Board Members J. Woodfin Thomas, Chairman, District 4 Mark G. Dewane, Vice Chairman, District 2 Mary A. Harden, RN, Director, District 1 Kate Brophy McGee, Director, District 3 Mary Rose Garrido Wilcox, Director, District 5 **President & Chief Executive Officer** Stephen A. Purves, FACHE **Clerk of the Board** Melanie Talbot **Meeting Location** Virginia G. Piper Charitable Trust Pavilion 2609 East Roosevelt Street Phoenix, Arizona 85008 3rd Floor, Board Room	**AMENDED AGENDA – General Session Meeting** **Maricopa County Special Health Care District Board of Directors** **Mission Statement** The Valleywise Health's mission is to provide exceptional care, without exception, every patient, every time.

Welcome
The Board of Directors is the governing body for the Maricopa County Special Health Care District. Each member represents one of the five districts in Maricopa County. Members of the Board are public officials, elected by the voters of Maricopa County. The Board of Directors sets policy and the President & Chief Executive Officer, who is hired by the Board, directs staff to carry out the policies.

How Citizens Can Participate
Each meeting is open to the public and there is a "Call to the Public" at the beginning of each meeting. An individual may address the Board of Directors at this time or when the agenda item to be addressed is reached. If you wish to address the Board, please complete a Request to Speak form Speaker's Slip and deliver it to the Clerk of the Board prior to the Call to the Public. If you have anything that you wish distributed to the Board and included in the official record, please hand it to the Clerk who will distribute the information to the Board members and Valleywise Health Senior Staff.

Speakers will be called in the order in which requests to speak are received. Your name will be called when the Call to the Public has been opened or when the Board reaches the agenda item which you wish to speak. As mandated by the Arizona Open Meeting Law, officials may not discuss items not on the agenda, but may direct staff to follow-up with the citizen.

Public Rules of Conduct
The Board Chair shall keep control of the meeting and require the speakers and audience to refrain from abusive or profane remarks, disruptive outbursts, applause, protests, or other conduct which disrupts or interferes with the orderly conduct of the business of the meeting. Personal attacks on Board members, staff, or members of the public are not allowed. It is inappropriate to utilize the Call to the Public or other agenda item for purposes of making political speeches, including threats of political action. Engaging in such conduct and failing to cease such conduct upon request of the Board Chair will be grounds for ending a speaker's time at the podium or for removal of any disruptive person from the meeting room, at the direction of the Board Chair.

Agendas are available within 24 hours of each meeting at Valleywise Health Medical Center, 2601 East Roosevelt, Phoenix, Arizona 85008 and on the internet at https://valleywisehealth.org/about/board-of-directors/. 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.

3/25/2024 4:22 PM

▪ Virginia G. Piper Charitable Trust Pavilion ▪
▪ 2609 East Roosevelt Street ▪ Phoenix, Arizona 85008 ▪
▪ 3rd Floor, Board Room ▪

Wednesday, March 27, 2024
1:00 p.m.

Access to the meeting room will start at 12:50 p.m., 10 minutes prior to the start of the meeting.

One or more members of the Board of Directors of the Maricopa County Special Health Care District may be in attendance by technological means. Board members attending by technological means will be announced at the meeting.

Pursuant to A.R.S. § 38-431.03(A)(3), or any applicable and relevant state or federal law, the Board may vote to recess into an Executive Session for the purpose of obtaining legal advice from the Board's attorney or attorneys on any matter listed on the agenda. The Board also may wish to discuss any items listed for Executive Session discussion in General Session, or the Board may wish to take action in General Session on any items listed for discussion in Executive Session. To do so, the Board will recess Executive Session on any particular item and reconvene General Session to discuss that item or to take action on such item.

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

1:00 **Call to Order**

Roll Call

Pledge of Allegiance

Call to the Public
This is the time for the public to comment. The Board of Directors 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

General Session, Presentation, Discussion and Action:

1:05 1. Approval of Consent Agenda: 15 min
Note: Approval of contracts, minutes, IGAs, proclamations, etc. 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 Board member.

a. Minutes:

i. **Approve** Maricopa County Special Health Care District Board of Directors meeting minutes dated February 28, 2024
Melanie Talbot, Chief Governance Officer; and Clerk of the Board

b. Contracts:

i. **Approve** amendment #1 to the agreement (90-24-003-1-01) between Maricopa County Department of Public Health and Maricopa County Special Health Care District dba Valleywise Health, for services related to the Community Health Needs Assessment (2023-2026)
Michelle Barker, DHSc, Senior Vice President Ambulatory Services; and Chief Executive Officer Federally Qualified Health Centers

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

1:05 1. Approval of Consent Agenda, cont.:

b. Contracts, cont.:

ii. **Approve** amendment #9 to the provider services agreement (90-13-242-1-09) between Health Choice and Maricopa County Special Health Care District dba Valleywise Health, for participation in the quality incentive program
Renee Clarke, MBA, Senior Vice President, Managed Care

iii. **Approve** a new agreement (MCO-24-007-MSA) between Humana Dental Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, to allow members to receive dental services through Valleywise Health dental providers
Renee Clarke, MBA, Senior Vice President, Managed Care

iv. **Approve** amendment #3 to the facility participation agreement (MCO-20-003-03) between United Behavioral Health, Inc and Maricopa County Special Health Care District dba Valleywise Health, to allow members to continue to receive behavioral health services through Valleywise Health facilities
Renee Clarke, MBA, Senior Vice President, Managed Care

v. **Approve** a new cooperative agreement (90-24-239-1) between Progressive Services, Inc dba Progressive Roofing and Maricopa County Special Health Care District dba Valleywise Health, for future roof repair projects for Valleywise Health facilities
Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer

vi. **Approve** a new mission support program commitment (90-18-239-4) between Dignity Health dba St. Joseph's Hospital and Medical Center and Maricopa County Special Health Care District dba Valleywise Health, to provide mission support for behavioral health services in Maricopa County
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

vii. **Approve** amendment #1 to the contract (90-23-106-1-01) between LaneTerralever, LLC and Maricopa County Special Health Care District dba Valleywise Health, to extend the contract for creative, digital marketing, web and/or media services
Runjhun Nanchal, MHA, Senior Vice President, Strategy, Marketing and Communications

viii. **Approve** an intergovernmental agreement (90-24-274-1) between Arizona Health Care Cost Containment System (AHCCCS) and Maricopa County Special Health Care District dba Valleywise Health, for the administration of the Safety Net Services Initiative (SNSI) for the Contract Year ending September 30, 2024. Valleywise Health shall transfer public funds to AHCCCS in the amount of $2,474,249.88 for the administration of the SNSI
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

ix. **Approve** an intergovernmental agreement (90-24-274-2) between Arizona Health Care Cost Containment System (AHCCCS) and Maricopa County Special Health Care District dba Valleywise Health, for the support of the Safety Net Services Initiative (SNSI) for the Contract Year ending September 30, 2024. Valleywise Health shall transfer public funds to AHCCCS in the amount of $61,856,247.10 in support of the SNSI
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

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

1:05 1. Approval of Consent Agenda, cont.:

c. Governance:

i. **Approve** affidavit appointing Adeola Adelayo, MD, as Deputy Medical Director in the Department of Psychiatry
Gene Cavallo, MC, LPC, Senior Vice President, Behavioral Health Services

ii. **Approve** Amended and Restated Maricopa County Special Health Care District Cafeteria Plan (Internal Revenue Code Section 125)
Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer

iii. **Approve** Valleywise Health Foundation's ALL IN Campaign donor recognition requests
Lisa Hartsock, MPH, CFRE, Foundation Relations Executive

d. Medical Staff:

i. **Approve** Valleywise Health's Medical Staff credentials for March 2024
Mark M. MacElwee, MD, Chief of Staff

ii. **Approve** Valleywise Health's Advanced Practice Clinician/Allied Health Professional Staff credentials for March 2024
Mark M. MacElwee, MD, Chief of Staff

iii. **Approve** proposed revisions to policy 39016 S - Credentialing in the Event of a Disaster
Mark M. MacElwee, MD, Chief of Staff

iv. **Approve** proposed revisions to policy 39020 T - Medical Staff Credentials
Mark M. MacElwee, MD, Chief of Staff

v. **Approve** proposed revisions to policy 39026 T Operational Credentialing
Mark M. MacElwee, MD, Chief of Staff

vi. **Approve** proposed revisions to the Nurse Practitioner Emergency Medicine Privileges and Practice Prerogatives
Mark M. MacElwee, MD, Chief of Staff

vii. **Approve** proposed revisions to the Physician Assistant Emergency Medicine Privileges and Practice Prerogatives
Mark M. MacElwee, MD, Chief of Staff

viii. **Approve** proposed revisions to the Nurse Practitioner Surgery Privileges and Practice Prerogatives
Mark M. MacElwee, MD, Chief of Staff

ix. **Approve** proposed revisions to the Physician Assistant Surgery Privileges and Practice Prerogatives
Mark M. MacElwee, MD, Chief of Staff

e. Care Reimagined Capital:

i. Intentionally Left Blank – No Handout

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

1:05 1. Approval of Consent Agenda, cont.:

f. Capital:

i. Intentionally Left Blank – No Handout

End of Consent Agenda

1:20 2. Update on Valleywise Health's Workplace Violence Committee 10 min
Crystal Garcia, MBA/HCM, RN, Vice President, Specialty Services, Quality and Patient Safety

1:30 3. Discussion and **Possible Action** on Valleywise Health's 2024 Legislative Agenda and/or the Maricopa County Special Health Care District's position regarding proposed State and Federal legislative items 10 min
Michael Fronske, Legislative and Governmental Affairs Director

1:40 4. Discuss and Review Fiscal Year 2025 Budget Calendar 5 min
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

1:45 5. Discuss and Review Valleywise Health's February 2024 Financials and Statistical Information 15 min
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

2:00 6. Discuss, Review and **Approve** the Maricopa County Special Health Care District's Employee Benefits Program for Fiscal Year 2025 10 min
Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer

2:10 7. Update on Care Reimagined Projects 10 min
Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer

2:20 8. Review and **Possible Action** on the Following Reports to the Board of Directors: 15 min

a. Monthly Marketing and Communications Report (February 2024)
Runjhun Nanchal, MHA, Senior Vice President, Strategy, Marketing and Communications

b. Monthly Care Reimagined Capital Purchases Report (February 2024)
Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer

c. Monthly Valleywise Health Employee Turnover Report (February 2024)
Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer

2:35 9. Concluding Items 10 min

a. Old Business: - No Handout

February 28, 2024
Legislative Agenda
- Provide more information on House Bill 2686

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

2:35 9. Concluding Items, cont.:

a. Old Business, cont.:

February 28, 2024, cont.:
Legislative Agenda, cont.:
- Provide status of House Bill 2042

Care Reimagined Update
- Provide information on the type of seating that will be in the chapel at the new acute care tower
- Provide a list of the action items identified during the Day in the Life and Mock Move for Facility/Building Systems and Construction categories, and how they relate to late change orders

January 24, 2024
Compliance Training
- Future discussion on disclosure of gifts District Board members receive

Care Reimagined Update
- Once available, provide the date that the Conference and Administration Center will be decommissioned

November 21, 2023
Consent Agenda
- Future discussion on disclosure of gifts District Board members receive

Behavioral Health Update
- Provide information to the Maricopa County Board of Supervisors on projects, programs and services made possible with the ARPA grant funding

Care Reimagined Update
- Once available, provide the date that the Conference and Administration Center will be decommissioned

June 28, 2023
Care Reimagined Update
- When projects are complete, compose a letter from the Board, outlining everything that was accomplished/made possible, and send to stakeholders

May 24, 2023
April 2023 Financials
- How will fixed costs change (old facilities vs new facilities); include the change in utility costs and maintenance costs

August 24, 2022
Monthly Update on Care Reimagined Projects
- Work with organized neighborhood groups near Valleywise Health Medical Center to build connections and invite to opening of new hospital

b. Board Member Requests for Future Agenda Items or Reports - No Handout

c. Comments - No Handout
   i. Chairman and Member Closing Comment
   ii. President and Chief Executive Officer Summary of Current Events

2:45 **Adjourn**

1.a.i. Minutes - Meeting Minutes dated February 28, 2024

Minutes

DRAFT

Maricopa County Special Health Care District
Board of Directors Meeting
Virginia G. Piper Charitable Trust Pavilion
2609 East Roosevelt Street, Phoenix, Arizona 85008
3rd Floor, Board Room
February 28, 2024, 1:00 p.m.

Present:	J. Woodfin Thomas, Chairman, District 4 Mark G. Dewane, Vice Chairman, District 2 Mary A. Harden, RN, Director, District 1 Kate Brophy McGee, Director, District 3 Mary Rose Garrido Wilcox, Director, District 5 – *participated remotely*
Others Present:	Steve A. Purves, FACHE, President & Chief Executive Officer Michael D. White, MD, MBA, Executive Vice President, Chief Clinical Officer Claire Agnew, CPA, MBA, Executive Vice President, Chief Financial Officer Lia Christiansen, MBC, Executive Vice President, Chief Administrative Officer Sherry Stotler, RN, MSN, Senior Vice President, Chief Nursing Officer Mark M. MacElwee, MD, Chief of Staff Ijana Harris, JD, Senior Vice President, General Counsel
Guest Presenters/ Speakers:	Crystal Garcia, MBA/HCM, RN, Vice President, Specialty Services, Quality and Patient Safety Gene Cavallo, MC, LPC, Senior Vice President, Behavioral Health Services Martha Steiner, MSN-L, RN, Vice President, Behavioral Health Nursing and Clinical Care Michael Fronske, Legislative and Governmental Affairs Director William J. Sims, JD, Sims Mackin, Ltd., Board Counsel
Recorded by:	Melanie Talbot, Chief Governance Officer; and Clerk of the Board Cynthia Cornejo, Senior Deputy Clerk of the Board

Call to Order:

Chairman Thomas called the meeting to order at 1:00 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, she noted that four of the five voting members of the Maricopa County Special Health Care District Board of Directors were present, which represented a quorum. Director Brophy McGee arrived shortly after roll call.

For the benefit of all participants, Ms. Talbot announced the Board member participating remotely.

Pledge of Allegiance

Chairman Thomas led the Pledge of Allegiance.

Note: Director Brophy McGee arrived at 1:01 p.m.

Call to the Public

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

Mission Statement

Mr. Purves read the mission statement aloud.

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda

   a. Minutes:

      i. Approve Maricopa County Special Health Care District Board of Directors meeting minutes dated January 24, 2024

   b. Contracts:

      i. Approve amendment #10 to the agreement (C-90-00-31-1-10) between Evernorth Behavioral Health Inc fka Cigna Behavioral Health Inc and Maricopa County Special Health Care District dba Valleywise Health, to allow members to continue to receive behavioral health services through Valleywise Health facilities

      ii. Approve amendment #3 to the agreement (MCO-20-022-03) between Medica Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, to allow members to continue to receive healthcare services through Valleywise Health facilities

      iii. Approve amendment #2 to the contract (90-24-004-1-02) between Stericycle Inc and Maricopa County Special Health Care District dba Valleywise Health, to transfer services to the new acute care hospital

      iv. Approve a new agreement (MCO-24-005-MSA) between CoreCivic of Tennessee LLC and Maricopa County Special Health Care District dba Valleywise Health, to allow incarcerated individuals to receive healthcare services through Valleywise Health facilities and providers

      v. Approve amendment #3 to the contract (90-22-255-1-03) between Arizona Department of Health Services and Maricopa County Special Health Care District dba Valleywise Health, for the Well Woman Health Check Program grant which provides breast and cervical cancer screenings for uninsured and underinsured

      vi. Approve a new subcontract agreement (90-24-222-1) between Mercy Care and Maricopa County Special Health Care District dba Valleywise Health, for a mental health block grant for the First Episode Center(s)

      vii. Approve a new agreement (90-24-210-1) between Mainsail Parent LLC dba Aspirion and Maricopa County Special Health Care District dba Valleywise Health, for select accounts receivable outsourcing to include high balance discretionary denials

      viii. Approve amendment #3 to the agreement (MCO-20-003-03) between United Behavioral Health Inc and Maricopa County Special Health Care District dba Valleywise Health, to allow members to continue to receive behavioral healthcare services through Valleywise Health facilities

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

1. Approval of Consent Agenda

   b. Contracts, cont.:

      ix. Approve amendment #2 to the agreement (90-23-032-1-02) between Mercy Care and Maricopa County Special Health Care District dba Valleywise Health, for additional funding for the subcontract for the Coronavirus Response and Relief Supplemental Appropriations Act Mental Health Block Grant

   c. Governance:

      i. Approve affidavit appointing Ryan Mahelona, MD, and Hany Ashamalla, MD, as Deputy Medical Directors in the Department of Psychiatry

      ii. Approve revisions to policy 20075 MT – FQHC Credentialing and Privileging of Clinical Staff

   d. Medical Staff:

      i. Approve Valleywise Health's Medical Staff credentials for February 2024

      ii. Approve Valleywise Health's Advanced Practice Clinician/Allied Health Professional Staff credentials for February 2024

      iii. Approve revisions to policy 31202 T - Peer Review Policy

   e. Care Reimagined Capital:

      i. INTENTIONALLY LEFT BLANK

   f. Capital

      i. Approve capital expenditure request (CER #24-703A) for the buildout of the facilities department space at the Roosevelt campus for a cost of $498,266

      ii. Approve capital expenditure request (CER #24-439) to replace the roof at Valleywise Behavioral Health Center-Mesa for a cost of $958,000

MOTION: Director Harden moved to approve the consent agenda. Director Wilcox seconded.

VOTE: 5 Ayes: Chairman Thomas, Vice Chairman Dewane, Director Brophy McGee, Director Harden, Director Wilcox
0 Nay
Motion passed.

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

2. Discuss and Review the Quarterly Quality Report and Metrics Dashboard including but not limited to Patient Safety and Hospital Consumer Assessment of Healthcare Providers and Systems Results

Ms. Garcia outlined the quality results for the second quarter of fiscal year (FY) 2024, addressing the metrics that did not meet the established benchmark. To improve the hospital-wide inpatient, risk-adjusted mortality index, staff worked with various groups and expected the metric to meet the benchmark by the next quarter. Staff maintained collaboration with all departments to improve the STEMI: door-to-ballon metric.

She reviewed patient safety indicator (PSI) 08, in-hospital fall rate with fracture, noting there were two occurrences for the quarter, with one fall requiring surgical intervention. There were two perioperative hemorrhage or hematoma, PSI-09, for the quarter, causing the metric to miss the benchmark. Each case was reviewed, and no trends were identified.

Staff continued to work with surgeons to improve PSI-13, postoperative sepsis rate, and PSI-14, postoperative wound dehiscence rate. There were three cases of abdominopelvic accidental punctures or lacerations, PSI-15, in October 2023, which was uncommon. All cases were reviewed, and no commonalities were discovered. Monitoring would continue to ensure no trends developed.

She announced that improvements were made in PSI-04, death among surgical patients with serious treatable complications.

Ms. Garcia reviewed the FY 2024 second quarter Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) preliminary results, which declined from the prior quarter. The overall rating fluctuated from month to month. Staff compared Valleywise Health's results against other safety net hospitals and the National Research Corporation (NRC) average.

Director Harden asked if there was any correlation between the results and the average daily census.

Ms. Garcia stated staff compared the results against various factors and there was no correlation between the results and the average daily census. The Patient Experience Improvement Collaborative utilized a priority matrix, and determined the question that had the greatest impact on the overall score was 'got help as soon as wanted.'

The priority matrix was also used to determine the area of focus to improve the Net Promoter Score (NPS) for the specialty clinics and the Federally Qualified Health Centers (FQHCs). Valleywise Comprehensive Health Center-Peoria had exceeded the NPS benchmark, while there were opportunities for improvement at Valleywise Comprehensive Health Center-Phoenix. It was determined that the question related to 'seen in a timely manner' would have the greatest impact for the specialty clinics and 'registration staff helpful' would have the greatest impact at the FQHCs.

Director Harden questioned if the age of a facility influenced the scores.

Ms. Garcia stated that a newer building as well as patient volumes may factor into the results. The combined score for the ambulatory network was better than the benchmark, with 75.1% positive results for December 2023.

She reviewed the action plans in place to improve patient experience results for hospital, specialty clinics, and the FQHCs.

Director Brophy McGee requested additional information on the implementation of touchpoint wait times via Epic, the electronic medical record.

Ms. Garcia explained that staff researched the possibility of monitoring the patient flow electronically and was unsure if that option would work for Valleywise Health.

