical privileges in the hospital.

Workforce Member: Governing Council members, Valleywise Health employees, Providers, agents, and other Vallewise Health committee members whether or not they are paid by Valleywise Health (this includes the FACC).

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Strategic Item: – A Strategic Item is considered to be any material whose purpose is directed toward meeting Valleywise Health's mission and will directly increase revenue, reduce expenses or provide support for Valleywise Health contract negotiations.

Vendor: Any person or entity under contract with Valleywise Health to provide goods or services.

Contractors: A person or entity who is not employed by Valleywise Health and who is performing specific services as defined in their contract.

I. WORKFORCE MEMBER CONFLICT OF INTEREST AND GIFT POLICY:

1. **Solicitation**: Workforce Members are prohibited from soliciting any Gift, compensation arrangement, or investment or ownership interest from a Vendor, Contractor or a patient.

2. **Exception for Charitable Contributions**
   a) Solicitation and acceptance of charitable contributions by the Valleywise Health Foundation (hereinafter referred to as the Foundation) are governed in accordance with the Foundation's policies and procedures. The Foundation may solicit or accept donations from Vendors or Contractors that are unrestricted; are for a designated fund approved by the Foundation's Board of Directors; or, are otherwise approved by the President of the Foundation or its Board of Directors. The President of the Foundation has the authority to reject any contribution from a Valleywise Health Vendor or Contractor which he or she believes will inure to the benefit of any individual Valleywise Health employee or Provider or is designated for reimbursement or payment of specific employee or medical staff travel, meals, entertainment, or educational expenses, or specific Valleywise Health department operating expenses or capital expenditures. This provision does not preclude the Foundation from using Vendor or Contractor donated funds to pay for its own administrative or operating expenses.
   b) Valleywise Health employees and Providers, other than Foundation personnel, may not solicit or accept charitable contributions from Vendors or Contractors. Valleywise Health Workforce Members may not direct Vendors or Contractors to make donations to the Foundation as a method of circumventing this restriction. If a Vendor or Contractor informs a Workforce Member of his or her desire to make a donation, the Workforce Member may suggest that the Vendor or Contractor contact the Foundation to discuss Gift giving opportunities. Valleywise Health will not predicate the awarding of business contracts on donations or contributions from Vendors or Contractors to Valleywise Health, or its subsidiaries, affiliates, and supporting charitable organizations.
   c) Solicitations authorized by the Valleywise Health Administration to benefit outside charitable organizations and/or their beneficiaries or victims of tragic events are not prohibited under this policy. Examples of such solicitations include, but are not limited to, the United Way Campaign, the March of Dimes Campaign, The Arizona Foundation for Burns and Trauma, and solicitation of sponsorships, clothing, toys and other gifts for burn victims or victims of other tragedies.

3. **Gifts**: Workforce Members may accept Gifts of Nominal Value (under $25); however, Workforce Members may not accept any Gift in the form of cash or cash equivalents (including gift cards or gift certificates) from Vendors, Contractors or patients. The total value of Nominal Value Gifts accepted in any 12-month period from a single individual or entity may not exceed $250. Occasionally, Vendors, Contractors or patients will send a small amount of cash or a gift card in the mail to a Workforce Member. If it is impractical to return such gifts, they should be donated to the Foundation or shared with the entire unit/department.

4. **Promotional Items:** Promotional items such as coffee mugs, pens and toys, may be accepted from a Vendor or Contractor on an occasional basis if such items are of Nominal Value. Workforce Members are expected to exercise good judgment and avoid accepting or displaying promotional items that detract from Valleywise Health's professional image or give the impression that Valleywise Health is endorsing or promoting a Vendor's or Contractor's products or services.

5. **Gifts from Patients:** Patients sometimes show their appreciation by giving Gifts of food, flowers, and trinkets to employees and Providers. When such a Gift is received, the patient should be thanked and the Gift shared with the entire department or donated to a charitable organization. Tips cannot be accepted from patients and should be graciously refused. If a patient provides a non-perishable Gift which is believed to exceed Nominal Value, and the Gift cannot be politely returned or refused without causing offense or embarrassment, the Gift should be donated to a charitable organization.

6. **Gifts to Patients:** Workforce Members may not offer or provide Gifts to patients as a means of inducing patients to obtain services from Valleywise Health or rewarding patients for receiving services from Valleywise Health. In general, Gifts to patients are limited to items with a value of no more than $10 per item or $50 in the aggregate per patient per year. Gifts of cash or cash equivalents are not permitted. At times, Workforce Members may desire to assist a needy patient by paying for part of a patient's treatment or some other need. While this is commendable, care should be taken to follow Valleywise Health patient Gift giving policies to ensure that Gifts provided to patients do not appear to be an inducement or reward for the patient's use of Valleywise Health.

7. **Purchasing Decisions:** Under no circumstances may a Workforce Member solicit or accept any Remuneration from a Vendor or Contractor in exchange for promoting, recommending or purchasing the Vendor's or Contractor's products or services. A Workforce Member is prohibited from directly or indirectly influencing any decision regarding the purchase of any item or service from a Vendor or Contractor if such Workforce Member has a Financial Interest in the Vendor or Contractor. Directly or indirectly influencing a decision includes making recommendations, providing evaluations, voting on or promoting the purchase of an item or service. For example, a physician may not promote, evaluate or make a recommendation on a Vendor's product if he or she has accepted or has agreed to accept consulting fees, advisory board fees, royalties, free travel and entertainment, or Gifts of more than Nominal Value from the Vendor.

8. **Vendor and Contractor Restrictions:** Vendors and Contractors are strictly prohibited from offering or providing any Remuneration, including Gifts, to a Workforce Member other than Remuneration that a Workforce Member may accept pursuant to this policy. Under no circumstances may a Vendor or Contractor offer or provide any remuneration to a Workforce Member with the

intent of influencing, inducing or rewarding the Workforce Member's recommendation or decision to purchase any of the Vendor's or Contractor's products of services. Vendors and Contractors are prohibited from offering or making charitable contributions to the Valleywise Health Foundation as a means of circumventing this restriction. Vendors and Contractors are prohibited from making any charitable contribution that will inure to the benefit of any Workforce Member who is in a position to influence (i.e., Administration or Management) any decision concerning the Vendor or Contractor.

9. **Vendor and Contractor Promotions:** In general, Workforce Members may not allow Vendors or Contractors to display or promote their products on Valleywise Health property or at a Valleywise Health function. This is not intended to prevent Valleywise Health managers from having meetings with Vendors or Contractors to discuss their products where the products are presented to management or to purchasing teams for evaluation.

10. **Vendor and Contractor Paid Meals, Travel, Entertainment and Educational Expenses:**
    a) Workforce Members may accept a meal of nominal value from a current Vendor or Contractor during business meetings. If an item is considered to be a Strategic Item (see Definition) and is approved by the Valleywise Health President & CEO (or District Counsel for the President & CEO) on the "Strategic Items Declaration and Approval Form" (see Attachment One), the Workforce Member may exceed the limits in this section. The Strategic Item Declaration and Approval Forms will be monitored by the Compliance Department.
    b) Vendors and Contractors may provide meals or other perishable items to a department or group, but in no case may a Workforce Member solicit such Gifts from a Vendor or Contractor. The value of these items must be less than $50 per person per event. Workforce Members should exercise proper judgment in accepting meals and other perishable items as the continual acceptance of these items can lead to an appearance of impropriety. Departments and groups must track the number of meals and perishable items are provided by an individual Vendor or Contractor if more than three gifts are provided in any 12-month period.
    c) Workforce Members may attend Vendor or Contractor paid social events in order to further develop business relationships where the cost or fair market value of the event does not exceed $50 per person per event; however, Workforce Members may not attend sporting events or accept payment or reimbursement of any travel related expenses, including overnight lodging. Workforce Members should be mindful of avoiding the appearance of a conflict of interest and exercise good judgment in limiting the number of such events and choosing the most appropriate setting for discussing Valleywise Health business.
    d) Unless specified per contract, workforce members may attend Vendor or Contractor sponsored training or educational events, but a Workforce Member may not accept payment or reimbursement from the Vendor or Contractor for any travel related expenses, including overnight lodging, or

fees, stipends or honorariums for participating in the event. If registration fees are charged to the public for attendance at these events, Valleywise Health will pay these fees. These restrictions do not apply to payments or reimbursements made by a trade or professional association for a Workforce Member's attendance at the association's event or for industry sponsored research.

e) Workforce Members may not accept payment or reimbursement of travel related expenses, including overnight lodging, associated with site visits or other travel related to reviewing and evaluating a Vendor's or Contractor's products or services.

Workforce Members may not solicit payments or donations from Vendors or Contractors for sponsoring educational events administered by Valleywise Health; however, Vendors and Contractors may, if they offer to do so, sponsor educational events administered by Valleywise Health that conform with the ACCME's Standards to Ensure the Independence of CME Activities, regardless of whether CME credit is given through the event or if participants include non-physicians. For such events,

- Vendors or Contractors may not, in any way, control or have the ability to influence the speakers or educators,
- Vendors or Contractors may not select, provide, control, or have the ability to influence the speakers or educators,
- Vendors or Contractors may not display or promote their products or services, or distribute information concerning their products or services;
- Vendors or Contractors may not provide any Gifts to participants, attendees or event administrators before, during or after the event;
- Vendors or Contractors may not pay or reimburse directly to any individual any travel related expenses, including overnight lodging;
- Vendors or Contractors may not pay for meals subject to the limitation for Vendor paid meals to a department or group, i.e. meals valued at less than $50 per person per event;
- Speakers and educators must disclose to Valleywise Health and the participants any conflicts of interest, including, but not limited to, any Financial Interest in a sponsoring Vendors or Contractors if the speaker or educator will be referring to or discussing any of the Vendor's or Contractor's products or services as part of his or her presentation; and,
- Employees must ensure that all costs associated with the event regardless of any Vendor or Contractor payment contribution, and/or donation have been pre-approved as part of the employee's annual operating budget.

11. Vendor and Contractor Paid Capital Expenditures and Operating Expenses:

Workforce Members, other than Foundation personnel, may not solicit or accept payments, contributions or donations from Vendors or Contractors to pay for a Valleywise Health department's capital expenditures or operating expenses (except as otherwise provided in this policy for Vendor sponsored educational events and meals). Charitable contributions made by a Vendors or Contractors to the Foundation are distributed to Valleywise Health departments through restricted or unrestricted funds established by the Foundation's Board of

Directors and as authorized solely by the Foundation's policies and procedures or its Board of Directors. Valleywise Health employees or Providers may not establish or control restricted or unrestricted funds at the Foundation.

12. Use or Disclosure of Intellectual Property or Confidential Information:

a) Workforce Members shall only use or disclose Valleywise Health Intellectual Property or Confidential Information solely for the purpose of carrying out business activities as part of their authorized duties for Valleywise Health. Such use or disclosure must be consistent with Valleywise Health policy. (See, e.g. Valleywise Health Policy 42007 S "Research: Intellectual Property").Use or disclosure of Intellectual Property or Confidential Information in exchange for Remuneration or for any personal gain or advantage, or with the intent of causing harm to Valleywise Health, a Workforce Member or a patient, is an abuse of a Workforce Member's position, creates a serious conflict of interest for the Workforce Member, may violate confidentiality laws, may constitute intellectual property infringement, and may be considered theft of Valleywise Health property. Such use or disclosure may be subject to civil legal action, criminal prosecution and/or disciplinary action up to and including termination.

b) The provision above is not intended to prevent Workforce Members from sharing best practices or policies and procedures with other professionals in the healthcare industry for the purpose of improving healthcare operations. Such exchanges of ideas would not usually create a conflict of interest, but Workforce Members should exercise good judgment and share mainly information which represents ideas and not information specific to Valleywise Health.