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

2. Discuss and Review the Quarterly Quality Report and Metrics Dashboard including but not limited to Patient Safety and Hospital Consumer Assessment of Healthcare Providers and Systems Results, cont.

Ms. Garcia mentioned that inpatient behavioral health patient experience scores had performed better than benchmark for the second quarter of FY 2024.

3. Discuss and Review Quarterly Infection Control Metrics Dashboard

Ms. Garcia reviewed the infection control quality metrics for the second quarter of FY 2024, stating one metric did not meet the benchmark. The surgical site infection – colon surgery metric was reported semi-annually, with three cases occurring in the current reporting period. All cases were thoroughly reviewed, and no trends were identified.

She highlighted the sustained improvement related to Methicilillin-resistant Staphylococcus aureus (MRSA) bacteremia infections. While the rate increased slightly in December, the metric was within the benchmark. The actions to screen all patients and decolonize as needed were a great benefit to patients and the organization.

Director Wilcox applauded staff on the results of their efforts. She asked if there was information available for patients on how to access the patient portal, MyChart.

Dr. White said there was information included on the after-visit summary and, staff would be able to assist patients, as needed.

4. Update on Behavioral Health Programs and Services at Valleywise Health

Mr. Cavallo provided an update on behavioral health services throughout Valleywise Health, announcing the opening of an additional unit at partial capacity at Valleywise Behavioral Health Center-Maryvale. Sixteen of the 18 inpatient behavioral health units were in operation, or 344 of the 411 licensed beds.

Ms. Steiner expressed the importance of capacity management, as flu and COVID cases required units to be quarantined. There was continual monitoring of discharges, beds available, and the number of pending admissions to operate efficiently and better serve the needs of the community.

Mr. Cavallo reviewed a three-year comparison of behavioral health inpatient admissions, average daily census, staffed units, and occupancy rate. In December 2021, 17 units were open with the average daily census of 293 and in January 2024, 15 units were open with the average daily census of 295.

Ms. Steiner discussed the efforts to retain and recruit behavioral health clinical staff. Between July 2023 and September 2023, 131 employees were onboarded, however, there were also 71 total employment separations, resulting in a net positive 60 employees. Between October 2023 and December 2023, 89 employees were onboarded, with 58 total employment separations, resulting in a net positive 31 employees.

Director Harden referenced the employment separations and noted many quit without notice. She asked for additional information. There were also many probationary releases and she asked if the interview questions or onboard process needed to be reviewed.

Ms. Steiner stated that individuals quit without notice for a variety of reasons, in a variety of ways. To improve the number of probationary releases, staff worked with human resources to standardize the interview questions and soon, hiring managers would receive training to assist with the interview process.

Chairman Thomas clarified that the total number of separations was specific to the timeframe, not to the number of employees onboarded during that timeframe.

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

4. Update on Behavioral Health Programs and Services at Valleywise Health, cont.

Mr. Cavallo explained that due to the high number of vacancies and the reduced number of applicants, there were instances that individuals with less experience were given the opportunity to be successful with on-the-job-training in the various positions within the behavioral health department.

Ms. Steiner stated that recruiting and retaining behavioral health technicians (BHTs) was a focus, since the number of vacancies was increasing, and staff began utilizing contract labor to fill the gaps in staffing. While contract labor BHTs were experienced and allowed the organization to open the additional unit at partial capacity, it was a temporary fix.

She outlined the retention action plans, including restarting the Shared Governance Council and inviting BHTs to participate. The Council provided a space for staff to provide input on patient satisfaction, policies, and other operational topics. There were also efforts to embrace and celebrate the diverse workforce. The BHT clinical ladder had been expanded, with the addition of an entry level position, and updating the job descriptions and pay ranges. Current employees were then promoted to a higher level.

She outlined improvements made to fill the registered nurse (RN) vacancies within the behavioral health department. There was also less reliance on contract labor for RNs. That success was attributed to the SOAR (Sign On and Retention) and Grow Your Own programs.

Ms. Steiner provided an overview of ongoing challenges, including the concentrated acuity of patients treated, often requiring one-on-one staffing. When needed, admissions were held due to critical staffing shortages.

Mr. Cavallo reviewed the three-year employee retention and turnover rates, noting the year-over-year improvements in overall voluntary and BHT voluntary turnover rates. Significant improvements were made in RN voluntary and first year RN turnover rates.

Director Wilcox commended staff for opening additional beds. She asked if staff considered offering tours to members of the legislature, to provided education to those that were proposing bills that impacted operations. She suggested that the tours could also demonstrate how funds received from the Governor's office were benefiting the organization and the community.

Mr. Cavallo stated that he was always willing to provide tours and to inform elected officials about behavioral health services provided at Valleywise Health.

He provided an update on the outpatient behavioral health programs, including the Assertive Community Treatment (ACT) program. He announced that the program would soon relocate from within the Valleywise Behavioral Health Center-Mesa to a newly constructed building located on the same campus.

The First Episode Center located within Valleywise Community Health Center-Avondale was near capacity, at 88 members, while the First Episode Center based in Mesa, Arizona was at half capacity after seven months of operation. He explained most referrals to the First Episode Centers originated from the inpatient setting, after individuals had been petitioned for a court-ordered evaluation.

The Mesa Behavioral Health Specialty Clinic would also relocate to the new building on the Valleywise Behavioral Health Center-Mesa campus, with the ACT program. The First Episode Center based in Mesa would then be located within Valleywise Community Health Center-Mesa.

The Integrated Behavioral Health (IBH) program continued to expand and there were now over 45 team members, and services were available at all FQHCs and the two Comprehensive Health Centers.

He highlighted the new medication assisted treatment (MAT) program for opioid dependance which had expanded to six FQHCs.

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

4. Update on Behavioral Health Programs and Services at Valleywise Health, cont.

Director Brophy McGee noted the philosophical divide within the behavioral health community in relation to MAT.

Dr. White stated that an internal medicine physician, working with the behavioral health clinics for an addiction medicine fellowship, was providing guidance. There was good evidence of the effectiveness of MAT for the specific Valleywise Health patient population, however, non-medical assisted treatment, such as counseling, would be available for patients, as well.

Mr. Cavallo reviewed future behavioral health projects, including the timeline for the completion of the construction at Valleywise Behavioral Health Centers-Mesa and Maryvale. Construction of the new building at Valleywise Behavioral Health Center-Mesa was scheduled to be completed by the end of May 2024, with services beginning by September 2024. Renovations at Valleywise Behavioral Health Center-Maryvale were scheduled to be completed by mid-March 2024. He was working with the appropriate staff to coordinate grand opening ceremonies to celebrate the expansion of services.

5. Discussion and Possible Action on Valleywise Health's 2024 Legislative Agenda and/or the Maricopa County Special Health Care District's position regarding proposed State and Federal legislative items

Mr. Fronske reviewed the statistics of the current legislative session, which had been in session for 52 days, 1,629 bills had been introduced, and one bill had passed and was signed by the Governor. There had been no change to the budget process or proposed budgets.

Sixty-two bills had been sent to staff for comment, with 40 of those bills continuing through the process. There were an additional 50 bills that were being monitored. Mr. Fronske provided a status update for the bills the Board authorized staff to support. House Bill (HB) 2290, certificates of operations, interfacility transfers, and HB 2078, advisory committee, subcommittee; exemption, did not make it out of committee. HB 2035, insurance; claims; appeals; provider credentialing, had made it out of the House and was awaiting a hearing in the Senate.

He informed the Board that House Concurrent Resolution (HCR) 2060; lawful presence, e-verification program, had been introduced, noting that it would not impact the organization's ability to treat individuals in the hospital, but could have a negative impact within the community. The resolution could not be vetoed by the Governor and did not require a signature.

Mr. Fronske requested the ability to oppose three bills related to behavioral health. The first, HB 2744, involuntary treatment, guardians, agents, rights, which would allow for direct petitions by guardians and family members for court ordered evaluations, bypassing the current screening process. The second bill, Senate Bill (SB) 1578, involuntary treatment, substance abuse, would create a new category for court ordered treatment for individuals suffering from a substance abuse issue. The third bill, SB 1609, was a striker and would require inpatient psychiatric hospitals to discharge patients with a 30-day supply of all medications upon discharge. Staff was concerned that the bills would have a negative impact on the current processes and systems, and unfortunately, there had been no stakeholder meetings to outline those concerns and work toward solutions. However, staff would continue their attempts to reach out to the bill sponsors and provide education to others and propose amendment language.

Director Brophy McGee questioned the source of the bills and their reluctance to discuss the issues with staff.

Mr. Fronske said there were two groups advocating for the bills; Mad Moms and attorneys that were involved with the treatment of individuals within mental health institutions. He was unsure of the exact reasons why there was resistance in discussing the matters with key stakeholders.

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

5. Discussion and Possible Action on Valleywise Health's 2024 Legislative Agenda and/or the Maricopa County Special Health Care District's position regarding proposed State and Federal legislative items, cont.

Director Brophy McGee stated it was her understanding that staff's main concerns were that the bills would have unintended consequences and would disrupt the current petitioning process without proper structure and guidelines.

Mr. Fronske agreed and stated that the current system was not equipped to manage direct petitioning of individuals.

Director Harden was dismayed that the bills did not appear to advocate for the patients and asked if the Governor would be supportive, should the bills be passed.

Mr. Fronske said that staff's concerns with the bills had been relayed to the Governor's Office and there was a willingness to gain more information about those concerns. He was hopeful staff would have the opportunity to address specific provisions within each bill, as there were some components that the organization was neutral on.

Director Harden requested the status of HB 2686, health profession regulatory boards.

Mr. Fronske said that he was unsure of that specific bill but would gather information and send an update to the Board.

MOTION: Director Wilcox moved to authorize staff to oppose bills House Bill 2744, Senate Bill 1578, and Senate Bill 1609. Vice Chairman Dewane seconded.

Vice Chairman Dewane reiterated the questions around the motivation with the bills and the hesitancy with speaking to stakeholders.

Mr. Fronske stated that parents were sharing personal experiences with the behavioral health systems and processes, along with solutions they believed would improve that system. Unfortunately, those suggested solutions were not discussed with stakeholders to determine how the changes would impact the current system. Staff would continue efforts to provide education to legislators.

VOTE: 5 Ayes: Chairman Thomas, Vice Chairman Dewane, Director Brophy McGee, Director Harden, Director Wilcox
0 Nay
Motion passed.

Director Wilcox requested the status of HB 2042, food preparation; sale; cottage food.

Mr. Fronske said that he would gather information and send an update to the Board.

He provided an overview of the federal issues that staff was focused on, noting there was now legislation at the federal level, H.R. 7397; Reinforcing Essential Health Systems for Communities Act, would allow for funding to be quickly distributed to essential hospitals in times of crisis. He noted there was no funding currently attached to the designation, however, staff would continue to advocate for the passage. There would also be ongoing advocacy for 340B funding and protecting hospitals from site-neutral payment cut proposals.

Break from 2:26 p.m. to 2:35 p.m.

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

6. Discuss and Review Valleywise Health's January 2024 Financials and Statistical Information

Ms. Agnew reviewed statistical information for January 2024, noting total admissions were 5.3% better than budget, with 8.3% more acute admissions than budgeted, and behavioral health admissions missing budget by 3.3%, or 13 admissions. Emergency department visits were 16.5% better than budget and ambulatory visits better than budget by less than one percent, or 218 more visits than budgeted. She mentioned Valleywise Comprehensive Health Center-Phoenix and the Community Health Centers missed budget due to providers utilizing paid time off (PTO), Family Medical Leave Act (FMLA) time, and sick time.

Director Harden asked if a provider called out sick, where patients rescheduled with another provider, or was the appointment was cancelled.

Dr. White said that all efforts were made to reschedule the patient with another provider for the same day.

Ms. Agnew reviewed the year-to-date statistical information. Total admissions, emergency department visits and ambulatory visits were performing better than budget.

She discussed the payer mix for January 2024, stating the higher number of emergency department visits led to a higher percentage in the uninsured category.

She then reviewed the financial statements for January 2024, stating that the increased volumes throughout the organization resulted in a positive 6.3% variance for net patient revenue. Other revenue had a positive 13.7% variance due to the 340B program, retail pharmacy, and the Health II payment.

Ms. Agnew explained that when the budget was prepared, staff was operating under the assumption that the new acute hospital would have opened in late January or early February 2024.

She reviewed total operating expenses, noting salaries and wages and contract labor expenses were better than budget by 3.7% and 11.7%, respectively. She attributed the reduction in contract labor utilization to the SOAR program. There were negative variances in employee benefits, supplies and purchased services, attributing to the overall 3.5% negative variance.

Net assets, after factoring in non-operating revenue and expenses, and removing bond related activity, decreased by $12,683,384, compared to a budgeted decrease of $13,557,985, resulting in a positive $874,602 variance.

On a year-to-date basis, she highlighted the $7,687,715 reduction in contract labor expenses, a significant improvement year over year. Net assets, normalized, decreased by $55,624,955, compared for a budgeted decrease of $53,802,012, for a negative $1,822,942 variance. There were 66.6 days of cash on hand and 75.2 days in accounts receivable.

Chairman Thomas asked if the graduate medical education (GME) funding had been received.

Ms. Agnew said that the funds had not yet been received, however, the receipt was anticipated soon.

7. Update on Care Reimagined Projects

Ms. Christiansen provided an update on the Care Reimagined projects, highlighting the opening of the new acute care hospital was 42 days away. To date, approximately 14,323,446 manhours had been accumulated throughout the various projects. There were no changes to the program dashboard, which provided an overview of concerns.

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

7. Update on Care Reimagined Projects, cont.

Ms. Christiansen reviewed the construction progress of the new acute care hospital, noting that the focus was on completing the punch list and beginning the activation and planning work. She announced that the laboratory automation was complete, the department had migrated to the new building, and was testing the new equipment. The medical gas testing and certification was scheduled for completion by the end of the week. The pharmacy, central sterile and surgery departments would also begin transitioning to the new hospital. She shared photos of the progress made within the new hospital.

Director Harden asked what type of seating would be installed in the hospital chapel.

Ms. Christiansen said that the chapel would have flexible seating and photos would be provided to the Board.

She outlined the patient move schedule, which would begin with operationalizing the new emergency department at 3:00 a.m. on April 11, 2024. The subsequent inpatient departments would relocate throughout the day.

Director Harden asked what time Valleywise Health would divert ambulances and trauma cases to other hospitals.

Dr. White stated that staff would work with emergency medical services (EMS) partners to determine the timeline to complete the transition efficiently.

Chairman Thomas asked if there were advantages to scheduling the move during the week, as opposed to the weekend.

Ms. Christiansen stated there were advantages for the planned move date. She outlined the opening day assumptions, including reducing surgical cases and pausing elective inductions the week of the move.

She provided an overview of the Day in the Life (DIL) activities that occurred. In the first DIL, 21 scenarios were worked through and over 200 employees participated in the eight-hour event. The purpose of the exercise was to uncover areas for improvement. As anticipated, staff identified 319 action items that were categorized, and would be tracked and monitored. She provided examples of the action items. Staff also conducted a Mock Move exercise, moving 30 patients over seven hours. There were 95 action items identified during the exercise.

Director Brophy McGee requested the list of action items identified during the DIL and Mock Move, and how those items related to late change orders.

Director Harden asked what time the move of all patients would be completed.

Ms. Christiansen estimated that it would take approximately 13 hours to move all the patients to the new hospital, which would conclude in the late afternoon or early evening.

Over the next couple of months, staff would conduct packing and tagging seminars and provide departments with relocation guides. New equipment would be deployed to the final locations and additional DIL and Mock Move events were scheduled.

Ms. Christiansen provided an update on the Piper Pavilion, announcing the fifth floor was near completion, with furniture and information technology (IT) equipment being installed. The administrative buildings that currently house the District Medical Group (DMG) physicians would not be occupied once the move to new offices were completed.

Director Wilcox mentioned the employee excitement was evident in the videos produced of the DIL and Mock Moves. She also congratulated staff on the success of the Valleywise Health History movie.

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

8. Review and Possible Action on the Following Reports to the Board of Directors:

    a. Monthly Marketing and Communications Report (January 2024)

    b. Monthly Care Reimagined Capital Purchases Report (January 2024)

    c. Monthly Valleywise Health Employee Turnover Report (January 2024)

    d. Quality Management Council Meeting Minutes (January 2024)

    e. Quarterly Compliance Officer's Activities Report; Valleywise Health's Finance, Audit and Compliance Committee Activities Report

    f. Quarterly Valleywise Health Foundation's Report to Valleywise Health's President & Chief Executive Officer

    g. Fiscal Year 2023 Non-Privileged Patient Care Competency Report

Director Harden address item 8.c., Valleywise Health Employee Turnover Report, and asked if the report would soon include turnover rates by job classification.

Ms. Lara-Willars stated that the analytic module of the payroll program would soon be implemented, and that information would then be included in the report.

9. Discuss the Dignitary Wall at the new Valleywise Health Medical Center

Mr. Sims stated there were two components to the conversation. The first was to allow the Board members to discuss the Dignitary Wall and give direction to staff. The second component was to cure a potential unintended open meeting law (OML) violation. He explained that the Maricopa County Special Health Care District was created as a public body, and subject to the OML, allowing the public to attend meetings. He outlined how corresponding through e-mail could result in a violation, when three or more Board members were included in a discussion.

He outlined the specific circumstances, stating the Board Bylaws allowed Board members to request an item to be placed on the agenda. Should the Chairman refuse, two Board members, acting together, could add the item to the agenda. Recently, two Board members communicated their request, via email, to the Chairman to add an item to the agenda, however, that conversation included substantive discussion, leading to the unintended OML violation.

To address and rectify the violation, he notified the Ombudsman of the unintended violation, and had not yet received a response. He explained that the violation did not result in action being taken and the item was added to the today's agenda to continue the discussion that began through the emails. Upon the conclusion of the meeting, he would then notify the Ombudsman again, informing them the item was placed on a meeting agenda and discussed in a public meeting.

Mr. Purves explained that the Dignitary Wall would be located in the lobby of the new Valleywise Health Medical Center and was designed to recognize the important stakeholders involved in the planning, development and passage of Proposition 480, the bond initiative that funded Care Reimagined. There would also be recognition for the governing bodies, the Bond Advisory Committee (BAC) members, Chief Executive Officers, and Governors of Arizona.

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

9. Discuss the Dignitary Wall at the new Valleywise Health Medical Center, cont.

A diagram of the layout had been shared with the Board members, and one Board member questioned why specific individuals were included. They requested that the districts the Board members represented be added to the plaques. Mr. Purves explained the rationale for the inclusion of specific individuals, however, understood the need to include on the plaque, the district each Board member represented, while removing the officer titles. Other minor revisions were made, including leaving Mr. Purves' tenure open ended.

Director Harden asked if further discussion was needed to cure the OML violation.

Mr. Sims stated that the conversation addressed the violation, provided direction to allow staff to proceed with the production of the plaques and installation of the Dignitary Wall.

Director Wilcox requested the opportunity to offer suggestions for the Dignitary Wall. She suggested the inclusion of recognition for DMG and the medical staff.

Mr. Purves acknowledged DMG's contributions to the organization throughout the years, however, there were many members of the Senior Leadership team that had equally contributed to the success of Care Reimagined that would not be included on the Dignitary Wall. He noted that DMG would be recognized in other areas of the new hospital, including the hospital lobby and outside of the emergency department. He mentioned that DMG's Chief Executive Officer, Dr. Kote Chundu, was listed on the Dignitary Wall, as a BAC member.

Director Wilcox stated that other Board member's suggestions were considered and requested that staff consider her requests.

Mr. Purves understood Director Wilcox's concerns but believed that adding more individuals would create additional problems. Unfortunately, since the medical staff was a contracted vendor, there was not a mechanism in place to allow their inclusion in such items.

Vice Chairman Dewane stated that he was confident that staff had invested a lot of time and effort into the design of the Dignitary Wall. He believed that staff would determine the appropriateness of including or omitting specific information, such as officer titles and represented districts.

Chairman Thomas commented that it was customary to include officer titles.

Mr. Purves reiterated the recommendations from the Board and stated that staff would proceed with the production of plaques and installation of the Dignitary Wall.

Director Brophy McGee said that the design of the Dignitary Wall was an administrative decision.

Mr. Sims stated that he would inform the Ombudsman that the unintentional OML violation had been cured, in his opinion.