13. Special Rules Regarding Referring Providers:

a) Remuneration provided to a referring Provider or the Providers' employer may not vary based on the volume or value of referrals to, or other business generated for, Valleywise Health.

b) Remuneration may not be provided to a referring Provider or the Provider's employer with the intent of inducing or rewarding the Provider's referrals to Valleywise Health.

c) Non-cash Compensation, including Gifts, with an aggregate value of up to $489 may be provided by Valleywise Health to a referring Provider during any calendar year as long as the Compensation is not solicited by the Provider or the Provider's employer and the amount of Compensation is not determined in a manner which takes into account the volume or value of referrals or other business generated by the referring physician. Examples of non-cash Compensation include holiday gift baskets, restaurant meals, and tickets to sporting or social events.

d) Medical staff incidental benefits, such as cafeteria meals and parking, may be provided to referring Provider if:
   - the value of each benefit does not exceed $30 per occurrence and per physician;

- the benefits are provided to all Providers in the same specialty without regard to the volume or value of referrals or other business generated between the parties;
- the benefits are provided only during periods when the Providers are making rounds or are engaged in other services or activities that benefit the hospital or its patients;
- the Compensation is reasonably related to the provision of, or designed to facilitate directly or indirectly the delivery of, medical services at the hospital; and,
- the benefits are provided by the hospital and used by the Providers only on the hospital's campus. Benefits, including, but not limited to, internet access, pagers, or two-way radios, used away from the campus only to access hospital medical records or information or to access patients or personnel who are on the hospital campus, as well as the identification of the Provider on a hospital web site or in hospital advertising, will meet the "on campus" requirement.

e) Free or discounted compliance training may be provided to referring Provider as long as the training is held in the local community or service area.

14. **Research Activities**: Disclosure of Significant Financial Interest

a) All individuals responsible for the design, conduct, or reporting of the results of work performed or to be performed under a Public Health Service (PHS) sponsored project, an industry sponsored research study, or other research activity, referred to as "**Investigator**." This includes, but is not limited to, the Principal Investigator, other investigators, Research Assistants or Coordinators, and any other individuals (including personnel from other institutions) who are involved in accomplishing project objectives. It may include students (graduate and undergraduate) and other personnel listed as authors on project results, even if they are not paid from the project.

b) What is a "Significant Financial Interest"?

1. With regard to **Publicly-Traded Entities**, Payments or value exceeding $5,000 (when aggregated for an Investigator and the Investigator's spouse and dependent children) from a single entity during the prior 12 months. This includes any salary, consultant payments, honoraria, paid authorship, equity interest (stock, stock option or other ownership interest).
2. With regard to **Privately Held Entities**, Payments or value exceeding $5,000 (when aggregated for an Investigator and the Investigator's spouse and dependent children) from a single entity during the prior 12 months or when the Investigator and the investigator's spouse/domestic partner and dependent children hold any equity interest (stock, stock option, or other ownership interest).
3. With regard to **Intellectual Property**, Intellectual property rights and interests (patents, copyrights) upon receipt of income related to such rights and interests.
4. With regard to **Travel Reimbursements**, any reimbursed or sponsored travel related to the Investigator's Institutional Responsibilities during the

prior 12 months (with the exception of travel that is reimbursed or sponsored by a Federal, state, or local government agency, an institution of higher education, an academic teaching hospital, a medical center, or a research institute that is affiliated with an institution of higher education).

5. The term "Significant Financial Interest" **does not include**: salary, royalties, or other remuneration paid by Valleywise Health to the Investigator if the Investigator is currently employed or otherwise appointed, including intellectual property rights assigned to the Institution and agreements to share royalties related to such rights; income from investment vehicles, such as mutual funds and retirement accounts; income from seminars, lectures, or teaching engagements sponsored by a Federal, state, or local government agency, an institution of higher education, an academic teaching hospital, a medical center, or a research institute affiliated with an institution of higher education; or income from service on advisory committees or review panels for a Federal, state, or local government agency, an institution of higher education, an academic teaching hospital, a medical center, or a research institute affiliated with an institution of higher education.

c) **What are "Institutional Responsibilities**?" An Investigator's Institutional Responsibilities means the Investigator's professional responsibilities on behalf of the Institution, including activities such as research, teaching, clinical or other professional practice, academic activities, scholarly events, institutional committee memberships, and service on panels such as Institutional Review Boards or Data and Safety Monitoring Boards.

d) **Review Process and Guidelines**- The Valleywise Health Department of Compliance in conjunction with the Valleywise Health Research Department will review the Investigator's Detailed Disclosure Form to ensure completeness and consistency with prior disclosures (if applicable). The form, along with any supporting documentation shall be forwarded to the Oversight Committee on Conflict of Interest (OCCI) for review. The OCCI will consider whether any of the disclosed Significant Financial Interests of the Investigator are related to the project and whether the financial interest could directly and significantly affect the design, conduct, or reporting of the project.

For example, a direct effect would occur when the project results would be directly relevant to the development, manufacturing, or improvement of the products or services of the entity in which the Investigator has a Significant Financial Interest, or when the entity is a proposed subcontractor or participant in the project. A significant effect on the financial interest is one that will materially affect the value of the entity, its earnings, or sales of its products. The following are examples of when an Investigator would be deemed to have a financial conflict of interest (FCOI): (i) if the Investigator (together with Investigator's spouse or domestic partner and dependent children) has a Significant Financial Interest in an entity that could be affected by the research results from a proposed PHS-funded grant or contract, or an industry sponsored contract, based on an analysis of the scope and subject matter of the proposed project described in the

application, or (ii) the Investigator (together with Investigator's spouse or domestic partner and dependent children) has a Significant Financial Interest in an entity that licenses technology from Valleywise Health which has resulted in license income and that technology is the subject of a proposed PHS-funded award, or other funded award. In making this determination, the designated institutional official(s) may consult with all appropriate institutional and governmental officials.

If the OCCI determines that an identified FCOI was not disclosed or reviewed in a timely fashion, the OCCI will develop and implement a Mitigation Plan for the FCOI.

For disclosures of Significant Financial Interest greater than $5,000 but less than $10,000 the OCCI will review the information and make a determination of whether a conflict exists. Disclosures of Significant Financial Interests of amounts in excess of $10,000 shall be submitted to the Valleywise Health Chief Compliance Officer, with a recommendation from the OCCI for review and approval, or continuing management.

15. **Arizona's Conflict of Interest Laws**
    a) Workforce Members are obligated to comply with the provisions set forth in this Policy as well as the provisions contained in Arizona's Conflict of Interest Laws, A.R.S. 38-501 through 38-511.
    b) In the event that there is a conflict between the provisions of this policy and the provisions in Arizona's Conflict of Interest Laws, the more restrictive and more limiting provision shall control.

16. **Disclosure of Conflicts of Interest**:
    a) Employees
        - All employees must complete the Valleywise Health disclosure statement at the time of employment. The recruiter will consult with the Chief Compliance Officer concerning any new hire that has a conflict of interest prior to the new hire's start date.
        - All employees at or above the Unit Manager level and all Purchasing department employees and Facilities Development/Engineering management staff must complete a disclosure statement annually (in the Code of Conduct and Ethics). The disclosure statement is recorded in the Learning Management System.

    a) Providers and Medical Staff Researchers
        - All Providers must complete the Valleywise Health Code of Conduct and Ethics Form annually during annual compliance education. The Director of Medical Staff Services will consult with the Chief Compliance Officer (CCO) if a potential conflict of interest is disclosed during the initial appointment or at any reappointment.
        - Medical Staff Researchers will complete the Valleywise Health Conflict of Interest Disclosure Form annually. The CCO and the Director of Research will review and will manage and maintain disclosure statements in accordance with guidelines listed in #14 above.

- Providers and Medical Staff Researchers will re-submit a disclosure statement as any additional financial interest arises.
- Medical Staff Services will maintain disclosure statements in the Medical Staff's credentialing file.

b) Purchasing Decisions
   - All Workforce members who participate in purchasing decisions must disclose any conflicts of interest prior to participation. Participation may include, but is not limited to, performing evaluations of a product or service, recommending the purchase of a product or service, contract negotiation, voting to purchase a product or service or including a medication in the Valleywise Health formulary.
   - Workforce Members who have a conflict of interest must recuse themselves from participation in the decision-making process. If a manager or chairman of a purchasing or product evaluation committee believes extenuating circumstances exist that would allow an individual with a conflict of interest to participate in the decision-making process, the CCO should be consulted for a decision.

c) It is the duty of every workforce member to seek guidance from the Valleywise Health CCO or District Counsel prior to engaging in any activity which might lead to a conflict of interest or perception of same with Valleywise Health.

d) Workforce Members who fail to comply with this procedure will be subject to disciplinary action, up to and including termination.

II. THE MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT BOARD OF DIRECTORS CONFLICT OF INTEREST AND GIFT POLICY

The Maricopa County Special Health Care District Board of Directors shall comply with the District Board Conflict of Interest and Gift Policy (See 99305 G).

References:

Arizona Revised Statutes 38-501 - 38-511
Form #44239 Valleywise Health Conflict of Interest Form
The District Board Conflict of Interest and Gift Policy (See 99305 G)

Attachment One
Strategic Item Declaration and Approval Form

I. Strategic Item Declaration		
No.	**Item**	**Item Information**
1	**Name of Workforce Member**	
2	**Strategic Item Name**	
3	**Strategic Item Description**	
4	**Linkage to Strategic Plan**	
II. Strategic Item Approval		
This item is deemed a Strategic Item and meals and travel expenses related to the above item can be accepted by the Workforce Member that exceed section 10 of the Conflict of Interest and Gift policy. (Gifts are not included is this approval). X_____ CEO/ or District Legal Counsel (If for the CEO) X_____ Chief Compliance Officer		
III. Tracking of Strategic Items		
No	**Item/Meeting Date**	
1		
2		
3		

Valleywise Health Policy & Procedure - Approval Sheet

(**Before submitting, fill out COMPLETELY**.)

POLICY RESPONSIBLE PARTY: Chief Compliance Officer

DEVELOPMENT TEAM(S):

Policy #: 01291 S

Policy Title: Compliance: Conflict of Interest

e-Signers: L.T. Slaughter, Jr., Chief Compliance Officer

Place an X on the right side of applicable description:

New -

Retire - **–**

Revised with Minor Changes –

Revised with Major Changes -

Please list revisions made below: (Other than grammatical changes or name and date changes)

Updated definition of Gift, Vendor and referenced the new District Board of Directors Conflict of Interest and Gift Policy (Draft)_____.

List associated form(s): (If applicable)
Form #44239 Valleywise Health Conflict of Interest Form

Reviewed and Approved by in Addition to Responsible Party and E-Signer(s):

Committee: System-wide P&P	**12/23**
Committee:	**00/00**
Committee:	**00/00**
Reviewed for EPIC:	**N/A**
Other:	**00/00**
Other:	**00/00**

8. FQHC Ambulatory Operational Dashboards

FQHC Measures

As of January 2025

Access

Average of Appointment Fill Rates FYTD

91.1%

New Patient Availability (Days)

16.2

No Show Rate FYTD

16.9%

Referrals Ready to Book in ≤ 3 Days by Percentage (FYTD)

95.8%

Patient Satisfaction

Press Ganey FYTD

76.7%

Quality

Quality measures at or Above Target CYTD

Meet or Exceeding Target Goal	38%
Within 10% of the Target Goal	23%
>10% Outside target Goal	38%

Financial

% Variance of Revenue FYTD

6%

% Variance of Expenses FYTD

-4%

% Variance of Visits FYTD

4.5%

Valleywise Health

Ambulatory Pillars Dashboard

January 2025

Community Health Centers	Other FQHC Clinics	Mobile Unit

PATIENT EXPERIENCE - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Mobile Health Unit	Grand Total
Press Ganey Top Box Score FYTD *(Likelihood of recommending)*	≥80.8	75.9	75.2	82.7	75.0	74.2	82.6	78.8	79.3	89.6			79.0	74.6	76.5	71.4	20.0	71.5	59.0		71.5	88.24	76.7
	n-size	162	121	75	100	159	184	170	169	106			1,246	220	115	42	5	151	100		586	17	1,849

ACCESS - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Mobile Health Unit	Grand Total
Appointments Scheduled FYTD		19,006	21,674	8,429	19,736	19,367	25,749	25,969	19,422	22,096	1,196		182,644	30,517	25,199	10,326	2,065	19,646	16,980		104,733	683	288,060
Provider Appointment Fill Rate FYTD		95.0%	93.6%	89.5%	93.6%	92.9%	94.0%	87.8%	92.2%	95.5%	91.0%		93.0%	88.4%	87.5%	99.8%	n/a	96.7%	74.7%		87.7%	51.4%	91.1%
Scheduled Appointment No-Shows FYTD		2,657	3,165	1,616	3,355	3,373	4,826	5,361	3,406	4,584	201		32,544	4,740	3,904	923	380	2,846	3,344		16,137	120	48,801
No Show Rate FYTD	<18%	14.0%	14.6%	19.2%	17.0%	17.4%	18.7%	20.6%	17.5%	20.7%	16.8%		17.8%	15.5%	15.5%	8.9%	18.4%	14.5%	19.7%		15.4%	17.6%	16.9%