10. Concluding Items

a. Old Business:

January 24, 2024
Legislative Agenda

- Representative Cook's sponsored bills impact Valleywise Health

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

10. Concluding Items, cont.

    a. Old Business, cont.:

January 24, 2024, cont.
Compliance Training
- Future discussion on disclosure of gifts District Board members receive
- Provide a larger Enterprise Risk Management image

Care Reimagined Update
- Once available, provide the date that the Conference and Administration Center will be decommissioned
- Provide a list with dates of all the new tower grand opening events

November 21, 2023
Consent Agenda
- Future discussion on disclosure of gifts District Board members receive

Behavioral Health Update
- Provide information to the Maricopa County Board of Supervisors on projects, programs and services made possible with the ARPA grant funding

Care Reimagined Update
- Once available, provide the date that the Conference and Administration Center will be decommissioned

June 28, 2023
Care Reimagined Update
- When projects are complete, compose a letter from the Board, outlining everything that was accomplished/made possible, and send to stakeholders

May 24, 2023
April 2023 Financials
- How will fixed costs change (old facilities vs new facilities); include the change in utility costs and maintenance costs

August 24, 2022
Monthly Update on Care Reimagined Projects
- Work with organized neighborhood groups near Valleywise Health Medical Center to build connections and invite to opening of new hospital

    b. Board Member Requests for Future Agenda Items or Reports

    c. Comments
        i. Chairman and Member Closing Comment
        ii. President and Chief Executive Officer Summary of Current Events

Ms. Talbot reiterated the requests made throughout the meeting. She reviewed old business, noted the items that were completed, as well as the items that were ongoing.

Chairman Thomas commented that he attended a tour of the new hospital with the Finance, Audit and Compliance Committee, and he continued to be impressed. He also attended the Women's Luncheon, hosted by the Valleywise Health Foundation, and the premiere of the Valleywise Health History movie. He had since shared the movie with friends and family, all providing positive feedback.

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

10. Concluding Items, cont.

Mr. Purves stated that he had also received tremendous feedback on the movie and congratulated all involved with the production. He informed the Board of an upcoming American Hospital Association (AHA) Trustee virtual seminar on advocacy and encouraged the Board members to consider participating.

He announced that burn survivor, Mr. Jason Schechterle, provided a media tour of the new Diane & Bruce Halle Arizona Burn Center. A link of the coverage would be distributed to Board.

Adjourn

MOTION: Director Harden moved to adjourn the February 28, 2024, Maricopa County Special Health Care District Board of Directors Formal Meeting. Vice Chairman Dewane seconded.

VOTE: 5 Ayes: Chairman Thomas, Vice Chairman Dewane, Director Brophy McGee, Director Harden, Director Wilcox
0 Nays
Motion passed.

Meeting adjourned at 3:36 p.m.

_____
J. Woodfin Thomas, Chairman
Maricopa County Special Health Care District
Board of Directors

1.b.i. Contracts - 90-24-003-1-01

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Tuesday, February 20, 2024 9:59 AM
To: Melanie Talbot
Subject: Contract Approval Request: Amendment #1 to Community Health Needs Assessment (CHNA) 2023-2026 Maricopa County Department of Public Health

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: Amendment #1 to Community Health Needs Assessment (CHNA) 2023-2026 Maricopa County Department of Public Health
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
RFBA - Maricopa County Department of Public Health - CHNA Amendment.pdf		File	RFBA - Maricopa County Department of Public Health - CHNA Amendment.pdf
Valleywise 23-26 CHN Contract Amendment.pdf		File	Valleywise 23-26 CHN Contract Amendment.pdf
OIG MCDPH 2024.pdf		File	OIG MCDPH 2024.pdf
SAM MCDPH 2024.pdf		File	SAM MCDPH 2024.pdf

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title Amendment #1 to Community Health Needs Assessment (CHNA) 2023-2026
Contract Identifier Board - Amendment
Contract Number 90-24-003-1-01
Primary Responsible Party Golden-Grady, Lei Ronda D.

Departments	FQHC Administration
Product/Service Description	Amendment #1 to Community Health Needs Assessment (CHNA) 2023-2026
Action/Background	Approve Amendment #1 to the Agreement between Maricopa County Department of Public Health and Maricopa County Special Health Care District dba Valleywise Health for Community Needs Assessment (CHNA) 2023-2026 to update a few clauses of the boiler plate language. This includes language including specifying rights in data, as well as terms of contract renewal. All other terms and conditions of the original Contract shall remain in full force and effect. This is a non-financial amendment.
Evaluation Process	The requesting department has determined that the Contractor is performing satisfactorily and is meeting the goals and objectives of the organization.
Category	Other
Effective Date	
Term End Date	
Annual Value	$0.00
Expense/Revenue	Non-Financial
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	Maricopa County Department of Public Health

Responses

Member Name	Status	Comments
Pardo, Laela N.	Approved	Reviewed and approve.
Melton, Christopher C.	Approved	
Barker, Michelle J.	Approved	
Whitney, Warren W.	Approved	
Harris, Ijana M.	Approved	
White, Michael	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.ii. Contracts - 90-13-242-1-09

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, March 6, 2024 8:16 AM
To: Melanie Talbot
Subject: Contract Approval Request: Health Choice Professional Amendment 9 Health Choice Arizona

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: Health Choice Professional Amendment 9 Health Choice Arizona
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
90-13-242-1-09 Health Choice 2024 VBP Amend 9	2024 VBP Amendment	File	90-13-242-1-09 Health Choice Professional Amend 9.pdf

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title Health Choice Professional Amendment 9
Contract Identifier Board - Amendment
Contract Number 90-13-242-1-09
Primary Responsible Party Tucker, Collee K.
Departments
Product/Service Description 2024 VBP
Action/Background Approve a new Amendment 9 (90-13-242-1-09) between Health Choice and Maricopa County Special Health Care District dba Valleywise Health, for the provision of quality incentive program participation.

Evaluation Process	This is a new Amendment 9 (90-13-242-1-09) between Health Choice and Maricopa County Special Health Care District dba Valleywise Health. This Amendment updates terms of the quality incentive program including, quality measures, targets and performance expectations used to calculate incentive payments for health plan members assigned to Valleywise Health.
Category	Other
Effective Date	1/1/2024
Term End Date	
Annual Value	$0.00
Expense/Revenue	Revenue
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	Health Choice Arizona

Responses

Member Name	Status	Comments
Clarke, Tina R.	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.iii. Contracts - MCO-24-007-MSA

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, March 6, 2024 8:17 AM
To: Melanie Talbot
Subject: Contract Approval Request: Humana Dental Agreement Humana Dental Insurance Company

Message Information

From	Purves, Stephen
To	Talbot, Melanie;
Subject	Contract Approval Request: Humana Dental Agreement Humana Dental Insurance Company
Additional Information	Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
Humana Dental Agreement		File	MCO-24-007-MSA Humana Dental Agreement Eff 04012024 Pending Signature.pdf

Contract Information

Division	Contracts Division
Folder	Contracts \ Managed Care/Revenue
Status	Pending Approval
Title	Humana Dental Agreement
Contract Identifier	Board - New Contract
Contract Number	MCO-24-007-MSA
Primary Responsible Party	Orozco, Stephanie A.
Departments	
Product/Service Description	Commercial and Medicare Advantage
Action/Background	Approve a new agreement (MCO-24-007-MSA) between Humana Dental Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive dental services.

Evaluation Process	This is a new agreement (MCO-24-007-MSA) between Humana Dental Insurance Company and Maricopa County Special Health Care District dba Valleywise Health. This agreement will allow members to receive comprehensive dental services through Valleywise Health dental providers. This agreement excludes retail pharmacy and medical or behavioral health services which are covered through a relationship with a separate entity or agreement.
Category	Other
Effective Date	4/1/2024
Term End Date	
Annual Value	$0.00
Expense/Revenue	Revenue
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	Humana Dental Insurance Company

Responses

Member Name	Status	Comments
Tucker, Collee K.	Approved	
Clarke, Tina R.	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.iv. Contracts - MCO-20-003-03

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Tuesday, March 12, 2024 8:20 AM
To: Melanie Talbot
Subject: Contract Approval Request: United Behavioral Health Facility Participation Agreement Amendment 3 United Behavioral Health, Inc.

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: United Behavioral Health Facility Participation Agreement Amendment 3 United Behavioral Health, Inc.
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
MCO-20-003-03 Optum Behavioral Health Facility Participation Agreement Amendment 3		File	MCO-20-003-03 UBH Facility Amend 3 for signature 04152024 .pdf

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title United Behavioral Health Facility Participation Agreement Amendment 3
Contract Identifier Board - Amendment
Contract Number MCO-20-003-03
Primary Responsible Party Piper, Kimberly M.
Departments
Product/Service Description Behavioral Health Facility

Action/Background	Approve a new Amendment 3 (MCO-20-003-03) between United Behavioral Health, Inc. and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive behavioral health services.
Evaluation Process	This is a new Amendment 3 (MCO-20-003-03) between United Behavioral Health, Inc. and Maricopa County Special Health Care District dba Valleywise Health. This Amendment updates terms of the agreement allowing members to continue receiving comprehensive behavioral health services through Valleywise Health facilities. This document will replace Amendment 3 presented during February Board of Director meeting, due to effective date revision. This agreement excludes retail pharmacy and medical which is covered through a relationship with a separate entity.
Category	Other
Effective Date	4/15/2024
Term End Date	
Annual Value	$0.00
Expense/Revenue	Revenue
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	United Behavioral Health, Inc.

Responses

Member Name	Status	Comments
Tucker, Collee K.	Approved	Approved by Managed Care, Renee Clarke was skipped in approval process as she is out of office. CT
Tucker, Collee K.	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.v. Contracts - 90-24-239-1

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Tuesday, March 12, 2024 1:15 PM
To: Melanie Talbot
Subject: Contract Approval Request: Roofing-Job Order Contract Progressive Services, Inc. dba Progressive Roofing

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: Roofing-Job Order Contract Progressive Services, Inc. dba Progressive Roofing
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
Progressive Roofing-Amendment_1_-_Contract_Extension_8.1.24.pdf		File	Progressive Roofing-Amendment_1_-_Contract_Extension_8.1.24.pdf
SAM-Progressive Roofing-2024.pdf		File	SAM-Progressive Roofing-2024.pdf
OIG-Progressive Roofing-2024.pdf		File	OIG-Progressive Roofing-2024.pdf
BPM004399_STATEWIDE_ROOFING_JOC.pdf		File	BPM004399_STATEWIDE_ROOFING_JOC.pdf
Solicitation Response		File	BPM004399_STATEWIDE_ROOFING_JOC.pdf
Offer and Acceptance.pdf		File	Offer and Acceptance.pdf
RFBA TASK0612426.pdf		File	RFBA TASK0612426.pdf
.90-24-239-1 Cooperative Agreement-Progressive Roofing-Signed by Vendor.pdf		File	.90-24-239-1 Cooperative Agreement-Progressive Roofing-Signed by Vendor.pdf

Contract Information

Division Contracts Division
Folder Contracts \ Services - Management/Outsourcing

Status	Pending Approval
Title	Roofing-Job Order Contract
Contract Identifier	Board - New Contract
Contract Number	90-24-239-1
Primary Responsible Party	Hammer, Mary P.
Departments	MAINTENANCE
Product/Service Description	Roofing-Job Order Contract
Action/Background	Approve a new Cooperative Agreement between Progressive Services, Inc. dba Progressive Roofing and Maricopa County Special Health Care District dba Valleywise Health for a Roofing-Job Order Contract for all Valleywise Health Facilities. Through this Cooperative Agreement, Valleywise Health will access all roofing services, pricing, terms, and conditions as outlined in the State of Arizona Procurement Office Contract CTR061390. This agreement is effective as of the execution date and will remain effective through August 1, 2024, the State of Arizona Procurement Office may extend this contract for a term not to exceed August 1, 2027. FINANCIAL IMPLICATIONS: The anticipated annual expense is $250,000.00, which has been budgeted from operational funds for cost centers 207705, 507703, and 807703. This agreement is sponsored by Lia Christiansen, EVP, Chief Administrative Officer.
Evaluation Process	The Contractor was determined to meet the requirements of the requesting department and Valleywise Health. Procurement has been satisfied pursuant to HS-102B(1) of the Procurement Code in that contracts between Valleywise Health and other political subdivisions, cooperative purchasing agreements with governmental entities or other governments are exempt from the solicitation requirements of the Procurement Code.
Category	Co-op
Effective Date	
Term End Date	8/1/2024
Annual Value	$250,000.00
Expense/Revenue	Expense
Budgeted Travel Type	Yes
Procurement Number	
Primary Vendor	Progressive Services, Inc. dba Progressive Roofing

Responses

Member Name	Status	Comments
Pardo, Laela N.	Approved	Reviewed and approve.
Melton, Christopher C.	Approved	
Parker, Ricky L.	Approved	
Davis, Jori A.	Approved	
Harris, Ijana M.	Approved	
Christiansen, Lia K.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	

Talbot, Melanie L.	Current

1.b.vi. Contracts - 90-18-239-4

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, March 13, 2024 7:49 AM
To: Melanie Talbot
Subject: Contract Approval Request: Mission Support Program Commitment re: Behavioral Services (CY24) Dignity Health dba St. Joseph's Hospital and Medical Center

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: Mission Support Program Commitment re: Behavioral Services (CY24) Dignity Health dba St. Joseph's Hospital and Medical Center
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
90-18-239-4 (unsigned).pdf		File	90-18-239-4 (unsigned).pdf
OIG St. Joseph's 2024.pdf		File	OIG St. Joseph's 2024.pdf
SAM St. Joseph's 2024.pdf		File	SAM St. Joseph's 2024.pdf

Contract Information

Division Contracts Division
Folder Contracts \ Services - Professional/Facility (Medical/Clinical/Dental)
Status Pending Approval
Title Mission Support Program Commitment re: Behavioral Services (CY24)
Contract Identifier Board - New Contract
Contract Number 90-18-239-4
Primary Responsible Party Pardo, Laela N.
Departments HOSPITAL ADMINISTRATION

Product/Service Description	Mission Support Program Commitment re: Behavioral Services (CY24)
Action/Background	Approve a new Mission Support Program Commitment between the Maricopa County Special Health Care District dba Valleywise Health and Dignity Health dba St. Joseph's Hospital and Medical Center for mission support for Behavioral Services in Maricopa County. St. Josephs's Hospital and Valleywise Health have a long-standing partnership as shared under a joint mission to provide care to indigent patients, to educate physicians and other health care providers; to conduct and support medical research; and to render other services designed to promote the health and well-being of individuals within Maricopa County. St. Joseph's Hospital has made the commitment to provide to Valleywise Health the sum of $3,500,000.00 to support and promote our joint mission and to support the development of the education, training and research programs at Valleywise Health. Specifically, Dignity Health wishes to provide financial support to behavioral health services in Maricopa County. Behavioral Health services for the seriously mentally ill and those with other behavioral health needs are essential to the community and these services need to be expanded to ensure these individuals are supported in all aspects of their behavioral health recovery journey. The Mission Support Funds shall be paid by St. Joseph's Hospital to Valleywise Health annually during the term of this Commitment as follows: Payment Date: March 31, 2024 for the amount of $1,750,000 Payment Date: June 30, 2024 for the amount of $1,750,000 This agreement is sponsored by Claire Agnew, Ex. VP & Chief Financial Officer
Evaluation Process	
Category	Other
Effective Date	
Term End Date	
Annual Value	$3,500,000.00
Expense/Revenue	Revenue
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	Dignity Health dba St. Joseph's Hospital and Medical Center

Responses

Member Name	Status	Comments
Melton, Christopher C.	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.vii. Contracts - 90-23-106-1-01

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, March 13, 2024 7:49 AM
To: Melanie Talbot
Subject: Contract Approval Request: Amendment #1 - Extend Contract Term LaneTerralever, LLC

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: Amendment #1 - Extend Contract Term LaneTerralever, LLC
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
Amendment 1 - LaneTerralever - Extend Term.pdf		File	Amendment 1 - LaneTerralever - Extend Term.pdf
OIG - LaneTerralever, LLC 2024.pdf		File	OIG - LaneTerralever, LLC 2024.pdf
SAM - LaneTerralever, LLC 2024.pdf		File	SAM - LaneTerralever, LLC 2024.pdf
RFBA – LaneTerralever – Marketing Contract Amendment #1.pdf		File	RFBA – LaneTerralever – Marketing Contract Amendment 1.pdf

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title Amendment #1 - Extend Contract Term
Contract Identifier Board - Amendment
Contract Number 90-23-106-1-01
Primary Responsible Party Golden-Grady, Lei Ronda D.
Departments Marketing and Communications

Product/Service Description	Amendment #1 - Extend Contract Term
Action/Background	Approve Amendment #1 to the Contract between LaneTerralever, LLC and Maricopa County Special Health Care District dba Valleywise Health to extend the contract for Creative, Digital Marketing, Web and/or Media Services. This amendment extends the contract term for one year from April 1, 2024 to March 31, 2025, for an aggregate term of April 1, 2023 to March 31, 2025. This Amendment #1 will include services for an additional amount of $67,000.00 for an aggregate amount of $883,000.00 and has been budgeted for operational expenditure from the Marketing and Communications department. All other terms and conditions remain the same and in full effect. This amendment is sponsored by Runjhun Nanchal, Sr VP Strategy Marketing Communication
Evaluation Process	The requesting department has determined that the Contractor is performing satisfactorily and is meeting the goals and objectives of the organization. The requesting department has elected that the contract should be continued and extended.
Category	Other
Effective Date	
Term End Date	3/31/2025
Annual Value	$67,000.00
Expense/Revenue	Expense
Budgeted Travel Type	Yes
Procurement Number	90-23-106-RFP
Primary Vendor	LaneTerralever, LLC

Responses

Member Name	Status	Comments
Pardo, Laela N.	Approved	Reviewed and approve.
Melton, Christopher C.	Approved	
Nanchal, Runjhun S.	Approved	
Harris, Ijana M.	Approved	
Christiansen, Lia K.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.b.viii. Contracts - 90-24-274-1

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Monday, March 25, 2024 2:28 PM
To: Melanie Talbot
Subject: Contract Approval Request: IGA for Safety Net Services Initiative (SNSI) - Admin (IGA# YH24-0091-01-A) AHCCCS

Message Information

From	Whitney, Warren
To	Talbot, Melanie;
Subject	Contract Approval Request: IGA for Safety Net Services Initiative (SNSI) - Admin (IGA# YH24-0091-01-A) AHCCCS
Additional Information	Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
(Draft Copy) CYE24 VWH Admin IGA_03.25.24.pdf		File	(Draft Copy) CYE24 VWH Admin IGA_03.25.24.pdf

Contract Information

Status	Pending Approval
Title	IGA for Safety Net Services Initiative (SNSI) - Admin (IGA# YH24-0091-01-A)
Contract Identifier	Board - New Contract
Contract Number	90-24-274-1
Primary Responsible Party	Pardo, Laela N.
Departments	HOSPITAL ADMINISTRATION
Product/Service Description	IGA Administration of the Safety Net Services Initiative (SNSI) – Valleywise Health (IGA# YH24-0091-01-A)
Action/Background	Approve an Intergovernmental Agreement ("IGA") between Arizona Health Care Cost Containment System ("AHCCCS") and Maricopa County Special Health Care District dba Valleywise Health, for the Administration of the

Safety Net Services Initiative ("SNSI") and to enter into this IGA to contribute funds for health care services and for both Parties to jointly exercise powers for cooperative action. This IGA commences when signed by both parties and renews annually upon timely receipt by AHCCCS of an Attachement A from Valleywise Health for the Contract Year and the timely transfer of the payment made in accordance with Attachment A for the Contract Year.

The purpose of this Agreement is to set forth the procedures under which the Public Entity will, at its discretion, transfer public funds for use as the Non-federal Share of expenditures by AHCCCS for the administration of the Safety Net Services Initiative Payment IGA.

Valleywise Health has agreed to transfer public funds from Local Property Tax Assessments and in the amount of $2,474,249.88 as the Non-Federal Share of AHCCS expenditures for the administration of the SNSI for the Contract Year period from October 1, 2023 through September 30, 2024.

This new IGA is sponsored by Claire Agnew, EVP & Chief Financial Officer.