FINANCE - Ambulatory

		Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Mobile Health Unit	**** Grand Total FQHC	***** FYTD FQHC
In-Person Visits FYTD		10,229	11,136	4,079	10,354	9,988	11,783	13,394	9,987	8,079	533		89,562	14,754	12,634	6,581	507	11,070	10,556		56,102	419		166,918
Virtual Visits FYTD		631	847	503	421	700	1,208	652	507	1,919	59		7,447	1,778	176	9	10	161	16		2,150	0		24,395
Total Actual Visits (includes Nurse Only Visits) FYTD		10,860	11,983	4,582	10,775	10,688	12,991	14,046	10,494	9,998	592		97,009	16,532	12,810	6,590	517	11,231	10,572		58,252	419		191,313
Budgeted Visits FYTD		12,321	10,876	4,289	10,929	11,107	12,075	12,306	9,466	10,371	666		94,406	16,233	12,860	5,565	886	10,896	9,516		55,956	529		183,134
Variance FYTD		(1,461)	1,107	293	(154)	(419)	916	1,740	1,028	(373)	(74)		2,603	299	(50)	1,025	(369)	335	1,056		2,296	(110)		8,179
Variance by % FYTD		-11.9%	10.2%	6.8%	-1.4%	-3.8%	7.6%	14.1%	10.9%	-3.6%	-11.1%		2.8%	1.8%	-0.4%	18.4%	-41.6%	3.1%	11.1%		4.1%	-20.8%		4.5%
Total Number of Patients seen by provider FYTD		10,440	11,636	4,436	9,927	10,280	12,516	13,696	10,127	8,529	465		92,052	16,102	11,412			10,705	10,191		48,410	367	140,829	

BEHAVIORAL HEALTH - Ambulatory

Finance	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen		BH Psychiatry		BH FYTD	PEC	PXC
In-Person Visits FYTD		377	222	105	485	625	554	215	203		370		5,586	818	1,612
Virtual Visits FYTD		1,361	1,187	701	1,268	2,134	841	1,693	810		2,945		14,798	1,858	0
Total Actual Visits FYTD		1,738	1,409	806	1,753	2,759	1395	1,908	1013		3315		20,384	2,676	1,612
Budget Visits FYTD		2,213	1,267	628	1,426	2,176	1271	1,684	1276		2578		18,021	1,916	1,585
Variance FYTD		(475)	142	178	327	583	124	224	(263)		737		2,363	760	27
Variance by % FYTD		-21.5%	11.2%	28.3%	22.9%	26.8%	9.7%	13.3%	-20.6%		28.6%		13.1%	39.7%	1.7%

DENTAL - Ambulatory

Finance		Avondale	Chandler							McDowell **			Dental FYTD	PEC	PXC
Actual Visits FYTD		1,624	1,880							1,984			15,249	3,387	6,374
Budget Visits FYTD		1,665	1,764							2,039			14,222	3,008	5,746
Variance FYTD		-41	116							-55			1027	379	628
% Variance FYTD		-2.5%	6.6%							-2.7%			7.2%	12.6%	10.9%

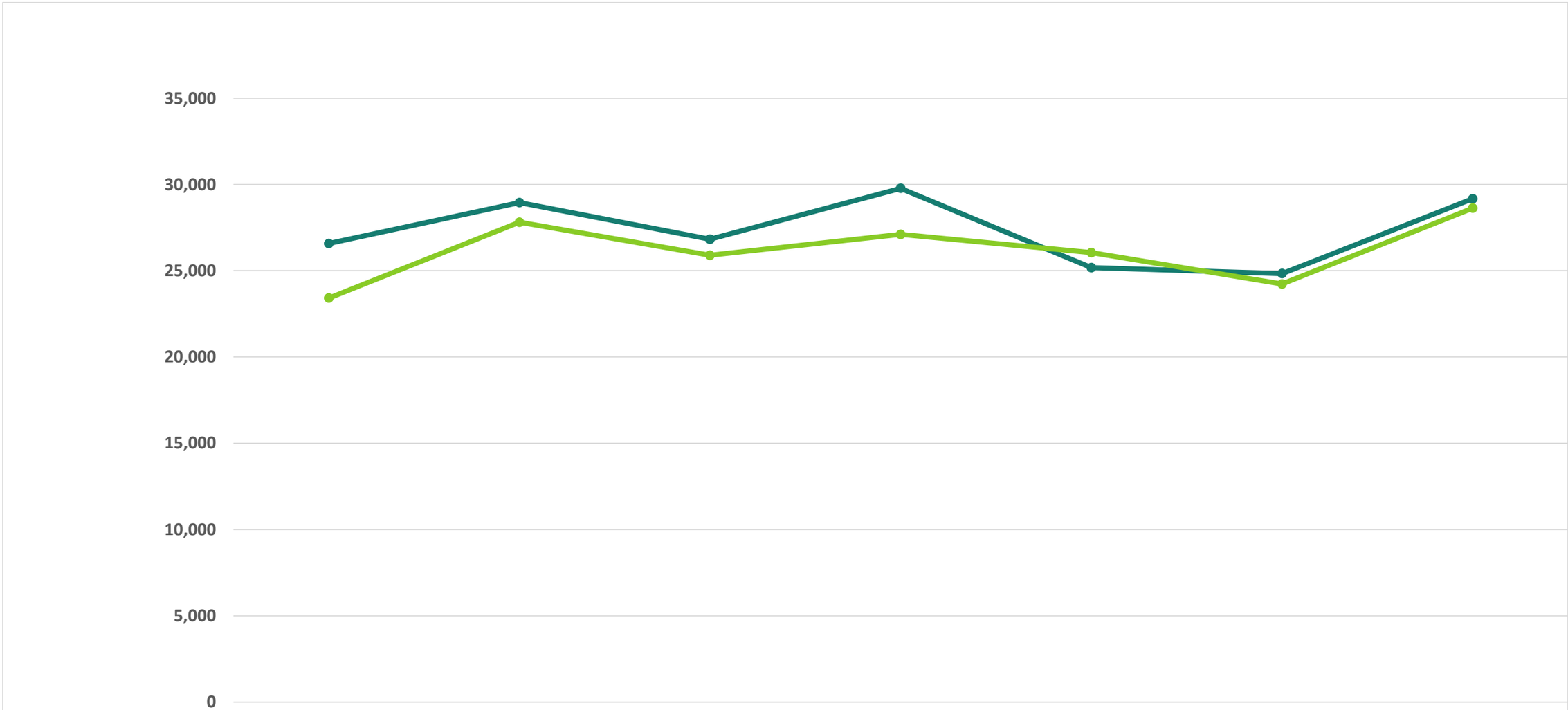
LEGEND:

- Not in Target
- 5% less than the target
- Target ≥ 95%

** Specialty HIV Community Health Center
*** Specialty HIV Community Health Clinic - McDowell Services
**** Grand Total FQHC for Total Number of Patients seen by provider FYTD includes Community Health Centers & Other FQHCs
***** FYTD FQHC for Actual/Budgeted Visits includes Community Health Centers, Other FQHCs, Dental, & OP Behavioral Health Clinics

Valleywise Health

FQHC Grand Total Actual vs Budgeted Visits
FY 2025 Trend



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
FYTD Actual Visits	26,574	28,949	26,824	29,779	25,178	24,834	29,175
FYTD Budgeted Visits	23,417	27,810	25,891	27,110	26,046	24,229	28,630

Ambulatory Care

Quality /Regulatory Metrics	Reporting Program	2023 UDS National Average	2022 UDS National Average	CYTD 2023	Desired Direction	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	June 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	YTD
Unified Data System																		
Body Mass Index (BMI) Screening and Follow-Up Plan	HRSA	> 67.13%	> 61.04%	92.31%	↑	✓ 88.52%	✓ 90.00%	✓ 91.00%	✓ 91.68%	✓ 92.14%	✓ 92.32%	✓ 92.54%	✓ 92.62%	✓ 92.75%	✓ 92.84%	✓ 92.86%	✓ 92.84%	✓ 92.74%
Numerator						11,701	18,898	25,203	30,516	35,632	39,102	42,822	45,897	48,054	51,111	53,449	55,188	55,672
Denominator						13,219	20,997	27,696	33,285	38,671	42,354	46,276	49,556	51,813	55,055	57,561	59,444	60,027
Cervical Cancer Screening	HRSA	> 54.96%	> 53.99%	57.20%	↑	✓ 56.60%	✓ 55.73%	✓ 56.07%	✓ 56.53%	✓ 56.83%	✓ 57.30%	✓ 57.33%	✓ 57.46%	✓ 59.17%	✓ 59.34%	✓ 59.29%	✓ 59.31%	✓ 59.37%
Numerator						4,087	6,271	8,122	9,744	11,308	12,420	13,484	14,466	15,606	16,558	17,241	17,747	17,964
Denominator						7,221	11,252	14,485	17,237	19,899	21,676	23,520	25,174	26,373	27,905	29,081	29,922	30,258
Childhood Immunization Status (CIS)	HRSA	> 30.23%	> 33.23%	37.62%	↑	✗ 15.90%	✗ 16.88%	✗ 17.35%	✗ 17.83%	✗ 18.91%	✗ 19.11%	✗ 19.42%	✗ 18.98%	✓ 41.25%	✓ 40.52%	✓ 40.17%	✓ 39.16%	✓ 39.31%
Numerator						62	108	139	164	198	210	222	224	495	498	511	502	515
Denominator						390	640	801	920	1,047	1,099	1,143	1,180	1,200	1,229	1,272	1,282	1,310
Colorectal Cancer Screening	HRSA	> 41.10%	> 42.82%	46.18%	↑	✗ 33.81%	✗ 36.12%	✗ 37.84%	! 39.28%	! 40.95%	! 42.13%	✓ 43.46%	✓ 44.65%	✓ 45.67%	✓ 46.76%	✓ 47.40%	✓ 48.09%	✓ 48.01%
Numerator						2,646	4,444	6,070	7,457	8,865	9,870	10,986	11,926	12,671	13,615	14,271	14,874	14,951
Denominator						7,827	12,303	16,041	18,983	21,649	23,430	25,280	26,711	27,745	29,117	30,110	30,929	31,139
Controlling High Blood Pressure	HRSA	> 65.68%	> 63.40%	58.07%	↑	✗ 55.02%	! 57.13%	! 58.04%	! 59.45%	! 60.23%	! 61.77%	! 63.31%	✓ 63.57%	! 63.26%	! 62.69%	! 61.36%	! 60.75%	! 60.73%
Numerator						2,889	4,729	6,265	7,594	8,733	9,700	10,430	10,820	11,008	11,192	11,132	11,140	11,191
Denominator						5,251	8,277	10,794	12,774	14,499	15,703	16,475	17,020	17,402	17,854	18,142	18,336	18,426
Diabetes: Hemoglobin A1c Poor Control	HRSA	< 28.81%	< 30.42%	29.87%	↓	✗ 60.66%	✗ 52.48%	✗ 45.20%	✗ 40.32%	✗ 35.87%	✗ 33.50%	! 32.10%	! 31.75%	! 31.04%	! 30.03%	! 29.60%	! 29.14%	! 29.14%
Numerator						2,222	3,044	3,415	3,571	3,589	3,612	3,711	3,867	3,910	3,943	3,998	4,029	4,049
Denominator						3,663	5,800	7,555	8,857	10,006	10,782	11,560	12,179	12,595	13,129	13,509	13,826	13,896
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	HRSA	> 75.78%	> 76.83%	76.08%	↑	! 76.52%	! 76.76%	! 76.31%	! 76.03%	! 76.27%	! 76.27%	! 76.42%	! 76.52%	✓ 76.72%	✓ 76.59%	✓ 76.36%	✓ 76.21%	! 75.17%
Numerator						528	849	1,079	1,253	1,408	1,511	1,627	1,714	1,796	1,868	1,912	1,957	1,944
Denominator						690	1,106	1,414	1,648	1,846	1,981	2,129	2,240	2,341	2,439	2,504	2,568	2,586
Screening for Clinical Depression and Follow-Up Plan if positive screen	HRSA	> 71.60%	> 70.02%	73.77%	↑	! 67.06%	! 69.50%	✓ 71.00%	✓ 73.11%	✓ 74.11%	✓ 75.62%	✓ 76.92%	✓ 77.70%	✓ 78.14%	✓ 79.25%	✓ 79.73%	✓ 80.39%	✓ 80.42%
Numerator						7,743	12,607	16,997	21,081	25,194	28,263	31,598	34,411	46,776	50,401	53,106	55,167	55,806
Denominator						11,546	18,139	23,941	28,834	33,996	37,376	41,077	44,287	59,860	63,595	66,604	68,620	69,394
Tobacco Use: Screening and Cessation Intervention	HRSA	> 84.90%	> 84.60%	90.12%	↑	! 81.84%	✓ 84.96%	✓ 86.85%	✓ 87.66%	✓ 88.13%	✓ 88.73%	✓ 89.31%	✓ 89.50%	✓ 89.28%	✓ 89.56%	✓ 89.69%	✓ 89.82%	✓ 89.83%
Numerator						3,222	7,640	12,022	16,515	21,442	25,202	29,175	32,562	36,184	39,687	42,263	44,343	44,812
Denominator						3,937	8,992	13,843	18,840	24,329	28,404	32,666	36,384	40,527	44,313	47,122	49,369	49,885
Weight Assessment & Counseling for Nutrition & Physical Activity for Children & Adolescents	HRSA	> 71.50%	> 69.81%	78.14%	↑	✗ 46.99%	✗ 50.71%	✗ 54.42%	✗ 57.29%	✗ 61.10%	! 64.69%	! 69.17%	✓ 71.99%	✓ 73.87%	✓ 76.45%	✓ 77.93%	✓ 79.22%	✓ 79.09%
Numerator						1,016	1,823	2,584	3,410	4,375	5,145	6,245	7,190	7,982	8,968	9,795	10,220	10,460
Denominator						2,162	3,595	4,748	5,952	7,160	7,953	9,029	9,988	10,805	11,731	12,569	12,900	13,226
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	HRSA	> 77.31%	> 76.07%	75.29%	↑	✓ 76.40%	✓ 76.88%	✓ 76.90%	✓ 76.71%	✓ 76.64%	✓ 76.60%	✓ 76.43%	✓ 76.50%	✓ 79.16%	✓ 79.35%	✓ 79.38%	✓ 79.05%	! 77.05%
Numerator						3,470	5,543	7,222	8,493	9,605	10,363	11,109	11,710	11,921	12,458	12,854	13,109	12,825
Denominator						4,542	7,210	9,392	11,071	12,533	13,529	14,535	15,307	15,059	15,700	16,194	16,584	16,644
Breast Cancer Screening	HRSA	> 52.40%	> 50.28%	61.32%	↑	✓ 53.51%	✓ 55.39%	✓ 56.07%	✓ 57.41%	✓ 58.32%	✓ 59.88%	✓ 60.80%	✓ 61.04%	✓ 61.62%	✓ 62.32%	✓ 62.46%	✓ 62.67%	✓ 62.65%
Numerator						1,829	2,937	3,817	4,593	5,263	5,790	6,301	6,639	6,926	7,314	7,530	7,740	7,777
Denominator						3,418	5,302	6,807	8,000	9,025	9,670	10,364	10,876	11,240	11,737	12,056	12,350	12,414
HIV Screening	HRSA	> 48.45%	> 43.82%	67.50%	↑	✓ 71.15%	✓ 70.15%	✓ 70.15%	✓ 70.07%	✓ 69.99%	✓ 69.96%	✓ 69.90%	✓ 69.95%	✓ 70.67%	✓ 70.64%	✓ 70.66%	✓ 70.86%	✓ 70.83%
Numerator						8,937	13,823	18,089	21,725	25,302	27,801	30,524	32,931	34,866	37,159	39,169	40,549	41,096
Denominator						12,561	19,706	25,787	31,005	36,150	39,739	43,667	47,076	49,334	52,604	55,434	57,221	58,022