Evaluation Process	
Category	IGA
Effective Date	
Term End Date	9/30/2024
Annual Value	$2,474,249.88
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	AHCCCS

Responses

Member Name	Status	Comments
Melton, Christopher C.	Approved	
Harris, Ijana M.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Approved	
Whitney, Warren W.	Approved	
Talbot, Melanie L.	Current	

1.b.ix. Contracts - 90-24-274-2

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Monday, March 25, 2024 3:04 PM
To: Melanie Talbot
Subject: Contract Approval Request: IGA for Safety Net Services Initiative (SNSI) - Support (IGA# YH24-0091-01-S) AHCCCS

Message Information

From Purves, Stephen
To Talbot, Melanie;
Subject Contract Approval Request: IGA for Safety Net Services Initiative (SNSI) - Support (IGA# YH24-0091-01-S) AHCCCS
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
(Draft Copy) CYE24 VWH Support IGA_03.22.24.pdf		File	(Draft Copy) CYE24 VWH Support IGA_03.22.24.pdf

Contract Information

Division Contracts Division
Folder Contracts \ Services - Consulting/Auditing & Other
Status Pending Approval
Title IGA for Safety Net Services Initiative (SNSI) - Support (IGA# YH24-0091-01-S)
Contract Identifier Board - New Contract
Contract Number 90-24-274-2
Primary Responsible Party Pardo, Laela N.
Departments HOSPITAL ADMINISTRATION
Product/Service Description IGA for Safety Net Services Initiative (SNSI) - Support (IGA# YH24-0091-01-S)

Action/Background	Approve an Intergovernmental Agreement ("IGA") between Arizona Health Care Cost Containment System ("AHCCCS") and Maricopa County Special Health Care District dba Valleywise Health, for the Support of the Safety Net Services Initiative ("SNSI") and to enter into this IGA to contribute funds for health care services and for both Parties to jointly exercise powers for cooperative action. This IGA commences when signed by both parties and renews annually upon timely receipt by AHCCCS of an Attachment A from Valleywise Health for the Contract Year and the timely transfer of the payment made in accordance with Attachment A for the Contract Year. The purpose of this Agreement is to set forth the procedures under which the Public Entity will, at its discretion, transfer public funds for use as the Non-federal Share of expenditures by AHCCCS in support of the Safety Net Services Initiative Payment IGA. Valleywise Health has agreed to transfer public funds from Local Property Tax Assessments and in the amount of $61,856,247.10 as the Non-Federal Share of AHCCS expenditures in support of the SNSI for the Contract Year period from October 1, 2023 through September 30, 2024. This new IGA is sponsored by Claire Agnew, EVP & Chief Financial Officer.
Evaluation Process	
Category	IGA
Effective Date	
Term End Date	9/30/2024
Annual Value	$61,856,247.10
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	AHCCCS

Responses

Member Name	Status	Comments
Melton, Christopher C.	Approved	
Harris, Ijana M.	Approved	
Whitney, Warren W.	Approved	
Agnew, Claire F.	Approved	
Purves, Stephen A.	Approved	
Talbot, Melanie L.	Current	

1.c.i. Governance -
Deputy Medical Director in the Department of Psychiatry

OFFICIAL APPOINTMENT AND OATH OF OFFICE

STATE OF ARIZONA, COUNTY OF ARIZONA
KNOW ALL MEN BY THESE PRESENTS:

That I, **CAROL KLINE OLSON, M.D.,** Psychiatric Medial Director of Maricopa County Special Health Care District, State of Arizona, do hereby constitute and appoint Adeola Adelayo MD., my lawful Deputy Medical Director in all matters, to act as if I were present, same to become effective on _____.

CAROL KLINE OLSON, M.D.
Psychiatric Medical Director

STATE OF ARIZONA, COUNTY OF MARICOPA,

I, ADEOLA ADELAYO, do solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution and laws of the State of Arizona, that I will bear true faith and allegiance to the same and defend them against all enemies, foreign and domestic, and that I will faithfully and impartially discharge the duties of the Office of Deputy Medical Director according to the best of my ability, so help me God (or so I do affirm).

Adeola Adelayo, MD.
Signature

ADEOLA ADELAYO
Print Name

Subscribed and sworn to before me on this 16th day of February, 2024.

SARAH BERMAN
Notary Public - State of Arizona
MARICOPA COUNTY
Commission # 637997
Expires September 9, 2026

NOTARY PUBLIC IN AND FOR THE
COUNTY OF MARICOPA, STATE OF ARIZONA

I hereby certify that the above appointment was approved by the **MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT BOARD OF DIRECTORS** at a meeting held _____, 20_____.

CLERK, BOARD OF DIRECTORS

§ 38-231. Officers and employees required to take loyalty oath; form; classification; definition

A. In order to ensure the statewide application of this section on a uniform basis, each board, commission, agency and independent office of this state, and of any of its political subdivisions, and of any county, city, town, municipal corporation, school district and public educational institution, shall completely reproduce this section so that the form of written oath or affirmation required in this section contains all of the provisions of this section for use by all officers and employees of all boards, commissions, agencies and independent offices.

B. Any officer or employee who fails to take and subscribe to the oath or affirmation provided by this section within the time limits prescribed by this section is not entitled to any compensation until the officer or employee does so take and subscribe to the form of oath or affirmation prescribed by this section.

C. Any officer or employee having taken the form of oath or affirmation prescribed by this section, and knowingly at the time of subscribing to the oath or affirmation, or at any time thereafter during the officer's or employee's term of office or employment, does commit or aid in the commission of any act to overthrow by force, violence or terrorism as defined in § 13-2301 the government of this state or of any of its political subdivisions, or advocates the overthrow by force, violence or terrorism as defined in § 13-2301 of the government of this state or of any of its political subdivisions, is guilty of a class 4 felony and, on conviction under this section, the officer or employee is deemed discharged from the office or employment and is not entitled to any additional compensation or any other emoluments or benefits which may have been incident or appurtenant to the office or employment.

D. Any of the persons referred to in article XVIII, § 10, Constitution of Arizona, as amended, relating to the employment of aliens, are exempted from any compliance with this section.

E. In addition to any other form of oath or affirmation specifically provided by law for an officer or employee, before any officer or employee enters upon the duties of the office or employment, the officer or employee shall take and subscribe the following oath or affirmation:

State of Arizona, County of Maricopa I,
Adeola Adelayo
(type or print name)
do solemnly swear (or affirm) that I will support the Constitution of the United States and the Constitution and laws of the State of Arizona, that I will bear true faith and allegiance to the same and defend them against all enemies, foreign and domestic, and that I will faithfully and impartially discharge the duties of the office of Deputy (name of office) Medical Director according to the best of my ability, so help me God (or so I do affirm).

(signature of officer or employee)

F. For the purposes of this section, "officer or employee" means any person elected, appointed or employed, either on a part-time or full-time basis, by this state or any of its political subdivisions or any county, city, town, municipal corporation, school district, public educational institution or any board, commission or agency of any county, city, town, municipal corporation, school district or public educational institution.

1.c.ii. Governance - Amended and Restated Maricopa County Special Health Care District Cafeteria Plan (Internal Revenue Code Section 125)

Amended and Restated

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT CAFETERIA PLAN

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
CAFETERIA PLAN

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MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
CAFETERIA PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2023~~3~~4, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 2006. The Plan shall be known as Maricopa County Special Health Care District Cafeteria Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 "**Administrator**" means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 "**Affiliated Employer**" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "**Benefit**" or "**Benefit Options**" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "**Cafeteria Plan Benefit Dollars**" means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 "**Code**" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 "**Compensation**" means the amounts received by the Participant from the Employer during a Plan Year.

1.7 "**Dependent**" means any individual who qualifies as a dependent under the self-funded plan for purposes of that plan or under Code Section 152 (as modified by Code Section 105(b)).

"**Dependent**" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 "**Effective Date**" means January 1, 2006.

1.9 "**Election Period**" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 "**Eligible Employee**" means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 "**Employee**" means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 "**Employer**" means Maricopa County Special Health Care District and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In

addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 "**Employer Contribution**" means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V and as set forth in Section 3.1.

1.14 **"Health Savings Account"** or ("HSA") means a health savings account described in Article 4.8 and to which contributions may be made consistent with Articles III, 4.8 and annual limits of the Code.

1.145 "**Insurance Contract**" means any contract issued by an Insurer underwriting a Benefit.

1.156 "**Insurer**" means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.167 "**Key Employee**" means an Employee described in Code Section 416(0(1) and the Treasury regulations thereunder.

1.178 "**Participant**" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.189 "**Plan**" means this instrument, including all amendments thereto.

1.1920 "**Plan Year**" means the 12-month period beginning July 1 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.201 "**Premium Expenses**" or "**Premiums**" mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.212 "**Premium Expense Reimbursement Account**" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.223 "**Salary Redirection**" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.2~~3~~4. "**Salary Redirection Agreement**" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 "**Short Term Disability**" a short-term disability is an instance that puts you out of work temporarily, such as an injury, illness or procedure.

1.246 "**Spouse**" means "**spouse**" as defined in the self-funded plan for purposes of that plan or the "spouse," as defined under Federal law, of a Participant, unless legally separated by court decree.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of the month coinciding with or next following the date on which he met the eligibility requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employers insured or self-funded Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) Termination of employment. The Participant's termination of employment, subject to the provisions of Section 2.5;

(b) Death. The Participant's death, subject to the provisions of Section 2.6; or

(c) Termination of the plan. The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit**. With regard to Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.

(b) **Dependent Care FSA**. With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability**. With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

The Employer shall make available to each Participant an Employer Contribution to be used for any Benefit under the Plan in an amount to be determined by the Employer prior to the beginning of each Plan Year. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits hereunder. The Employer's Contribution shall be made on a pro rata basis for each pay period of the Participant. If a Participant fails to make any election of Benefit Option, there shall be no Employer Contribution (i.e., the Employer Contribution shall not be available in cash).

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his Employer Contributions and/or Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

(3) Health Insurance Benefit

(4) Dental Insurance Benefit

(5) Vision Insurance Benefit

(6) Short Term Disability~~Supplemental Life Insurance Benefit~~

(7) Health Savings Account(s)

~~(6)~~

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) Coverage for Participant and Dependents. Each Participant may elect to be covered under a health Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) Employer selects contracts. The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such health Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) Employer selects contracts. The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit,

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employees vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) Employer selects contracts. The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract Incorporated by reference. The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.7 SHORT TERM DISABILITY~~SUPPLEMENTAL LIFE INSURANCE BENEFIT~~

(a) Coverage for Participants. Each Participant may elect Short Term Disability Benefits.

~~(a)~~ Contract incorporated by reference. The rights and conditions with respect to the benefits payable for Short Term Disability coverage shall be determined from the contract therefrom and such Contract shall be incorporated herein by reference.

~~Coverage for Participants or Dependents. Each Participant may elect supplemental life insurance benefits in addition to the benefits provided to Participants by Employer.~~

~~(b) Participants select coverage and amounts. Participants will determine the amount(s) of supplemental life insurance benefits and pay for those benefits without assistance from Employer. The Employer is not a party to the supplemental life insurance benefits selected by the Participant.~~

~~(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such supplemental life insurance contract shall be determined therefrom and such Supplemental Life Insurance Contract shall be incorporated herein by reference.~~

4.8 HEALTH SAVINGS ACCOUNT(S)

To the extent that the Participant authorizes contributions to a Health Savings Account, an eligible Participant may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account referred to in this Article is intended to qualify as a health savings account under Internal Revenue Code section 223 and shall be interpreted in a manner consistent with such Code section.

~~4.8~~4.9 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) 25% concentration test. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employers insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE IN STATUS

(a) Change in status defined. Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employers group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the

consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) Special enrollment rights. Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) Qualified Medical Support Order. Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) Medicare or Medicaid. Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social

Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) Cost increase or decrease. If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) Loss of coverage. If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) Addition of a new benefit. If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) Loss of coverage under certain other plans. A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a stale Children's Health Insurance Program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) Change of coverage due to change under certain other plans. A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or

Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) Change in dependent care provider. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) Health FSA cannot change due to insurance change. A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) "Health Flexible Spending Account" means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may be reimbursed for the cost of any medicine or drug that is allowed under the Code..

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,550.00.

(b) The minimum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $260.00.

(c) Participation in Other Plans. All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the

Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) Expenses must be incurred during Plan Year. All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) Reimbursement available throughout Plan Year. The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Payments. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrators discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) Claims for reimbursement. Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) Card only for medical expenses. Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) Card issuance. Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change

in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) Maximum dollar amount available. The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) Only available for use with certain service providers. The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) Card use. The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed by applicable law..;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) Substantiation. Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) Correction methods. If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) "Dependent Care Flexible Spending Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) "Qualifying Dependent" means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) Plan limits. Notwithstanding any provision contained in this Dependent Care Flexible Spending Account to the contrary, the following limits apply in addition to the Code limits. The minimum amount that may be allocated to the Dependent Care Flexible Spending Account by a Participant in or on account of any Plan Year is $260.00.

(b) Code limits. Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) 2~~5~~6% test for shareholders. It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrators discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) Claims for reimbursement. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Insurance claims. Any claim for Benefits underwritten by the self-funded plan shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employers claims review procedure.

(b) Dependent Care Flexible Spending Account or Health Flexible Spending Account claims. Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the

Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) Appeal. Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) Review of appeal. A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) Forfeitures. Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim

is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal in writing (or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary

or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be incorporated by reference or required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participants gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's

gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable. Supplemental life insurance benefits funded with Participant pre-tax income may subject life insurance proceeds to taxation. Participant is solely responsible for the selection of such benefits and any related tax consequences.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Arizona.

11.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) Application. If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) Disclosure of PHI. The Plan shall not disclose Protected Health Information to any member of the Employers workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) PHI disclosed for administrative purposes. Protected Health Information disclosed to members of the Employers workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or

reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) PHI disclosed to certain workforce members. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employees workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employers workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employers workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) Certification. The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employers workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) Implementation. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) Agents or subcontractors shall meet security standards. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) Employer shall ensure security standards. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act ~~and ERISA Section 712~~.

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

11.23 CARES ACT COMPLIANCE

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Cares Act with respect to FSA coverage of over-the-counter medications and menstrual products.

IN WITNESS WHEREOF, this Plan document is hereby executed this ____ day of _____.

Maricopa County Special Health Care District

By_____
EMPLOYER

Amended and Restated

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT CAFETERIA PLAN

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
CAFETERIA PLAN

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MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
CAFETERIA PLAN

INTRODUCTION

The Employer has amended this Plan effective January 1, 2024, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their Dependents and beneficiaries. The concept of this Plan is to allow Employees to choose among different types of benefits based on their own particular goals, desires and needs. This Plan is a restatement of a Plan which was originally effective on January 1, 2006. The Plan shall be known as Maricopa County Special Health Care District Cafeteria Plan (the "Plan").

The intention of the Employer is that the Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under the Plan be excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended.

ARTICLE I
DEFINITIONS

1.1 "**Administrator**" means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing written acceptance with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 "**Affiliated Employer**" means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 "**Benefit**" or "**Benefit Options**" means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 "**Cafeteria Plan Benefit Dollars**" means the amount available to Participants to purchase Benefit Options as provided under Section 4.1. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 "**Code**" means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 "**Compensation**" means the amounts received by the Participant from the Employer during a Plan Year.

1.7 "**Dependent**" means any individual who qualifies as a dependent under the self-funded plan for purposes of that plan or under Code Section 152 (as modified by Code Section 105(b)).

"**Dependent**" shall include any Child of a Participant who is covered under an Insurance Contract, as defined in the Contract, or under the Health Flexible Spending Account or as allowed by reason of the Affordable Care Act.

For purposes of the Health Flexible Spending Account, a Participant's "Child" includes his/her natural child, stepchild, foster child, adopted child, or a child placed with the Participant for adoption. A Participant's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the calendar year.

The phrase "placed for adoption" refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

1.8 "**Effective Date**" means January 1, 2006.

1.9 "**Election Period**" means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. However, an Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.10 "**Eligible Employee**" means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

1.11 "**Employee**" means any person who is employed by the Employer. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 "**Employer**" means Maricopa County Special Health Care District and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan. In

addition, where appropriate, the term Employer shall include any Participating, Affiliated or Adopting Employer.

1.13 "**Employer Contribution**" means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V and as set forth in Section 3.1.

1.14 **"Health Savings Account"** or **("HSA")** means a health savings account described in Article 4.8 and to which contributions may be made consistent with Articles III, 4.8 and annual limits of the Code.

1.15 "**Insurance Contract**" means any contract issued by an Insurer underwriting a Benefit.

1.16 "**Insurer**" means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.17 "**Key Employee**" means an Employee described in Code Section 416(0(1) and the Treasury regulations thereunder.

1.18 "**Participant**" means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 "**Plan**" means this instrument, including all amendments thereto.

1.20 "**Plan Year**" means the 12-month period beginning July 1 and ending June 30. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 "**Premium Expenses**" or "**Premiums**" mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.22 "**Premium Expense Reimbursement Account**" means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant shall be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.23 "**Salary Redirection**" means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 "**Salary Redirection Agreement**" means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 "**Short Term Disability**" a short-term disability is an instance that puts you out of work temporarily, such as an injury, illness or procedure.

1.26 "**Spouse**" means "**spouse**" as defined in the self-funded plan for purposes of that plan or the "spouse," as defined under Federal law, of a Participant, unless legally separated by court decree.

ARTICLE II
PARTICIPATION

2.1 ELIGIBILITY

Any Eligible Employee shall be eligible to participate hereunder as of the date he satisfies the eligibility conditions for the Employer's group medical plan, the provisions of which are specifically incorporated herein by reference. However, any Eligible Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 EFFECTIVE DATE OF PARTICIPATION

An Eligible Employee shall become a Participant effective as of the first day of the month coinciding with or next following the date on which he met the eligibility requirements of Section 2.1.

2.3 APPLICATION TO PARTICIPATE

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete a Salary Redirection Agreement during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employers insured or self-funded Benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) Termination of employment. The Participant's termination of employment, subject to the provisions of Section 2.5;

(b) Death. The Participant's death, subject to the provisions of Section 2.6; or

(c) Termination of the plan. The termination of this Plan, subject to the provisions of Section 10.2.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefit Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Insurance Benefit**. With regard to Benefits provided under Section 4.1, the Participant's participation in the Plan shall cease, subject to the Participant's right to continue coverage under any Insurance Contract or self-funded benefit for which premiums have already been paid.

(b) **Dependent Care FSA**. With regard to the Dependent Care Flexible Spending Account, the Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for employment related Dependent Care Expense reimbursements for claims incurred up to the date of termination and submitted within 90 days after termination, based on the level of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **COBRA applicability**. With regard to the Health Flexible Spending Account, the Participant may submit claims for expenses that were incurred during the portion of the Plan Year before the end of the period for which payments to the Health Flexible Spending Account have already been made. Thereafter, the health benefits under this Plan including the Health Flexible Spending Account shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease. However, such Participant's spouse or Dependents may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. In no event may reimbursements be paid to someone who is not a spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account.

ARTICLE III
CONTRIBUTIONS TO THE PLAN

3.1 EMPLOYER CONTRIBUTION

The Employer shall make available to each Participant an Employer Contribution to be used for any Benefit under the Plan in an amount to be determined by the Employer prior to the beginning of each Plan Year. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits hereunder. The Employer's Contribution shall be made on a pro rata basis for each pay period of the Participant. If a Participant fails to make any election of Benefit Option, there shall be no Employer Contribution (i.e., the Employer Contribution shall not be available in cash).

3.2 SALARY REDIRECTION

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he elects pursuant to Section 4.1, his Compensation will be reduced in an amount equal to the difference between the cost of Benefits he elected and the amount of Employer Contribution available to him. Such reduction shall be his Salary Redirection, which the Employer will use on his behalf, together with his Employer Contribution, to pay for the Benefits he elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the first day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article IV.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

3.3 APPLICATION OF CONTRIBUTIONS

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld for the Health Flexible Spending Account or Dependent Care Flexible Spending Account shall be credited to such fund or account. Amounts designated for the Participant's Premium Expense Reimbursement Account shall likewise be credited to such account for the purpose of paying Premium Expenses.

3.4 PERIODIC CONTRIBUTIONS

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, with regard to the Health Flexible Spending Account, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year.

ARTICLE IV
BENEFITS

4.1 BENEFIT OPTIONS

Each Participant may elect any one or more of the following optional Benefits:

(1) Health Flexible Spending Account

(2) Dependent Care Flexible Spending Account

In addition, each Participant shall have a sufficient portion of his Employer Contributions and/or Salary Redirections applied to the following Benefits unless the Participant elects not to receive such Benefits:

(3) Health Insurance Benefit

(4) Dental Insurance Benefit

(5) Vision Insurance Benefit

(6) Short Term Disability

(7) Health Savings Account(s)

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Health Flexible Spending Account option, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFIT

Each Participant may elect to participate in the Dependent Care Flexible Spending Account option, in which case Article VII shall apply.

4.4 HEALTH INSURANCE BENEFIT

(a) Coverage for Participant and Dependents. Each Participant may elect to be covered under a health Contract for the Participant, his or her Spouse, and his or her Dependents.

(b) Employer selects contracts. The Employer may select suitable health Contracts for use in providing this health insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such health Contract shall be determined therefrom, and such Contract shall be incorporated herein by reference.

4.5 DENTAL INSURANCE BENEFIT

(a) Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employer's dental Insurance Contract. In addition, the Participant may elect either individual or family coverage under such Insurance Contract.

(b) Employer selects contracts. The Employer may select suitable dental Insurance Contracts for use in providing this dental insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit,

(c) Contract incorporated by reference. The rights and conditions with respect to the benefits payable from such dental Insurance Contract shall be determined therefrom, and such dental Insurance Contract shall be incorporated herein by reference.

4.6 VISION INSURANCE BENEFIT

(a) Coverage for Participant and/or Dependents. Each Participant may elect to be covered under the Employees vision Insurance Contract. In addition, the Participant may elect either individual or family coverage.

(b) Employer selects contracts. The Employer may select suitable vision Insurance Contracts for use in providing this vision insurance benefit, which policies will provide uniform benefits for all Participants electing this Benefit.

(c) Contract Incorporated by reference. The rights and conditions with respect to the benefits payable from such vision Insurance Contract shall be determined therefrom, and such vision Insurance Contract shall be incorporated herein by reference.

4.7 SHORT TERM DISABILITY

(a) Coverage for Participants. Each Participant may elect Short Term Disability Benefits.

(b) Contract incorporated by reference. The rights and conditions with respect to the benefits payable for Short Term Disability coverage shall be determined from the contract therefrom and such Contract shall be incorporated herein by reference.

4.8 HEALTH SAVINGS ACCOUNT(S)

To the extent that the Participant authorizes contributions to a Health Savings Account, an eligible Participant may elect to have a portion of his or her Compensation contributed to a Health Savings Account. The Account referred to in this Article is intended to qualify as a health savings account under Internal Revenue Code section 223 and shall be interpreted in a manner consistent with such Code section.

4.9 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

(b) 25% concentration test. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may not occur in violation of Code Section 125, it may, but shall not be required to, reduce contributions or non-taxable Benefits in order to assure compliance with the Code and regulations. Any act taken by the Administrator shall be carried out in a uniform and nondiscriminatory manner. With respect to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among Health Flexible Spending Account Benefits and Dependent Care Flexible Spending Account Benefits, and once all these Benefits are expended, proportionately among self-funded Benefits. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V
PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.2.

Notwithstanding the foregoing, an Employee who is eligible to participate in this Plan and who is covered by the Employers insured or self-funded benefits under this Plan shall automatically become a Participant to the extent of the Premiums for such insurance unless the Employee elects, during the Election Period, not to participate in the Plan.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Participant shall be given the opportunity to elect, on an election of benefits form to be provided by the Administrator, which spending account Benefit options he wishes to select. Any such election shall be effective for any Benefit expenses incurred during the Plan Year which follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

With regard to Benefits available under the Plan for which no Premium Expenses apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized or made for the subsequent Plan Year for such Benefits.

With regard to Benefits available under the Plan for which Premium Expenses apply, any Participant who fails to complete a new benefit election form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have made the same Benefit elections as are then in effect for the current Plan Year. The Participant shall also be deemed to have elected Salary Redirection in an amount necessary to purchase such Benefit options.

5.4 CHANGE IN STATUS

(a) Change in status defined. Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the

Participant, Spouse or Dependent gains or loses eligibility for coverage, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

Regardless of the consistency requirement, if the individual, the individual's Spouse, or Dependent becomes eligible for continuation coverage under the Employers group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage. However, this does not apply for COBRA eligibility due to divorce, annulment or legal separation.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

(1) Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a Spouse, legal separation or annulment;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a Dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

Notwithstanding anything in this Section to the contrary, the gain of eligibility or change in eligibility of a child, as allowed under Code Sections 105(b) and 106, and guidance thereunder, shall qualify as a change in status.

(b) Special enrollment rights. Notwithstanding subsection (a), the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that such Participant meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) Qualified Medical Support Order. Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child, under that individual's plan and such coverage is actually provided.

(d) Medicare or Medicaid. Notwithstanding subsection (a), a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.

(e) Cost increase or decrease. If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

A cost increase or decrease refers to an increase or decrease in the amount of elective contributions under the Plan, whether resulting from an action taken by the Participants or an action taken by the Employer.

(f) Loss of coverage. If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) Addition of a new benefit. If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected Participants may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those Eligible Employees who are not participating in the Plan may opt to become Participants and elect the new or newly improved benefit package option.

(h) Loss of coverage under certain other plans. A Participant may make a prospective election change to add group health coverage for the Participant, the Participant's Spouse or Dependent if such individual loses group health coverage sponsored by a governmental or educational institution, including a stale Children's Health Insurance Program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

(i) Change of coverage due to change under certain other plans. A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a Spouse's, former Spouse's or Dependent's employer if (1) the cafeteria plan or other benefits plan of the Spouse's, former Spouse's or Dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a Spouse's, former Spouse's or Dependent's employer.

(j) Change in dependent care provider. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Section 152(a)(1) through (8).

(k) Health FSA cannot change due to insurance change. A Participant shall not be permitted to change an election to the Health Flexible Spending Account as a result of a cost or coverage change under any health insurance benefits.

ARTICLE VI
HEALTH FLEXIBLE SPENDING ACCOUNT

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Health Flexible Spending Account. Periodic payments reimbursing Participants from the Health Flexible Spending Account shall in no event occur less frequently than monthly.

6.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

(a) "Health Flexible Spending Account" means the account established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) "Highly Compensated Participant" means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

(1) one of the 5 highest paid officers;

(2) a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or

(3) among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants).

(c) "Medical Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may be reimbursed for the cost of any medicine or drug that is allowed under the Code..

A Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(d) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account.

6.3 FORFEITURES

The amount in the Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

(a) Notwithstanding any provision contained in this Health Flexible Spending Account to the contrary, the maximum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $2,550.00.

(b) The minimum amount that may be allocated to the Health Flexible Spending Account by a Participant in or on account of any Plan Year is $260.00.

(c) Participation in Other Plans. All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the statutory limit. If a Participant participates in multiple cafeteria plans offering health flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total Health Flexible Spending Account contributions under all of the cafeteria plans are limited to the statutory limit (as adjusted). However, a Participant employed by two or more employers that are not members of the same controlled group may elect up to the statutory limit (as adjusted) under each Employer's Health Flexible Spending Account.

6.5 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Health Flexible Spending Account not to discriminate in violation of the Code and the Treasury regulations thereunder.

(b) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination under this Health Flexible Spending Account, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall

be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Flexible Spending Account by the member of the group in whose favor discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

6.6 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Flexible Spending Account. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

6.7 HEALTH FLEXIBLE SPENDING ACCOUNT CLAIMS

(a) Expenses must be incurred during Plan Year. All Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year subject to Section 2.5, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

(b) Reimbursement available throughout Plan Year. The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Flexible Spending Account for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) Payments. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrators discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an

independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Flexible Spending Account, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

(d) Claims for reimbursement. Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment.

6.8 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) Card only for medical expenses. Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) Card issuance. Such card shall be issued upon the Participant's Effective Date of Participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) Maximum dollar amount available. The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section 6.4.

(d) Only available for use with certain service providers. The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) Card use. The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed by applicable law..;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) Substantiation. Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) Correction methods. If such purchase is later determined by the Administrator to not qualify as a Medical Expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) if subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in this program may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Cafeteria Plan the terms below shall have the following meaning:

(a) "Dependent Care Flexible Spending Account" means the account established for a Participant pursuant to this Article to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents of Participants.

(b) "Earned Income" means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) "Employment-Related Dependent Care Expenses" means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) "Qualifying Dependent" means, for Dependent Care Flexible Spending Account purposes,

(1) a Participant's Dependent (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Cafeteria Plan Benefit Dollars to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Cafeteria Plan Benefit Dollars that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9 of this Program, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 ANNUAL STATEMENT OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

(a) Plan limits. Notwithstanding any provision contained in this Dependent Care Flexible Spending Account to the contrary, the following limits apply in addition to the Code limits. The minimum amount that may be allocated to the Dependent Care Flexible Spending Account by a Participant in or on account of any Plan Year is $260.00.

(b) Code limits. Notwithstanding any provision contained in this Article to the contrary, amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)).

7.10 NONDISCRIMINATION REQUIREMENTS

(a) Intent to be nondiscriminatory. It is the intent of this Dependent Care Flexible Spending Account that contributions or benefits not discriminate in favor of the group of employees in whose favor discrimination may not occur under Code Section 129(d).

(b) 26% test for shareholders. It is the intent of this Dependent Care Flexible Spending Account that not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Plan Year will be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Plan Year) owns more than 5 percent of the stock or of the capital or profits interest in the Employer.

(c) Adjustment to avoid test failure. If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 129 it may, but shall not be required to, reject any elections or reduce contributions or non-taxable benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Dependent Care Flexible Spending Account by the affected Participant that elected to contribute the highest amount to such account for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section are satisfied, or until the amount designated for the account equals the amount designated for the account of the affected Participant who has elected the second highest contribution to the Dependent Care Flexible Spending Account for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied.

Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited.

7.11 COORDINATION WITH CAFETERIA PLAN

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Dependent Care Flexible Spending Account. The enrollment and termination of participation under the Cafeteria Plan shall constitute enrollment and termination of participation under this Dependent Care Flexible Spending Account. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

7.12 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT CLAIMS

The Administrator shall direct the payment of all such Dependent Care claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrators discretion, payments may be made directly to the service provider. In its discretion in administering the Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement under this Program for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Dependent or Dependents for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household;

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) Claims for reimbursement. If a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment.

ARTICLE VIII
BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) Insurance claims. Any claim for Benefits underwritten by the self-funded plan shall be made to the Employer. If the Employer denies any claim, the Participant or beneficiary shall follow the Employers claims review procedure.

(b) Dependent Care Flexible Spending Account or Health Flexible Spending Account claims. Any claim for Dependent Care Flexible Spending Account or Health Flexible Spending Account Benefits shall be made to the Administrator. For the Health Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be submitted within 90 days after termination of employment. For the Dependent Care Flexible Spending Account, if a Participant fails to submit a claim within 90 days after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for reimbursement must be submitted within 90 days after termination of employment. If the Administrator denies a claim, the Administrator may provide notice to the Participant or beneficiary, in writing, within 90 days after the claim is filed unless special circumstances require an extension of time for processing the claim. The notice of a denial of a claim shall be written in a manner calculated to be understood by the claimant and shall set forth:

(1) specific references to the pertinent Plan provisions on which the denial is based;

(2) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such information is necessary; and

(3) an explanation of the Plan's claim procedure.

(c) Appeal. Within 60 days after receipt of the above material, the claimant shall have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. The claimant or his duly authorized representative may:

(1) request a review upon written notice to the Administrator;

(2) review pertinent documents; and

(3) submit issues and comments in writing.

(d) Review of appeal. A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing), in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision of the Administrator shall be written and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, with specific references to the pertinent Plan provisions on which the decision is based.

(e) Forfeitures. Any balance remaining in the Participant's Health Flexible Spending Account or Dependent Care Flexible Spending Account as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section 6.3 or Section 7.8, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

ARTICLE IX
ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

If the Employer elects, the Employer shall appoint one or more Administrators. Any person, including, but not limited to, the Employees of the Employer, shall be eligible to serve as an Administrator. Any person so appointed shall signify acceptance by filing acceptance in writing (or such other form as acceptable to both parties) with the Employer. An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal in writing (or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconciles any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INSURANCE CONTROL CLAUSE

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

9.5 INDEMNIFICATION OF ADMINISTRATOR

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

ARTICLE X
AMENDMENT OR TERMINATION OF PLAN

10.1 AMENDMENT

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

10.2 TERMINATION

The Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Contract shall be paid in accordance with the terms of the Contract.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account, but all payments from such fund shall continue to be made according to the elections in effect until 90 days after the termination date of the Plan. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI
MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.11.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be incorporated by reference or required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participants gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable. Supplemental life insurance benefits funded with Participant pre-tax income may subject life insurance proceeds to taxation. Participant is solely responsible for the selection of such benefits and any related tax consequences.

11.8 INDEMNIFICATION OF EMPLOYER BY PARTICIPANTS

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would

have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

11.9 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.10 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Arizona.

11.11 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.12 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.13 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B, and related regulations. This Section shall only apply if the Employer employs at least twenty (20) employees on more than 50% of its typical business days in the previous calendar year.

11.14 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Regulation 1.125-3.

11.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.16 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.17 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) Application. If any benefits under this Cafeteria Plan are subject to the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), then this Section shall apply.

(b) Disclosure of PHI. The Plan shall not disclose Protected Health Information to any member of the Employers workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(c) PHI disclosed for administrative purposes. Protected Health Information disclosed to members of the Employers workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(d) PHI disclosed to certain workforce members. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employees workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

(1) An authorized member of the Employers workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(2) In the event that any member of the Employers workforce uses or discloses Protected Health Information other than as permitted by this Section and

the Privacy Standards, the incident shall be reported to the Plan's privacy official. The privacy official shall take appropriate action, including:

(i) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

(iii) mitigation of any harm caused by the breach, to the extent practicable; and

(iv) documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(e) Certification. The Employer must provide certification to the Plan that it agrees to:

(1) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

(2) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(4) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

(5) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(6) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(7) Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(8) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the

Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(9) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(10) Ensure the adequate separation between the Plan and members of the Employers workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above.

11.18 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"):

(a) Implementation. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(b) Agents or subcontractors shall meet security standards. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(c) Employer shall ensure security standards. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 11.17.

11.19 MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act.

11.20 GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act.

11.21 WOMEN'S HEALTH AND CANCER RIGHTS ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998.

11.22 NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act.

11.23 CARES ACT COMPLIANCE

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Cares Act with respect to FSA coverage of over-the-counter medications and menstrual products.

IN WITNESS WHEREOF, this Plan document is hereby executed this ____ day of _____.

Maricopa County Special Health Care District

By_____
EMPLOYER

1.c.iii. Governance - Valleywise Health Foundation's ALL IN Campaign donor recognition requests

DATE: March 12, 2024

TO: J. Woodfin Thomas, Chairman, District 4
Mark G. Dewane, Vice Chairman, District 2
Mary A. Harden, R.N., Director, District 1
Kate Brophy McGee, Director, District 3
Mary Rose Wilcox, Director, District 5

FROM: Lisa Hartsock, Foundation Relations Executive

SUBJECT: Donor Recognition Requests

These donor recognition requests are submitted for Board approval. The Donor Recognition Guidelines, adopted in November 2019, have been followed and are attached as reference.

Valleywise Health Foundation

2024 BOARD OF DIRECTORS

March 12, 2024

The Valleywise Health Foundation requests recognizing the campaign gifts listed below with signage in highly visible locations, appropriate for the area the gift supports.

A gift of $243,000 from the Del E. Webb Foundation in support of the Hybrid Operating Room. The Valleywise Health Foundation requests recognition of this gift within the surgical suite area.

A gift of $25,000 from Mike and Cynthia Watts in support of the mission of Valleywise Health. The Valleywise Health Foundation requests recognition of this gift within the new Valleywise Health Medical Center.

A gift between $25,000 - $50,000 from each of the following donors: Gene Cavallo, Lia Christiansen, Sherry Stotler, Michael White, and Warren Whitney and Marcia Scott. The Valleywise Health Foundation requests their gifts be recognized in areas identified within the gift level guidelines.

A gift between $10,000 - $24,999 from each of the following donors: Claire Agnew, Jo-el Detzel, Lisa Hartsock, Martha Steiner, and Kelly Summers. The Valleywise Health Foundation requests their gifts be recognized in areas identified within the gift level guidelines.

Valleywise Health
Donor Recognition Guidelines

The Valleywise Health Foundation (the "Foundation") is the 501 c 3 nonprofit organization established to solely support the mission of Valleywise Health with philanthropic gifts. The Foundation is responsible for operating with the highest standards of ethical behavior, using best practices and policies, and providing contemporary donor stewardship and recognition programs.

The Foundation seeks gifts from individuals, foundations, corporations, and other organizations to advance the Valleywise Health mission in support of strategies, facilities, and programs aligned with top Valleywise Health institutional priorities. ALL IN, a four-year $25 million comprehensive campaign launching in January 2020, offers multiple opportunities for donors to associate their names or the names of those they honor/memorialize with Valleywise Health.

The Foundation and Valleywise Health leadership recommend adoption of these guidelines for donor recognition opportunities during this four-year campaign. Qualifying gifts, gift levels, and the approval process are as follows:

1. **Qualifying gifts of $7,500 and higher** will be recognized in a Donor Honor Roll in electronic form during the active years of fundraising and in a permanent Honor Roll after successful completion of the campaign.

2. **Donors making qualifying gifts of $10,000 and higher** may be provided recognition opportunities in keeping with the type of gift, gift amount, and donor preferences.

A. Qualifying gifts and pledges are subject to the following guidelines:
   i. All recognition opportunities at Valleywise Health are reserved for those making financial contributions to the Foundation.
   ii. All recognition opportunities will adhere to Covenant A.2. of the Cooperative Service Agreement (adopted 7/2018), attached hereto.
   iii. Naming recognition will follow these approved guidelines for facilities and programs. Exceptional gifts (i.e., those outside the categories listed in this document) require review specified in the Foundation's Gift Acceptance Policy (adopted 9/2018).
   iv. Recognition opportunities and gift ranges will align with institutional priorities and program budgets.

B. Gifts and pledges with recognition opportunities ($10,000 and higher) undergo the following approval process:
   i. A gift agreement will be written for each qualified gift or pledge.
   ii. All naming commitments will be reviewed by the Foundation Executive Committee and the Valleywise Health CEO and EVPs.
   iii. The Special Health Care District Board of Directors will receive the list of naming commitments for approval; a commitment may be rescinded if the gift is inconsistent with these guidelines.
   iv. Approved commitments will be finalized with signed donor gift agreements.

3. **The gift levels and recognition opportunities** are as follows, based on the size, visibility and marketing potential:

A. Facilities (internal and external physical spaces):

i. A gift of **$10,000 or more** may include recognition with examination rooms, patient care rooms, or offices.
ii. A gift of **$25,000 or more** may include recognition with classrooms or meeting rooms.
iii. A gift of **$50,000 or more** may include recognition with large classrooms or auditoriums.
iv. A gift of **$200,000 or more** may include recognition with facility lobbies, waiting areas, or gardens.
v. A gift of **$350,000 or more** may include recognition with a wing or service area.
vi. A gift of **$750,000 or more** may include recognition with emergency departments.
vii. A gift of **$3M or more** may include recognition with the support services building, the community health centers or behavioral health centers (in Phoenix and Mesa).
viii. A gift of **$5M or more** may include recognition with the comprehensive health centers
ix. A gift of **$7M or more** may include recognition with the behavioral health center (in Maryvale)
x. A gift of **$10M or more** may include recognition with the new burn center
xi. A gift of **$15M or more** may include recognition with the new medical center
xii. As a guideline, these facility recognition opportunities will be for no less than 20 years or the useful life of the facility. If there is a change in the space during that time, a comparable space will be found and named (in consultation with the donor if he/she is living or with the family or trustees if the donor(s) is deceased). At the end of the 20 years, if there is a change in the space, the Foundation is not obligated to find a naming opportunity for a comparable space.
xiii. In addition, if at the end of 20 years the Foundation has an opportunity to offer the naming opportunity of the space for a new gift, the Foundation may do so. The Foundation will consult the donor or any known living relatives if the donor(s) is deceased to determine his/her/their interest in making an additional gift prior to the removal of the name.

B. Programs:

i. Suitable gifts may name programs for operational support.
ii. The total philanthropic commitment should equal at least 50% of the program's annual operating budget
iii. Three-year minimum commitments are expected for this opportunity

4. **Dedication opportunities** offer recognition of a generous donation from a corporation, foundation or individual with signage/acknowledgement of the support, while not intended to fund the entire room, service area, or facility.

1.d.i. Medical Staff - Medical Staff Credentials for March 2024

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

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**
Adeola Yetunde Adelayo, M.D.	Courtesy	Psychiatry	4/01/2024 to 03/31/2026	
Reynaldo Hernandez, M.D.	Active	Emergency Medicine	4/01/2024 to 03/31/2026	
Chijioke Chris Iwuchukwu, M.D.	Courtesy	Radiology	4/01/2024 to 03/31/2026	
Jonathan Jinhee Lee, M.D.	Courtesy	Surgery (Neurosurgery)	4/01/2024 to 03/31/2026	

LOCUM TENENS/SPECIAL CARE PRIVIILEGES		
NAME	**DEPARTMENT/SPECIALTY**	**COMMENTS***
Scott Graham Edwards, M.D.	Orthopedic Surgery (Hand Surgery)	Locum Tenens Privileges requested for 4/01/2024 to 09/30/2024 to fill an urgent patient care need.