‡ -

****Data is pulled from the UDS dashboard on the 1st Friday of every month**

Data Not Available	~
Data is not final and subject to change	‡
Equal or greater than benchmark	✓
Less than 10% negative variance	!
Greater than 10% negative variance	✗

*Known issue - childhood immunizations measure logic not currently recognizing PCV15 or PCV20 vaccine formulations
-Result/Impact: false negative scoring on measure
-Resolution: 2024 value set update expected in Q3 Epic Upgrade

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

	Data Source	Owner	Frequency	System
PATIENT EXPERIENCE - Ambulatory				
Press Ganey Top Box Score (Likelihood of recommending)	The Press Ganey patient experience survey uses a Likert-type scale of 5 responses: very poor, poor, fair, good, and very good. The Top Box score reflects the percentage of patient responses answered 'very good' to the overall patient experience assessment question: "Likelihood of your recommending our practice to others?". *Scores are limited to include only FQHC departments by location. McDowell - Mesa is included under the Mesa overall score. **Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments within each community health center are excluded from locational roll ups** *Grand Totals reflect responses under the Medical Practice question set - values for Diabetes Education and Antepartum Testing although reflected on the dashboard are not included in the Grand Total roll up, as these areas are evaluated under the Outpatient Services question set and cannot currently be combined.	NRC Real Time Score Summary *pulled by Amanda Jacobs	Monthly	NRC Health - Department Summary Report
ACCESS - Ambulatory				
Appointments Scheduled FYTD	All appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD. *Note: For active providers only - FYTD does not account for historical provider information	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
Provider Appointment Fill Rate FYTD	Provider schedule utilization metric calculated by number of patients to appointment slots available. *For MTD and FYTD. Data is pulled from Epic Clarity: Availability table, which looks at the Provider Templates. **Limited to MD, NP, PA, and Midwives - as of February 2024 data*	FQHC Clinic Performance Dashboard FQHC Provider Availability *pulled by Amanda Jacobs	Monthly	Tableau
Scheduled Appointment No-Shows FYTD	All No- show appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD.	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
No Show Rate FYTD	Percentage of Scheduled Patients who were a "No show" patient or same day cancellation. *For FYTD.	Amanda Jacobs	Monthly	Formula
FINANCE - Ambulatory				
In-Person Visits FYTD	Total Actual Visits (includes nurse only visits) FYTD - Virtual Visits FYTD	Nancy Horskey	Monthly	Axiom
Virtual Visits FYTD	Virtual Telemedicine Visits (telephonic/audio/visual/other virtual type) FYTD	Nancy Horskey	Monthly	Axiom
Total Actual Visits (includes nurse only visits) FYTD	All visits per Clinic (visit count methodology). For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	All budgeted visits per Clinic (visit count methodology) For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - Budgeted Visits FYTD. For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD / Budgeted Visits FYTD (%) For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Total Number of Patients seen by provider	Completed visits for provider only	Maria Aguirre	Monthly	Epic - Clarity Query
Grand Total FQHC	Includes Month Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula
FYTD FQHC	Includes FYTD Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula

Valleywise Health

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Data Dictionary

Federally Qualified Health Centers

	Data Source	Owner	Frequency	System
FINANCE - BEHAVIORAL HEALTH				
In-Person Visits FYTD	Total Actual Visits (includes nurse only visits) FYTD - Virtual Visits FYTD	Nancy Horskey	Monthly	Axiom
Virtual Visits FYTD	Virtual Telemedicine Visits (telephonic/audio/visual/other virtual type) FYTD	Nancy Horskey	Monthly	Axiom
Total Actual Visits FYTD	Actual Visits per BH Clinic (all visits per Valleywise Health month end visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	Budgeted Visits per BH Clinic (all visits per Valleywise Health month end visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - FYTD Budgeted Visits	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD/ Budgeted Visits FYTD (%)	Amanda Jacobs	Monthly	Formula
FINANCE-DENTAL				
Actual Visits FYTD	All visits per Dental Clinic (visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	All budgeted visits per Dental Clinic (visit count methodology) For fiscal year to date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - FYTD Budgeted Visits	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD/ Budgeted Visits FYTD (%)	Amanda Jacobs	Monthly	Formula

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
QUALITY - Ambulatory					
Quality /Regulatory Metrics	**Required by:**		Quality	Monthly	
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	**CMS69v12**	**Description:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters **Numerator:** Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period **Denominator:** All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0069v12*	Quality	Monthly	EPIC/UDS
Cervical Cancer Screening	**CMS124v12**	**Description:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women age 21-64 who had cervical cytology performed within the last 3 years * Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years **Numerator:** Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: * Cervical cytology performed during the measurement period or the two years prior to the measurement period for women 24-64 years of age by the end of the measurement period * Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are 30 years or older at the time of the test **Denominator:** Women 24-64 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0124v12*	Quality	Monthly	EPIC/UDS
Childhood Immunization Status (CIS)	**CMS117v12**	**Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (Hib); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday **Numerator:** Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday **Denominator:** Children who turn 2 years of age during the measurement period and who have a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0117v12*	Quality	Monthly	EPIC/UDS

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
Colorectal Cancer Screening	**CMS130v12**	**Description:** Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer **Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: * Fecal occult blood test (FOBT) during the measurement period * Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period * Colonoscopy during the measurement period or the nine years prior to the measurement period * Stool DNA (sDNA) withFIT during the measurement period or the two years prior to the measurement period * CT Colonography during the measurement period or the four years prior to the measurement period **Denominator**: Patients 46-75 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0130v12*	Quality	Monthly	EPIC/UDS
Controlling High Blood Pressure	**CMS165v12**	**Description**: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period **Numerator:** Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period **Denominator:** Patients 18-85 years of age by the end of the measurement period who had a visit during the measurement period and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0165v12*	Quality	Monthly	EPIC/UDS
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	**CMS122v12**	**Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period **Numerator:** Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period. **Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0122v12*	Quality	Monthly	EPIC/UDS
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	**CMS164v7**	**Description:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period or who had an active diagnosis of IVD during the measurement period, and who had documented use of aspirin or another antiplatelet during the measurement period **Numerator:** Patients who had an active medication of aspirin or another antiplatelet during the measurement year **Denominator:** Patients 18 years of age and older with a visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement year ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS164v7.html*	Quality	Monthly	EPIC/UDS

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Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
Screening for Clinical Depression and Follow Up Plan	**CMS2v13**	**Description:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Numerator:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Denominator**: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0002v13*	Quality	Monthly	EPIC/UDS
Tobacco Use: Screening and Cessation Intervention:	**CMS138v12**	**Description:** Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Numerator:** *Patients who were screened for tobacco use at least once during the measurement period and *Who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Denominator:** Patients aged 12 years and older seen for at least two medical visits in the measurement period or at least one preventive medical visit during the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0138v12*	Quality	Monthly	EPIC/UDS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**CMS155v12**	**Description:** Percentage of patients 3–17* years of age who had an outpatient visit with a primary care physician or OB/GYN and who had evidence of height, weight, and body mass index (BMI) percentile documentation, who had documentation of counseling for nutrition, and who had documentation of counseling for physical activity during the measurement period **Numerator:** Children and adolescents who have had: *their height, weight, and BMI percentile recorded during the measurement period and *counseling for nutrition during the measurement period and *counseling for physical activity during the measurement period **Denominator:** Patients 3 through 17 years of age by the end of the measurement period, with at least one outpatient visit with a PCP or OB/GYN during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0155v12*	Quality	Monthly	EPIC/UDS

		Data Source	Owner	Frequency	System
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**CMS347v7**	**Description:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: *All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure; OR *Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR *Patients aged 40-75 years with a diagnosis of diabetes; OR *Patients aged 40 to 75 with a 10-year ASCVD risk score of >= 20 percent **Numerator:** Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period **Denominator:** All patients who were previously diagnosed with or currently have a diagnosis of clinical ASCVD, including an ASCVD procedure. Patients aged 20 to 75 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia.Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes. Population 4: Patients aged 40 to 75 at the beginning of the measurement period with a 10-year ASCVD risk score (i.e., 2013 ACC/AHA ASCVD Risk Estimator or the ACC Risk Estimator Plus) of >= 20 percent during the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0347v7*	Quality	Monthly	EPIC/UDS
Breast Cancer Screening	**CMS125v12**	**Description:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period **Numerator:** Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period **Denominator:** Women 52-74 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0125v12*	Quality	Monthly	EPIC/UDS
HIV Screening	**CMS349v6**	**Description:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for Human immunodeficiency virus (HIV) **Numerator:** Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday **Denominator:** Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2024/cms0349v6*	Quality	Monthly	EPIC/UDS