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Shana Marissa Feinberg, D.O.	Psychiatry	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Adolescent, Adult, Geriatric Psychiatry Privileges.
Pradeepto Ghosh, M.D.	Internal Medicine (Cardiology)	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Basic Ambulatory Cardiology Core & Cardiology Core Privileges.
Daniel Edward Hintze, M.D.	Psychiatry	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Adolescent, Adult, Geriatric Psychiatry Privileges.
Babette Witkind Koenig, D.O.	Emergency Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Procedural Sedation Privileges.

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
Tristan Leopold Pasek, M.D.	Internal Medicine (Critical Care Medicine & Pulmonary Disease)	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Internal Medicine Core Privileges.
Kyle Campbell Phipps, D.O.	Internal Medicine (Palliative Medicine)	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Palliative Medicine Core Privileges.
Amelia Catherine Van Handel, M.D.	Surgery (Plastic Surgery)	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Microvascular Surgery Privileges.
Aaron F. Wittenberg, M.D.	Radiology	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for General Radiology Core Privileges, Invasive Radiology Procedures and Procedural Sedation Privileges.

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**DEPARTMENT/SPECIALTY**	**APPOINTMENT DATES**	**COMMENTS**
R. Michael Brady, M.D.	Courtesy	Obstetrics & Gynecology	04/01/2024 to 03/31/2026	
Christopher S. Brendemuhl, D.M.D.	Active	Dentistry	04/01/2024 to 03/31/2026	
Daniel E. Brooks, M.D.	Courtesy	Emergency Medicine	04/01/2024 to 03/31/2026	
Laura A. Don, M.D.	Active	Psychiatry	04/01/2024 to 03/31/2026	
Iman Feiz-Erfan, M.D.	Active	Surgery (Neurosurgery)	04/01/2024 to 03/31/2026	
Elizabeth Mary Nesset Ferguson, M.D.	Active	Surgery (Plastic Surgery)	04/01/2024 to 03/31/2026	
Andrea Beth Ferrari, M.D.	Active	Emergency Medicine	04/01/2024 to 03/31/2026	
Daniel G. Gridley, M.D.	Active	Radiology	04/01/2024 to 03/31/2026	
Serge Hougeir, M.D.	Courtesy	Emergency Medicine	04/01/2024 to 03/31/2026	
Babette Witkind Koenig, D.O.	Courtesy	Emergency Medicine	04/01/2024 to 03/31/2026	
Robert L. Johnson, M.D.	Courtesy	Obstetrics & Gynecology	04/01/2024 to 03/31/2026	
Kelvin S. Panesar, M.D.	Courtesy	Pediatrics (Pediatric Pulmonology)	04/01/2024 to 03/31/2026	
Bryan Roth, D.P.M.	Active	Surgery (Podiatry)	04/01/2024 to 03/31/2026	
Alexander Toledo, D.O.	Courtesy	Emergency Medicine	04/01/2024 to 03/31/2026	
Melissa F. Villamor Ballecer, D.D.S.	Active	Dentistry	04/01/2024 to 03/31/2026	
Aaron F. Wittenberg, M.D.	Courtesy	Radiology	04/01/2024 to 03/31/2026	

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

WAIVER REQUEST			
NAME	**SPECIALTY/PRIVILEGES**	**CATEGORY**	**COMMENTS**
Kassandra Jean Kosinski Romero, M.D.	Internal Medicine	Active	▪ Requesting a temporary waiver from the "Threshold Eligibility Criteria" requirements specific to Medical Staff Credentials Policy - Article 2.A.1.(m): Board Certification requirement ▪ Requesting a permanent waiver from the "Threshold Eligibility Criteria" requirements specific to Medical Staff Credentials Policy - Article 2.A.1.(a): having a current, unrestricted license to practice in Arizona and having never had a license to practice revoked or suspended by any state licensing agency. Chair of Internal Medicine is in support of the two above named waiver requests.

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Tristan Leopold Pasek, M.D.	Internal Medicine	Withdrawal: Basic Critical Care Privileges	Dr. Pasek has Critical Care Core Privileges
Aaron F. Wittenberg, M.D.	Radiology	Withdrawal: Balloon Kyphoplasty / Percutaneous Vertebroplasty	Voluntary Relinquishment of Privileges due to non-utilization of privileges

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Byron James Garn, M.D.	Pediatrics (Cardiology)	Courtesy to Inactive	Resigned effective February 20, 2024
Erin MacKenzie Garvey, M.D.	Surgery (Pediatric Surgery)	Courtesy to Inactive	Resigned effective February 22, 2024
Joseph N. Graziano, M.D.	Pediatrics (Cardiology)	Courtesy to Inactive	Resigned effective February 20, 2024
Roberta I. H. Matern, M.D.	Family & Community Medicine	Active to Inactive	Resigned effective March 31, 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.

1.d.ii. Medical Staff - Advanced Practice Clinician - Allied Health Professional Staff Credentials for March 2024

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

Michele Dee Kassmeier, P.A.-C.

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**
Spenser Kensington Dauwalder, A.G.A.C.N.P.	Internal Medicine	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Danielle Catherine Nelson, P.A.-C.	Emergency Medicine	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Miriam Segura, L.C.S.W.	Psychiatry	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Yevigeniy Slutskiy, L.P.C.	Psychiatry	Practice Prerogatives on file	04/01/2024 to 03/31/2026	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Jessica Lynn Curtisi, A.G.A.C.N.P.	Internal Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Nurse Practitioner Palliative Medicine Privileges.
Esperanza Hernandez, Ph.D.	Psychiatry	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Psychology Core Privileges.
Michele Dee Kassmeier, P.A.-C.	Orthopedic Surgery	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Therapeutic Procedures Privileges.
Kaylee Ann Paciora, P.A.-C.	Orthopedic Surgery	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Orthopedic Surgery - Physician Assistant Core Privileges, Assist in Surgery, Minor Surgery and Therapeutic Procedures Privileges.
Kelly Jo Plencner-Vega, C.N.M.	Obstetrics & Gynecology	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Certified Nurse Midwife Core Privileges.

Recommended by Credentials Committee: March 5, 2024
Recommended by Medical Executive Committee: March 12, 2024
Submitted to MSHCDB: March 27, 2024

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Curtis E. Finch, O.D.	Surgery	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Michaela Kathleen Hoffmann, P.A.-C.	Emergency Medicine	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Michele Dee Kassmeier, P.A.-C.	Orthopedic Surgery	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Kelly Jo Plencner-Vega, C.N.M.	Obstetrics & Gynecology	Practice Prerogatives on file	04/01/2024 to 03/31/2026	
Wendy Michelle Spencer, Psy.D.	Psychiatry	Practice Prerogatives on file	04/01/2024 to 03/31/2026	

WAIVER REQUEST			
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**COMMENTS**
Kristen Becker, Psy.D.	Psychiatry	Practice Prerogatives on file	Requesting a permanent waiver from the "Threshold Eligibility Criteria" requirements specific to the Advanced Practice Clinician/Allied Health Policy – Article 3.A.1.(j): demonstrating recent clinical activity in their primary area of practice during at least two of the last three years. Chairman of Psychiatry is in support of this waiver.
Farah Campbell Massardi, P.A.-C.	Surgery	Practice Prerogatives on file	Requesting a permanent waiver from the Surgical Clinical Basic Core and Surgical Clinical Core Privileges criteria to be eligible to apply for privileges: • Applicants for initial appointment must be able to demonstrate provision of services, for at least 50 patients, reflective of the scope of privileges requested, during the past 12 months in a setting similar in scope and complexity to Valleywise Health; or demonstrate successful completion from an Accredited Review Commission on Education for the Physician Assistant-approved program. Chairman of Surgery and Supervising Physician are in support of this waiver.

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.

1.d.iii. Medical Staff - Policy 39016 S - Credentialing in the Event of a Disaster

Valleywise Health Administrative Policy & Procedure

Effective Date: 07/03

Reviewed Dates: 09/04, 01/07. 10/08, 01/11, 01/13, 07/19

Revision Dates: 03/07, 10/08, 01/11, O7/17, 9/21, 3/24

Policy #: 39016 S

Policy Title: Medical Staff/Medical Staff Services: Credentialing Practitioners in the Event of Disaster

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

Purpose:
To define a modified credentialing and privileging process for volunteer practitioners providing services at the Valleywise Health when the disaster plan has been implemented and the immediate needs of the patients cannot be met. The provisions of this policy shall be carried out in accordance with the Medical Staff Credentials Policy, Article 4.

Definitions:
Advanced Practice Clinicians: Individuals other than Medical Staff members who are licensed healthcare professionals who are board/nationally certified and have at least a master's degree. APCs (e.g., NP, CNM, CRNA, and PA-C) 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. APCs as defined in this policy are credentialed/privileged through the Medical Staff Services process.

Allied Health Professional: 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. AHPs as defined in this policy are credentialed/privileged through the Medical Staff Services process.~~A health care practitioner other than a Medical Staff member who is authorized to provide patient care services in the Hospital who have been granted clinical privileges.~~

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

Medical Staff: All physicians, dentists, oral surgeons and podiatrists who have been appointed to the Medical Staff by the Board. Medical Staff are also referred to as Attendings.

Provider: A Medical Staff Member with Clinical Privileges, Resident, or Allied Health Professional.

Residents: 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 Member of the Medical Staff of the pertinent clinical disciplines with appropriate clinical privileges in the hospital.

Policy:

When the disaster plan has been implemented and the immediate needs of the patients cannot be met, the Chief Medical Officer or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners (physicians and other independent health care professionals) ("volunteers"), practitioners in accordance with the Credentials Policy, Article 4.

Procedure:

1. Before this policy is permitted to go into effect, the Valleywise Health Emergency Preparedness Plan will need to be activated, and it must be determined that the Valleywise Health medical staff cannot meet the immediate patient needs.

2. All staff should be alerted to direct the volunteer practitioner to the person(s) designated in the Valleywise Health Emergency Preparedness policies to process disaster privilege (the director of medical staff services, medical staff manager, medical staff coordinator, or other individual designated by the Chief Executive Officer) to process emergency privileges.

3. Disaster privileges are granted on a case-by-case basis after verification of identity and licensure. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the Hospital will obtain his or her valid government-issued photo identification (e.g., driver's license or passport) and at least one of the following:
   a. A current picture practitioner hospital ID card that clearly identifies professional designation;
   b. A current license to practice;
   c. Primary source verification of license;
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organization or group;
   e. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or
   f. Confirmation by a current Hospital Employee or Medical Staff Member(s) with personal knowledge regarding practitioner's ability to act as a volunteer during a disaster.

4. The practitioner will be provided a Valleywise Health Emergency Disaster Privileges (EDP) Form for completion by the Hospital representative. (Linked form 44464 also copied below as Appendix A)

5. The Hospital representative must ensure completion of the EDP form and, if possible, obtain copies of identification documents.

6. Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

7. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

8. At a minimum, the following data will be verified and/or obtained:
   a. The respective licensing board to verify that the practitioner is in good standing;
   b. National Practitioner Data Bank (NPDB); and
   c. Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Arizona's Providers Suspensions and Terminations List, and Systems for Awards management (SAM).

   If information is received that is any cause for concern, the Chief of Staff or Chief Clinical Officer (CCO) will be notified; this may result in practitioner being prevented from providing any further patient care.

8. The Chief of Staff or CCO or his or her designee(s) shall make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours related to the continuation of the disaster privileges initially granted.

9. A record of the above information will be retained by Medical Staff Services.

10. The Chief of Staff, CCO, or their designee will grant emergency disaster privileges.

11. The Medical Staff will oversee the care provided by volunteer physicians and other licensed independent practitioners through direct observation, mentoring, or clinical record review.

12. The practitioner granted emergency disaster temporary privileges will be issued a temporary name badge or arm band during this time to identify them by name, credential (i.e., MD, DO., DDS, etc.) and clinical discipline to other healthcare staff.

13. Privileges granted under the Disaster Credentialing Policy subsequent to this policy may be ~~rescinded~~ withdrawn at any time, effective immediately, as determined by the Chief of Staff or CCO ~~without any stated cause~~.

14. ~~When the emergency situation no longer exists, these temporary, disaster privileges terminate~~Disaster privileges will expire automatically when the Hospital's disaster plan is no longer in effect or the emergency situation no longer exists. ~~Termination~~

~~14.~~15. There is no right to a hearing or appeal if disaster privileges expire or are withdrawn for any reason. ~~of these disaster privileges, regardless of the reason, shall not give rise to a hearing or review~~.

References: Credentials Policy, Article 4

Appendix A: EMERGENCY DISASTER PRIVILEGES REQUEST FORM 44464

(Applicable to Practitioners as Defined Herein)

In the case of an emergency/disaster, any individual who has been granted clinical privileges or practice prerogatives is permitted to do everything possible within the scope of his/her license. The purpose of this form is to ensure that the individual requesting disaster/local disaster privileges is qualified and licensed to provide care.

PLEASE PRINT LEGIBILY

_____ _____ _____ _____

Last Name First Middle Degree

SS#_____-_____-_____ DOB _____/_____/_____ Gender: _____

Professional License #_____ State_____ DEA # (if applicable) _____

_____ _____ _____

Professional School City/State/Country Year of Graduation

_____ _____ _____

Practicing Specialty Malpractice Carrier Coverage Amounts

_____ _____ _____

Primary Office Address City/State/Zip Office Telephone Number

_____ _____ _____

Office Fax Cell Phone Email (if applicable)

_____ _____ _____

Home Address City/State Zip

Do you have any current restrictions against your medical license or DEA Certificate? ☐Yes ☐ No If yes, please provide details: _____

I certify that I am trained and experienced in the privileges requested, hold a current unrestricted license to practice medicine in the state of _____, and a current DEA (if applicable), and that the information above is true and correct. I understand that in making this request I am bound by the applicable Medical Staff and Hospital bylaws, rules and regulations, and policies, and I agree to practice as directed by a member of the Valleywise Health medical staff. I further acknowledge that I am volunteering my medical services to Valleywise Health during this emergency and when the emergency no longer exists, these disaster/temporary privileges will be terminated, and I must request privileges through the normal Medical Staff process if I wish to continue treating patients at this facility.

_____ _____

Signature *Date*

APPROVAL:

Recommend Emergency Disaster Privileges be granted in specialty of: _____

_____ _____ _____

Chief of Staff/Designee (Print Name and Sign) Date Time

_____ _____ _____

Chief Medical Officer/Designee (Print Name and Sign) Date Time

FOR HOSPITAL USE ONLY:

Applicant Name: _____

Name of Individual Conducting Primary Source Verification: _____

- Copy of the following government issued identification obtained _____.; AND
- The following additional form of identification was obtained:

☐ A current picture practitioner hospital ID card that clearly identifies professional designation;
☐ A current license to practice;
☐ Primary source verification of license;
☐ Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organization or group;
☐ Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or
☐ Confirmation by a current Hospital Employee or Medical Staff Member(s) with personal knowledge regarding practitioner's ability to act as a volunteer during a disaster.

PRIMARY SOURCE VERIFICATION OF THE FOLLOWING:

- Current Licensure Verified – no restrictions. Date Verified _____ Via: _____ Initial:_____
- NPDB Queried. Date: _____Initial:_____ OIG & SAM[1] Queried: Date: _____ Initial: _____
- DEA (If applicable) _____All Schedules: ☐ Yes ☐ No Restrictions_____

NOTE: Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it shall be completed as soon as possible.

[1] Office of Inspector General (OIG) and Systems for Awards management (SAM)

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

POLICY RESPONSIBLE PARTY: Kristine Trulock, Director of Medical Staff Services

DEVELOPMENT TEAM(S): ~~, Dr. Ross Goldberg and~~ Dr. Michael D. White

Policy #:39016 S

Policy Title: Credentialing Practitioners in the Event of Disaster

e-Signers: Michael D. White, M.D., Chief Clinical Officer

Place an X on the right side of applicable description:

New -

Retire - **Reviewed - X**

Revised with Minor Changes - X

Revised with Major Changes -

Please list revisions made below: (Other than grammatical changes or name and date changes) Updated definitions and language to meet current standards.

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

Committee: Credentials Committee	**~~9/21~~03/2024**
Committee: Medical Executive Committee	**~~9/21~~03/2024**
Reviewed for EPIC:	**00/00**
Other: Maricopa County Special Health Care District Board	**~~9/21~~03/2024**
Other:	**00/00**
Other:	**00/00**

1.d.iv. Medical Staff - Policy 39020 T - Medical Staff Credentials

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF VALLEYWISE HEALTH

CREDENTIALS POLICY

~~APPROVED~~
~~JUNE 28, 2023~~DRAFT MARCH 2024

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Glossary.

1.B. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to ~~documents~~a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter~~one or more designees unless such delegation is expressly prohibited elsewhere in this Policy or the related Medical Staff documents~~.

(2) When ~~a Medical Staff member~~ an individual assigned a function under this Policy is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, and podiatrists must:

(a) have a current, unrestricted license to practice in Arizona and have never had a license to practice revoked, denied, or suspended by any state licensing agency;

(b) be employed by the Hospital, under contract with the Hospital, or be contracted and/or employed by a contractor of the Hospital;

(c) where applicable to their practice, have a current, unrestricted DEA registration or be eligible for an unrestricted DEA registration with their DEA registration in pending status;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(i) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(j) agree to fulfill all responsibilities for coverage, including call coverage, for their specialty as assigned by the department chairs;

(k) demonstrate recent clinical activity in their primary area of practice during at least two of the last three years;

(l) for all individuals who apply for initial staff appointment after December 2007, have successfully completed:

(1) a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in a specialty in which the applicant seeks clinical privileges;

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"); or

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; and

(m) satisfy (i) the Board certification, recertification, and/or maintenance of certification requirements, and (ii) clinical activity requirements specified in the threshold eligibility criteria for the clinical privileges being requested. Board certification shall be assessed at the time of the initial grant of clinical privileges and subsequently at reappointment.

(n) if practicing in the FQHC Clinic, document compliance with applicable basic life support requirements (i.e., BLS) or advanced life support requirements (i.e., ACLS, PALS, NRP);

(o) if located or covering in a Valleywise Community Health Center or a Valleywise Comprehensive Health Center, document compliance with applicable fingerprinting requirements under Arizona law.

(p) agree to comply with all policies, training and educational protocols, and orientation requirements that may be adopted by the MEC or the Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, patient safety initiatives, clinical protocols, and Medial Staff functions;

(q) document compliance with any immunization, vaccination, and/or health screening requirements as may be adopted by the MEC or the Hospital (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures).

2.A.2. Waiver of Threshold Eligibility Criteria:

(a) Any individual who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. Within 60 days of its receipt of all appropriate information, the Credentials Committee shall make a recommendation to the MEC. Any recommendation to grant a waiver must include the basis for such.

(c) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. This shall be accomplished within 60 days of its receipt of the Credentials Committee's recommendation. Any recommendation to grant a waiver must include the basis for such.

(d) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, the MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(e) No individual is entitled to a waiver or to a hearing in accordance with Article 7 of this Policy if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(f) An application for appointment that does not satisfy an eligibility criterion shall not be acted on until the Board has determined that a waiver should be granted.

(g) if a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent, and the individual does not have to request a waiver at subsequent recredentialing cycles.

2.A.3. Factors for Evaluation:

The following factors shall be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested, including current health status;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(a) is licensed to practice a profession in this or any other state;

(b) is a member of any particular professional organization;

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility; or

(d) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

Neither the Hospital nor the Medical Staff will discriminate in granting appointment, reappointment, and/or clinical privileges on the basis of national origin, culture, race,

gender, sexual orientation, gender identity, age, ethnic/national identity, religion, disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.~~No individual shall be denied appointment or reappointment at the Hospital on the basis of gender, race, creed, sexual orientation, or national origin.~~

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member specifically agrees to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of his or her privileges, to provide call coverage, consultations, and care for assigned patients;

(e) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;

(f) to comply with clinical practice protocols and guidelines that are established by the MEC, or to clearly document the clinical reasons for variance;

(g) to inform the CCO and the Chief of Staff (notification may be provided to the Medical Staff Services Department to facilitate CCO and Chief of Staff review) of any change in the member's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:

- changes in licensure status, DEA controlled substance authorization, or professional liability insurance coverage,
- the filing of a professional liability lawsuit against the member,
- changes in the member's Medical Staff status (appointment and/or privileges) at any other hospital,

- indictment, conviction, or a plea of guilty or no contest in any criminal matter,

- exclusion or preclusion from participation in Medicare or any sanctions imposed, and

- any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident shall be reviewed by the Chief of Staff and the CCO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they shall forward the matter for further review under the Practitioner Health Policy or this Credentials Policy.);

(h) to immediately submit to a blood, hair, and/or urine test, or to a complete physical and/or mental evaluation, if the Chief of Staff and the CCO are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leaders;

(i) to maintain a current e-mail address with Medical Staff Services, which shall be the official mechanism used to communicate all Medical Staff information to the member other than peer review information pertaining to the member and/or protected health information of patients;

(j) to appear for, and participate in, personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(k) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(l) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(m) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(n) to seek consultation whenever necessary;

(o) to complete in a timely manner all medical and other required records, containing all information required by the Hospital, regardless of medium;

(p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(q) to promptly pay any applicable dues, assessments, and/or fines;

(r) to satisfy continuing medical education requirements;

(s) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital; and

2.B.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response reconciling the information. The Credentials Committee will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

2.B.3. Burden of Providing Information:

(a) Individuals seeking appointment, ~~and~~ reappointment, and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment, ~~and~~ reappointment, and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the application are current, accurate, and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the additional information required, the application will be deemed to be withdrawn and the individual may not submit another application for appointment or clinical privileges for a period of one (1) year.~~Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.~~

(d) The individual seeking appointment,~~ or~~ reappointment, and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the

ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives or agents, or any~~,~~ and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, ~~reports, statements,~~ communications, and/or disclosures involving the individual that are made, taken, or received by ~~the Hospital, its authorized agents, or third parties~~any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, its Medical Staff, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and/or clinical privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes these third parties to release this information to the Hospital, its Medical Staff, Medical Staff Leaders, and their ~~and its~~ authorized

representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a qualified agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital, its Medical Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities, managed care organizations, ~~government regulatory and licensure boards or agencies,~~ and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, reappointment, clinical privileges, and/or participation at the requesting organization/facility, ~~and any licensure or regulatory matter.~~(ii) persons or entities external to the Hospital that are assessing the individual's professional qualifications, competence, or health pursuant to a review that the individual has been notified is occurring under applicable Hospital or Medical Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any peer review information in response to such inquiries does not waive any associated privilege, and any and all disclosures shall be made with the understanding that the receiving entity will only use such peer review information for peer review purposes.

(d) Access to Information by Individuals:

(i) Upon request, an individual will be informed of the status of his or her application for appointment, reappointment and/or clinical privileges.

(ii) An individual seeking initial appointment, reappointment, and/or clinical privileges has the right to review information submitted in support of his or her application, upon a request made pursuant to the Valleywise Health policy on Practitioner Access to Credential Files.

(iii) If an individual disputes any information that was obtained in the verification process during the appointment, reappointment, and/or privileging process, the individual will be notified that he or she may submit, in writing, a correction or clarification of the relevant information. Any correction or clarification submitted by the individual will be considered in accordance with the Valleywise Health Policy on Practitioner Access to Confidential Files.

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in Article 7 of this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff members, Advanced Practice Clinicians, Allied Health Professionals, authorized representatives, agents, and employees who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues~~If an individual institutes legal action challenging any credentialing, privileging, or peer review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs and damages incurred in defending such legal action, including reasonable attorney's fees and lost revenues~~.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(i) whether or not appointment or clinical privileges are granted;

(ii) throughout the term of any appointment or reappointment period and thereafter;

(iii) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's and Medical Staff's professional review activities; ~~and~~

(iv) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital~~.~~: and

(v) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Application:

(a) Applications for appointment shall be in writing and shall be on forms approved by the Board, upon recommendation by the MEC and Credentials Committee.

(b) An individual seeking initial appointment shall be sent a notification (i.e., letter or electronic communication) that outlines the threshold eligibility criteria for appointment outlined earlier in this Policy and the applicable criteria for clinical privileges, and the application form.

(c) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form, with copies of all required documents, must be returned to Medical Staff Services.

(b) As a preliminary step, the application shall be reviewed by Medical Staff Services and the CCO (if necessary) to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) Medical Staff Services shall oversee the process of gathering and verifying relevant information, including ECFMG certification (as applicable) and database profiles from/through professional sources, and confirming that all references and other information or materials deemed pertinent have been received.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references (at least two (2)) and other available sources, including the applicant's past or current department chairs

at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) A personal or phone interview(s) with the applicant may be conducted. The purpose of the interview(s) is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, the CCO, and/or the CEO.

3.A.4 Notification of Application Status and Right to Reconcile Information

(a) The applicant for appointment and reappointment has the right to inquire into the status of an application by contacting the Medical Staff Services Department.

(b) During the initial credentialing and recredentialing process, an applicant shall be given notice of any conflicting information and shall be given an opportunity to reconcile such information via letter or electronic communication. The following process shall be followed:

(1) The applicant shall be notified of the variation (i.e., letter or electronic communication) on a case-by-case basis to correct or clarify the relevant information. The notice shall detail the information that needs correction or clarification and where the information should be submitted.

(2) It is the burden of the applicant to correct or clarify variations identified in the application, in writing, once the appropriate notification has been provided.

(3) Confirmation shall be given to the applicant upon receipt of the additional information, which shall be maintained in his or her credentialing file.

(4) Any information that continues to be incomplete, or unsatisfactorily resolved, 30 days after the applicant has been sent notification of a variation in his or her initial credentialing and recredentialing application shall be deemed to be withdrawn, or shall result in an automatic relinquishment of privileges as noted in Section 2.B.2 of this document.

3.A.5. Department Chair Procedure:

(a) Medical Staff Services shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. Each chair shall prepare a written report and recommendation regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The department chair shall be available to the Credentials Committee, MEC, and the Board to answer any questions that may be raised with respect to that chair's report and findings.

3.A.6. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chair, any member of the department, an outside consultant, or another Medical Staff committee, if additional information is required regarding the applicant's qualifications.

(c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(d) After a determination that an applicant is otherwise qualified for appointment and clinical privileges, the Credentials Committee shall refer any questions about the applicant's ability to perform the privileges requested and the responsibilities of appointment to the Practitioner Wellness Committee for recommendations on what, if any, reasonable accommodations may be indicated in order to assure that the Practitioner is able to perform the privileges requested.

3.A.7. Medical Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with, and modification of, the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board through the Chief of Staff.

(c) If the recommendation of the MEC would entitle the applicant to request a hearing in accordance with Article 7 of this Policy, the MEC shall forward its recommendation to the CCO, who shall promptly send special notice to the applicant. The CCO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.8. Board Action:

(a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC, or to another source inside or outside the Hospital, for additional research or information; or

(3) reject or modify the recommendation.

(b) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the CCO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing in accordance with Article 7 of this Policy.

3.A.9. Notice of Final Board Action:

(a) Notice of favorable final action shall be given as soon as possible, but at least within 30 days, by the Chief Executive Officer to the chair of each department concerned and to the applicant.

(b) Final Board action and the notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which the individual is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

(c) Any final decision by the Board to deny, revise, limit, or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.10. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 60 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. FOCUSED PROFESSIONAL PRACTICE EVALUATION

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

(b) In order for a request for privileges to be processed, the applicant must satisfy all applicable threshold eligibility criteria, or be granted a waiver in accordance with Section 4.A.2(c).

(c) The clinical privileges recommended to the Board will be based upon consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely, including current health status;

(4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(5) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another Hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data for the applicant, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(d) The applicant has the burden of establishing his/her qualifications and current competence for all clinical privileges requested.

(e) The report of the chair of the clinical department in which privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the application for staff appointment or reappointment.

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This section applies to all requests for modification of clinical privileges during the term of appointment (additions and relinquishments), resignation from the Medical Staff, and waivers of eligibility criteria for privileges.

(b) Submitting a Request. Requests for privilege modifications and waivers must be submitted in writing to Medical Staff Services.

(c) Waivers of Eligibility Criteria.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(2) Requests for waivers in this section will be processed in the same manner as requests for waivers of appointment criteria, as described in Section 2.A.2 of this Policy.

(d) Additional Privileges.

(1) Requests for additional privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation. After consulting with the Chief of Staff, the CCO will act on the resignation request. No resignation will be effective until the individual has completed all medical records and has appropriately discharged or transferred responsibility for the care of any hospitalized patient who is under the individual's care.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a significant procedure not currently being performed at the Hospital or a significant new technique to perform an existing procedure ("new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Credentials Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(c) If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the

criteria, the Credentials Committee shall conduct research and may consult with experts, both those on the Hospital's Medical Staff and those outside the Hospital, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

(e) The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it shall then approve the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the individual seeking the privilege shall prepare and submit a comprehensive report to the individual's Department Chair who, in collaboration with the CCO, will make the determination as to whether the individual's department wishes to perform the requested privilege at the Hospital. The report shall specify the minimum qualifications needed to perform the procedure, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) If the Department Chair's and CCO's determination is favorable, the CCO shall then refer the request to the Credentials Committee. The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if privileges would be granted;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement and professional practice evaluation activities (including an assessment of outcomes data for all relevant specialties); and

(6) the impact, if any, on call coverage responsibilities.

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Oral and Maxillofacial Surgeons:

(a) Oral surgeons caring for patients who meet the ASA classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations) may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and MEC. They

must, nevertheless, have a relationship with an admitting service that is available to respond should any medical issue arise with a patient.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before oral surgery may be performed. In addition, an admitting service must be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The oral and maxillofacial surgeon shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws and this Policy.

4.A.6. Clinical Privileges for Podiatrists:

(a) Podiatrists caring for patients who meet the ASA classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations) may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with an admitting service that is available to respond should any medical issue arise with a patient.

(b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery may be performed. In addition, an admitting service must be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist shall be responsible for the podiatric surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Podiatrists may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws and this Policy.

4.A.7. Physicians in Training:

Physicians in training at the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each physician in training, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by Academic Affairs. The

applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.8. Telemedicine Privileges:

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Arizona;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) confirmation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an

applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO or "Designee", upon recommendation of the Department Chair and the Chief of Staff, under the following conditions:

(1) the applicant has submitted a complete application;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, profiles from OIG Medicare/Medicaid Exclusions, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank and from a criminal background check;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he/she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Credentials Committee after considering the evaluation of the department chair; and

(5) temporary privileges for a Medical Staff applicant shall be granted for a maximum period not to exceed one hundred twenty (120) days.

(b) Locum Tenens. The CEO or "Designee", upon recommendation of the Department Chair and the Chief of Staff, may grant temporary privileges (admitting and treatment) to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, ill, and/or otherwise needs coverage assistance for a period of time. This shall be done utilizing the same credentialing process set forth in (a) with respect to applicants to the Medical Staff. The only difference shall be the time period for the grant of locum tenens privileges. Specifically, the individual may exercise locum tenens privileges for a one six-month period.

(c) Other. Temporary privileges may also be granted in other limited situations by the CEO or "Designee", upon recommendation of the Department Chair and the

Chief of Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient; or

(2) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors shall be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank. The grant of clinical privileges in these situations shall not exceed 120 consecutive days.

(d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

(a) The CEO or "Designee" may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee, the department chair, or the CCO, terminate temporary clinical privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the department chair, the Chief of Staff, or the CCO may immediately terminate all temporary privileges. The department chair or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

(c) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal pursuant to Article 7 of this Policy.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CCO or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners (physicians and other independent health care professionals) ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the Hospital will obtain his or her valid government-issued photo identification (e.g., driver's license or passport), and at least one of the following:

(a) Current Hospital picture ID card that clearly identifies the individual's professional designation;

(b) Current license to practice;

(c) Primary source verification of the license;

(d) Identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical ~~Resource~~ Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups;

(e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(f) Confirmation by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) Based on oversight of each volunteer licensed independent practitioner, the CCO or the Chief of Staff or his or her designee(s) shall make a decision within 72 hours related to the continuation of the disaster privileges initially granted.

(6) The Medical Staff will oversee the care provided by volunteer physicians and other licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records and have no outstanding delinquencies at the time of reappointment;

(b) completed all continuing medical education requirements as necessary to maintain Arizona state licensure;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for initial appointment and the clinical privileges requested;

(e) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fee, if the reappointment application is not submitted in a timely manner.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy shall be considered. Additionally, the following factors shall be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, call coverage, consultation requests, participation in quality improvement and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other Medical Staff members shall not be identified);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least 120 days prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 30 days.

(b) Failure to return a completed application within 60 days shall result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at least 60 days prior to the expiration of the member's current term shall result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff leaders. Additional fees may be assessed for delinquent submission of reappointments, in accordance with Valleywise Health medical staff policies and procedures.

(c) Reappointment shall be for a period of not more than two years.

(d) Except as provided in paragraph (e), if an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.

(e) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet call coverage requirements, or denying the community access to needed medical services, the CEO or "Designee" shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO or "Designee" shall consult with the chair of the applicable department, the Chair of the Credentials Committee, or the Chief of Staff. The temporary clinical privileges shall be for a period not to exceed one hundred twenty (120) days.

(f) The application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(g) Medical Staff Services shall oversee the process of gathering and verifying relevant information. Medical Staff Services shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) If it becomes apparent to the Credentials Committee or the MEC that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain, or refute it. This meeting is not a hearing in accordance with Article 7, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the application for reappointment is the subject of an unresolved professional practice evaluation concern, an investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 60 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

(3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, call coverage, and the timely and adequate completion of medical records; and

(b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(4) The relevant Medical Staff leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management.

(6) The relevant Medical Staff leader(s), in conjunction with the CEO or CCO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy). Medical Staff leaders may also direct these matters to the MEC for further action.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the professional practice evaluation policy. Matters that cannot be appropriately resolved through collegial intervention or through the professional practice evaluation policy shall be referred to the MEC for its review in accordance with Section 6.C below.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

(a) Where initial collegial interventions or other progressive steps have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding~~Whenever a serious question has been raised, or where collegial or professional practice evaluation efforts have not resolved an issue, regarding~~:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the safety or proper care being provided to patients;

(~~2~~3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or

(~~3~~4) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter may be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, the CCO, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, the CCO, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and warrants further inquiry, and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an investigation.

6.C.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the code of conduct policy, practitioner health policy, or the professional practice evaluation policy), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an investigation has begun. The notification shall include:

(1) the date on which the investigation was commenced;

(2) the committee that will be conducting the investigation, if already identified;

(3) a statement that the physician will be given the opportunity to meet with the committee conducting the investigation before the Investigation concludes; and

(4) a copy of Section 6.C.3 of this Policy, which outlines the process for investigations.

This ~~N~~notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.C.3. Investigative Procedure:

(a) Selection of Investigating Committee.
Once a determination has been made to begin an investigation, the MEC shall investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised relate to clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).

(b) Investigating Committee's Review Process.
(1) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals.

A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee ~~It~~ shall also have available to it the full resources of the Medical Staff and the Hospital, ~~as well as~~including the authority to ~~use outside consultants~~arrange for an external review, if needed. An ~~outside consultant or agency~~ external review may be used whenever ~~a determination is made by~~ the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under investigation shall be notified of that decision and the nature of the external review. However, the individual under investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

~~(1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or~~

~~(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other members on the Medical Staff; or~~

~~(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.~~

(3~~c~~) The investigating committee may require a physical, behavioral, and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide

documentation of the results of such examination directly to the investigating committee.

(cd) Meeting with the Investigating Committee.

(1) The individual under investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the investigation and/or a written explanation of his or her perspective on the events that led to the investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be made by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

~~(1) This meeting is not a hearing in accordance with Article 7, and none of the procedural rules for hearings shall apply. Neither the investigating committee nor the individual being investigated shall have the right to be represented by legal counsel at this meeting.~~

(d) Time Frames for Investigation.

~~(e)~~ The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an ~~outside~~external review is not necessary. When an external~~outside~~ review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external~~outside~~ review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the

individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(e) Investigating Committee's Report.

(1~~f~~) At the conclusion of the investigation, the investigating committee shall prepare a report of the investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's~~with its findings, conclusions, and~~ recommendations.

(2~~g~~) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(~~1~~i) relevant literature and clinical practice guidelines, as appropriate;

(ii~~2~~) all of the opinions and views that were expressed throughout the review, including report(s) from any ~~outside~~exteranl review(s);

(iii~~3~~) any information or explanations provided by the individual under review~~;~~. and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.C.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee if one was appointed. ~~Specifically,~~In either case, at the conclusion of the investigation, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) recommend additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment and/or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) If ~~A~~a recommendation by the MEC ~~that~~ would entitle the individual to request a hearing in accordance with Article 7 of this Policy, the recommendation shall be forwarded to the CCO, who shall promptly inform the individual by special notice. The CCO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

~~(c) If the MEC makes a recommendation that does not entitle the individual to request a hearing in accordance with Article 7 of this Policy, it shall take effect immediately and shall remain in effect unless modified by the Board.~~

(c~~d~~) A determination by the MEC that does not~~In the event the Board considers a modification to the recommendation of the MEC that would~~ entitle the individual to request a hearing ~~in accordance with Article 7 of this Policy~~will take effect immediately.~~,~~ ~~t~~All such determinations shall be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification that would entitle the individual to request a hearing, the CCO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's professional practice evaluation activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.D.1. Grounds for Precautionary Suspension or Restriction:

(a) The MEC, or any Medical Staff Officer or department chair along with either the CEO or the CCO, shall have the authority to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital.

(b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing in accordance with Article 7 of this Policy.

(c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the Chief of Staff, and shall remain in effect unless it is modified by the CEO or MEC.

(e) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.D.2. MEC Procedure:

(a) The MEC shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the orderly operation of the Hospital, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing in accordance with Article 7 of this Policy based on the imposition or continuation of a precautionary suspension or restriction.

6.D.3. Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical

privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chair, the MEC, the CCO, and the CEO in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT

6.E.1. Failure to Complete Medical Records:

Failure to complete medical records in a timely manner shall result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff.

6.E.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported by the Medical Staff member to the CCO and the Chief of Staff.

(b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:

(1) Licensure: Revocation, expiration, suspension, or the placement of restrictions on an individual's license.

(2) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of restrictions on an individual's DEA controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.

(c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in Article 7 of this Policy, if the individual fails to satisfy and/or maintain any of the other threshold eligibility criteria set forth in this Policy, except for board certification, which shall be assessed at the time of reappointment.

(d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the Hospital after the occurrence of an event that results in automatic relinquishment, without notifying the Hospital of that event, then the relinquishment shall be deemed permanent.

(e) If the underlying matter leading to automatic relinquishment is resolved within 90 days, the individual may request reinstatement. Failure to resolve the matter within 90 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

(f) Request for Reinstatement.

(1) Requests for reinstatement following the expiration of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (f) (2) below.

(2) All other requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, the CCO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, and/or clinical privileges, in response to a written request from the Credentials Committee, the Professional Practice Evaluation Committee, the MEC, the CCO, the CEO, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment shall continue in effect until the information is provided to the satisfaction of the requesting party.

6.E.4. Failure/Refusal to Attend Special Conference:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the department chair, the Chief of Staff, the CCO, CEO, Credentials Committee, the Professional Practice Evaluation Committee, the MEC, or any other committee authorized to request such information, may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure or refusal of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure/refusal shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.E.5. Failure to Pay Dues/Assessments:

(a) Failure to pay dues or assessments within 30 days of the first notice of delinquency, as set forth in Section 1.D.1 of the Medical Staff Bylaws, shall result in the assessment of late fees.

(b) Failure to pay dues or assessments within 30 days of the second notice of delinquency shall result in the member's automatic relinquishment of privileges and resignation from the Medical Staff.

6.F. LEAVES OF ABSENCE

(1) Members of the Medical Staff must report to the CCO and/or the Chief of Staff any time they are away from Medical Staff and/or patient care responsibilities for

longer than 90 days. Requests must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(2) The CCO, in consultation with the Chief of Staff, may trigger an automatic medical leave if: (1) the reason for a leave of absence is related to a physical or mental health issue or otherwise to an individual's ability to care for patients safely and competently, or (2) if the CCO and/or Chief of Staff become aware of circumstances where an individual will be absent from his or her patient care responsibilities because of a Health Issue, as defined in the Practitioner Health Policy.

(3) The CCO shall then determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CCO shall consult with the Chief of Staff, and the relevant department chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(4) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, call coverage) during this period.

(5) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CCO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal in accordance with Article 7 of this Policy.

(6) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CCO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Medical Staff and Hospital.

(8) If an individual's current appointment and clinical privileges are due to expire during the leave, the individual must apply for reappointment while on leave, or his or her clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply for appointment. If during the leave of absence reappointment is granted, the individual shall, however, remain on leave until it has been terminated through the reinstatement process outlined in Section 6.E.

(9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal in accordance with Article 7 of this Policy.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges, whether at the time of initial appointment, reappointment, or during the course of appointment;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension), which entitles the individual to the procedures outlined in Section 6.D.1 of this Policy, which are deemed fair under the circumstances);

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) issuance of a letter of guidance, counsel, warning, or reprimand;

(b) imposition of conditions, proctoring, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);

(c) termination of temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) imposition of a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

(h) determination that an application is incomplete;

(i) determination that an application shall not be processed due to a misstatement or omission; or

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract~~.~~; or

(k) any other action that is not specifically listed in Section 7.A.1(a)

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CCO shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the CCO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The CCO shall schedule the hearing and provide, by special notice, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement ~~may be revised or amended at any time, even during~~does not bar the presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

(b) The hearing shall begin as soon as practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CCO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members with a majority of whom will be peers of the individual requesting the hearing (i.e., a practitioner with a similar or same degree such as an M.D. to an M.D. or a D.O.), and may include any combination of:

(a) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, and/or

(b) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 and Appendix A.

(b) Presiding Officer:

(1) The CCO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who may be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(a) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(b) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(c) maintain decorum throughout the hearing;

(d) determine the order of procedure;

(e) rule on all matters of procedure and the admissibility of evidence;

(f) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4~~3~~) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be an advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the CCO, after consulting with the Chief of Staff, may appoint a Hearing Officer to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer, or the Presiding Officer, shall be made in writing, within ten days of receipt of notice, to the CCO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The CCO shall rule on the objection and give notice to the parties. The CCO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

(a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other members of the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall also be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.C.4. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.5. Stipulations:

The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.6. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the Chief of Staff, and the CCO. In addition, administrative personnel may be present as requested by the CCO or the Chief of Staff.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone but shall be permitted only by the Presiding Officer or the CCO on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual

who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CCO. The CCO shall send by special notice a copy of the report to the individual who requested the hearing. The CCO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CCO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board shall schedule and arrange for an appeal. The individual requesting the appeal shall be given special notice of the time, place, and date of the appeal, and a copy shall also be provided to the other party. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board shall serve as the Review Panel and shall consider the record upon which the recommendation before it was made.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) The Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

7.G.1. Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, or (ii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC and the Hearing Panel. The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES

8.A. CONFLICT OF INTEREST GUIDELINES

8.A.1. General Principles:

(a) All those involved in credentialing, peer review and quality assurance activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(b) It is also essential that peers participate in credentialing, peer review and quality assurance activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) Recognizing the unique relationship between Valleywise Health and its contracted providers, the Hospital and the Medical Staff have determined that the fact that all members of the Medical Staff are professionally and contractually associated to each other which does not, in and of itself, preclude any individual from participating in credentialing and peer review activities at the Hospital. The potential conflicts of interest that could legitimately impact credentialing and peer review matters within Valleywise Health's structure are those described in Sections 8.A.2 and 8.A.3 below.

8.A.2. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, domestic partner, fiancé, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

8.A.3. Employment by or Contractual Relationship with the Hospital:

Recognizing the unique relationship between Valleywise Health and its contracted providers, the Hospital and the Medical Staff have determined that the fact that all members of the Medical Staff are professionally and contractually associated to each other, which does not, in and of itself, preclude any individual from participating in credentialing, peer review, or quality assurance activities at the Hospital. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

8.A.4. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

(a) being a direct competitor;

(b) close friendship;

(c) a history of personal conflict;

(d) personal involvement in the care of a patient which is subject to review;

(e) raising the concern that triggered the review; or

(f) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

8.A.5. Guidelines for Participation in Credentialing, Peer Review, and Quality Assurance Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used:

(a) Individual Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff Committee. This applies, but is not limited, to the following situations:

(1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and MEC's subsequent review of credentialing matters; and

(2) participation as case reviewers in peer review because of the Professional Practice Evaluation Committee's ("PPEC's") subsequent review of peer review matters.

(b) Credentials Committee, Leadership Council, or Professional Practice Evaluation Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a

practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested Member in a particular situation if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or skew the recommendation or determination of the committee

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) MEC. An Interested Member shall be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Board. In the event that a Board Member meets the criteria as an Interested Member, the Board Member shall recuse themselves when considering a recommendation that could affect the clinical privileges of a practitioner.

8.A.~~5~~6. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or actions of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

(c) not participate in the discussions or actions of the MEC when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

8.A.7. Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair shall consider whether the Interested Member's

presence would inhibit full and fair discussion of the issue before the committee skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

(b) Any Interested Member who is recused from participating in a committee meeting must leave the meeting room prior to the committee's final deliberation and determination but may answer questions and provide input before leaving.

(c) Any recusal will be documented in the committee's or Board's minutes.

(d) Whenever possible, an actual or potential conflict should be brought to the attention first to the involved committee chair, and if there is no acceptable resolution, to the Chief of Staff, the CCO, the CEO, or the Board, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

8.A.8. Other Considerations:

(a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, may call the conflict of interest to the attention of the Chief of Staff (or to the Vice-Chief of Staff if the Chief of Staff is the person with the potential conflict), the CCO, the CEO or the applicable committee chair. The member's failure to notify will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee, or where appropriate the Board Chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

(b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board Chair, guided by this Article.

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy;

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital; or

(4) when the disclosures are required by law.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

9.B. PEER REVIEW AND QUALITY ASSURANCE PROTECTION

(1) All credentialing, peer review, and quality assurance activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in accordance with Arizona and federal law. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all departments and divisions;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to department chairs, committee chairs and members, officers of the Medical Staff, the CCO, the CEO, and experts or consultants retained to assist in credentialing or peer review activities.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and privileged pursuant to Arizona law.

(2) All peer review committees and their activities shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 10

AMENDMENTS

This Policy may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments shall also be provided to all voting members of the Medical Staff at least 14 days prior to the MEC meeting and any member of the Medical Staff may submit written comments to the MEC. No amendment shall be effective unless and until it has been approved by the Board, which approval shall not be withheld unreasonably.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: ~~June 2023~~March 2024

Approval by the Board of Directors: ~~June 2023~~March 2024

REVISIONS:

10/2009 (Complete Revision – Previous Credentialing Policy contained in Medical Staff Bylaws), 06/2010, 6/2012, 6/2014, 2/2015, 05/2016, 01/2017, 3/2019, 9/2019, 08/2020, 05/2021, 06/2023, 3/2024

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	LEVELS OF PARTICIPATION									
	Provide Information	Individual Reviewer Application/ Case	Committee Member						Hearing Panel	Board
			Department, Specialized, or Trauma Multi-Disciplinary Peer Review	Credentials	Leadership Council	PPEC	MEC	Ad Hoc Investigating		
Family member	Y	N	R	R	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Direct competitor	Y	Y	Y	Y	Y	Y	Y	N	N	R
Close friends	Y	Y	Y	Y	Y	Y	Y	N	N	R
History of conflict	Y	Y	Y	Y	Y	Y	Y	N	N	R
Personally involved in care of patient	Y	Y	Y	Y	Y	Y	Y	N	N	R
Reviewed at prior level	Y	Y	Y	Y	Y	Y	Y	N	N	R
Raised the concern	Y	Y	Y	Y	Y	Y	Y	N	N	R

Y – (green "Y") means the Interested Member may serve in the indicated role, no extra precautions are necessary.

Y – (yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally-permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Department Peer Review, Specialized Peer Review Committee, Trauma Multi-disciplinary Peer Review Committee, Credentials Committee, Leadership Council, and PPEC have no disciplinary authority. In addition, the Chair of the Credentials Committee, Department Peer Review, Specialized Peer Review Committee, Trauma Multi-disciplinary Peer Review Committee, Leadership Council, or PPEC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would inhibit the full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

N – (red "N") means the individual may not serve in the indicated role.

R – (red "R") means the individual must be recused in accordance with the rules for recusal.

Rules for Recusal

- Interested Members must leave the meeting room prior to the committee's or Board's final deliberation and determination but may answer questions and provide input before leaving.
- Recusal shall be specifically documented in the minutes.
- Whenever possible, the actual or potential conflict should be raised and resolved prior to the meeting by the committee or Board chair and the Interested Member informed of the recusal determination in advance.
- No Medical Staff member has the RIGHT to demand recusal – that determination is within the discretion of the Medical Staff Leaders.
- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.

1.d.v. Medical Staff - Policy 39026 T Operational Credentialing

Valleywise Health Administrative Policy & Procedure

Effective Date: 04/10

Reviewed Dates: 03/18, 08/20

Revision Dates: 09/11, 04/12, 04/13, 04/14, 02/15, 03/16, 5/17, 06/19, 12/20, 04/21, 06/21, 09/21, 01/22, 10/22,03/2023, 03/2024

Policy #: 39026 T

Policy Title: Clinical Services/Medical Affairs: Operational Credentialing Policy and Procedure

Scope:
- **[ ] District Governance (G)**
- **[ ] System-Wide (S)**
- **[ ] Division (D)**
- **[ ] Multi-Division (MD)**
- **[x] Department (T) Medical Staff Services**
- **[ ] Multi-Department (MT)**

Purpose:
In accordance with Medical Staff Bylaws and Medical Staff and Advanced Practice Clinicians and Allied Health Professionals Policies, to further define the process for credentialing and re-credentialing members of the Medical Staff and Advanced Practice Clinician/Allied Health Professional staff in compliance with NCQA and HRSA (as used by the FQHC) standards, DNV, CMS, and health plan delegation agreements.

Definitions:

Advanced Practice Clinician (APC): Individuals other than Medical Staff members who are licensed healthcare professionals who are board/nationally certified and have at least a master's degree. APCs (e.g., NP, CNM, CRNA, and PA-C) 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 (AHP): 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. AHPs as defined in this policy are credentialed/privileged through the Medical Staff Services process.

AMA: American Medical Association
AOA: American Osteopathic Association
Certifacts: An official Display Agent for the American Board of Medical Specialties (ABMS) to serve as one of the LIPs of primary source equivalent ABMS

CMS: Centers for Medicare and Medicaid Services

Clinical Privileges: The authorization granted by the Maricopa County Special Health Care District Board ("Board") to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other privileging criteria and focused and ongoing professional practice evaluation standards with the results of the Board's decisions communicated to the LIPs.

CVO: Credentialing Verification Organization. Valleywise Health CVO is comprised of Medical Staff Services, Human Resources, Employee Health and Wellness, Center for Clinical Excellence. CVO includes the verification from a primary source.

Delegation Agreement – An agreement between Valleywise Health and a health plan that allows the health plan to accept the credentialing process of Valleywise Health, provided Valleywise Health meets the health plan's credentialing standards and successfully demonstrates compliance upon audit by the respective health plan.

DNV: Det Norske Veritas – A hospital accreditation program approved by the US Centers for Medicare and Medicaid Services (CMS). DNV performs annual deemed status surveys.

ECFMG: The Educational Commission for Foreign Medical Graduates for verification of a physician's graduation from a foreign medical school.

FQHC: Federally Qualified Health Center

Governing Body: An organized group or individual who assumes full legal authority and responsibility for operations of the hospital, medical staff, and administrative officials.

HRSA: Health Resources and Services Administration

LIP: Licensed Independent Practitioner who is permitted by law and by the Hospital to provide patient care services without direction or supervision, so long as their practice is consistent with state and federal law and/or Hospital policy, and within the scope of his, her, their license and consistent with the clinical privileges granted (e.g., Physicians [MD/DO], Dentists [DDS/DMD], Clinical Psychologists [Ph.D/Psy.D], License Professional Counselors, and Licensed Clinical Social Workers). Other AHP/APP, considered a LIP per the Health Resources and Services Administration ("HRSA") Health Center Program Compliance Manual, who may provide a medical level of care or performs surgical tasks consistent with the clinical privileges granted by the Hospital may and exercise those clinical privileges under the direction/supervision of a Supervising/Collaborating Physician pursuant to a written delegation agreement of supervision or collaborative agreement (e.g. Physician Assistant) or without direction or supervision/collaboration (e.g. Nurse Practitioner ("NP") or Certified Nurse Midwife ("CNM")), so long as their practice is consistent with state and federal law and/or Hospital policy.

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

MSS: Medical Staff Services

MEDICAL STAFF SERVICES PROFESSIONAL: All staff titles or roles authorized to access, modify and delete information as pertaining to credentialing/recredentialing, and other designated responsibilities.

NCQA: National Committee for Quality Assurance

Participating Practitioners: Medical Staff and APC/AHP Professional Staff as defined in the Medical Staff Credentialing Policy and Advanced Practice Clinicians and Allied Health Professionals Policy.

Preclusion List: A list generated by CMS that contains the names of prescribers, individuals, and/or entities that are unable to receive payment for Medicare Advantage

(MA) items and service and/or Part D drugs prescribed or provided to Medicare beneficiaries.

Primary Source Verification: Verification by the original source of a specific credential of the accuracy of a qualification reported by an individual health care practitioner. Primary source verification could include direct correspondence, telephone, fax, e-mail, or paper or online reports received from original sources (i.e., telephone confirmation from an educational institution that the individual graduated with the degree[s] listed on his or her application, confirmation through a state's database that a LIP's license is current, reports from credentials verification organizations). Designated examples of primary sources accepted but not limited to the following: AMA, ABMS/Certifacts, ECFMG, AOA, AAPA.

Secondary Source Verification: Documented verifications of credentials obtained through a verification report from a recognized entity considered as an acceptable source of information.

Virtual Meeting: A meeting conducted by way of either video or web-based conferencing with audio.

Policy:

Valleywise Health which includes the Valleywise Health Medical Center and all of its affiliated inpatient, ancillary, outpatient, and licensed health services, facilities, departments and programs, including the Valleywise Behavioral Health Centers (Maryvale, Mesa, Phoenix), Valleywise Comprehensive Health Centers (Phoenix and Peoria), Arizona Burn Center, Valleywise Emergency (Maryvale), and Valleywise Community Health Centers (Federally Qualified Health Care (FQHC) Clinics) that provide services within its scope of project/services ensures that such LIPs are licensed, certified, or registered as verified through a credentialing and re-credentialing process in accordance with the Valleywise Health Medical Staff Credentials Policy and Advanced Practice Clinicians and Allied Health Professionals Policy; and applicable Federal, state, and local laws; and competent and fit to perform the contracted or referred services, as assessed through a privileging process; and is operationalized as set forth in this policy.

Valleywise Health will determine in its decision-making the following considerations in relation to credentialing:

- Staffing composition (for example, use of nurse practitioners, physician assistants, certified nurse midwives) and its staffing levels (for example, full – and/or part-time staff);
- Approval authority for credentialing and privileging of its clinical staff;
- Credentialing protocols will be implemented (for example, a health center may contract with a credentials verification organization (CVO) to perform credentialing activities or it may have its own staff conduct credentialing), including whether to have separate credentialing processes for LIPS versus other provider types;
- Assessment of clinical competence and fitness for duty of its staff (for example, regarding clinical competence, a health center may utilize peer review conducted by its own LIPs or may contract with another organization to conduct peer review);
- Consistent with established privileging criteria whether to deny, modify, or remove privileges of its staff; whether to use an appeals process in conjunction with such determinations; and whether to implement corrective action plans in conjunction with the denial, modification, or removal of privileges;

- Consistent with its contracts/cooperative arrangements whether to disallow individual LIPs or organizations from providing health services on the health center's behalf.

A health care plan may delegate its credentialing function for LIPs who provide services at Valleywise Health. Health care plans, through a contractual agreement, may delegate the credentialing, re-credentialing and monitoring for adverse actions of all participating LIPs. The Delegation Agreement shall detail the delegated activities, responsibilities of the health plan and of Valleywise Health, and the process by which evaluation of the process shall occur.

Valleywise Health may sub-delegate primary source verification and, if applicable, shall conduct regular audits of all such delegated activities. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of the Medical Staff Credentials and Advanced Practice Clinicians and Allied Health Professionals Policies.

Procedure:

SECTION 1 – INITIAL CREDENTIALING/APPOINTMENT PROCEDURES

1.1 Verification of Information

The information that shall be collected and verified by professionals of the MSS Department working with the Credentials Committee shall include, but not be limited to:

1.1.1 Education and training will be verified using primary sources. Examples of primary sources include but not limited to the AMA/AOA profile or directly with the training program by written letter, or The Educational Commission for Foreign Medical Graduates (ECFMG) to verify a LIP's graduation from a foreign medical school.

1.1.2 All currently unrestricted professional licensures or certifications verified using primary source verification achieved with the appropriate state agencies, by a letter, telephone verification, licensing board website, or secure electronic communication obtained from the appropriate state licensing board. Telephone and electronic communication shall be appropriately documented with the date, time, and initials of the individual performing the verification. A current copy of the Drug Enforcement Administration (DEA) registration when applicable, with the date and number of each will be primary source verified with the U.S. Department of Justice Drug Enforcement Administration Diversion Control Division.

1.1.3 Specialty or sub-specialty board certification, recertification, or active candidate status verified by Certifacts, AMA/AOA profile, or directly with the ABMS/AOA Specialty Board.

1.1.4 Continuous professional liability insurance coverage as required in the Credentialing Policy. The applicant must include names of present and past insurance carriers and complete information on malpractice claims history and experience including past and pending claims, final judgments, or settlements. The National Practitioners Data Bank (NPDB) is queried for verification of any professional liability claims.

1.1.5 Any pending or completed action involving the withdrawal of an application for or the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary relinquishment (by expiration or resignation while under investigation or to avoid investigation) of: license or certificate to practice in any state or country; DEA or other controlled substances registration; specialty or sub-specialty board certification or eligibility; staff membership status, prerogatives, or clinical privileges at any hospital, clinic or health care institution; professional liability insurance coverage. The entities that shall verify this information shall include, but not be limited to the applicable state agency; health care affiliations; NPDB; and professional peer references.

1.1.6 Health Status, Fitness for Duty, Immunization, and Communicable Disease Status information provided in response to pertinent questions about a LIP's physical and mental health status or chemical/substance dependency/abuse that may impair his/her ability to provide professional services.

1.1.7 Charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another shall be elicited on the application.

1.1.8 All hospitals or health care organizations where the applicant had or has any association, employment, privileges or practice to include start and end dates of each affiliation. All time gaps in practice greater than three (3) months since graduation must be accounted for and shall be verified by an individual who can attest to the validity of the activity as specified by the applicant, or re-applicant.

1.1.9 Medicare sanctions are verified directly with the OIG and SAM (Office of the Inspector General and the System for Awards Management) websites or the NPDB.

1.1.10 The Medicare Opt-Out Report will be reviewed at initial appointment. If a LIP is identified they shall be deemed to not meet the qualifications for appointment as outlined in the credentialing policies.

1.1.11 The Preclusion List will be provided by each health plan to be reviewed monthly and at time of initial appointment.

1.1.12 The Social Security Administration's "Death Master File Index" will be used to screen the applicant's social security number through the background check process for applicants undergoing the initial credentialing process.

1.1.13 The National Plan and Provider Enumeration System ("NPPES") National Provider Identifier ("NPI") Registry will be queried to confirm/verify the applicant's individual "NPI" number at time of initial credentialing/appointment.

1.1.14 Clinical staff member's (LIPs) identity is verified through government issued picture identification.

1.1.15 All Medical Staff and APC/AHP Staff are enrolled in the NPDB Continuous Query Program with NPDB queries reviewed at time initial appointment/reappointment, new privilege requests, and on an ongoing/real-time basis as Continuous Query enrollment reports are made available.

1.1.16 Current documentation of basic life support training will be obtained and filed in the LIP's credential file (i.e., BLS, ACLS, PALS, NRP) if applicant is practicing in the FQHC Clinic.

1.1.17 Current Level 1 Fingerprint Clearance card issued by the Arizona Department of Public Safety at time of initial appointment/credentialing **OR** Record of fingerprinting application in process with the Arizona Department of Public Safety **and** a copy of completed/signed Arizona Department of Health Services Bureau of Child Care Licensing Criminal History Affidavit, in accordance with Arizona Revised Statute ("ARS") §36-425.03 (Children's Behavioral Health Programs) R9-10-1006 (11.)(c.)(vi), will be obtained and filed in the LIP's credential file if the applicant is located or covering in a Valleywise Community Health Center or a Valleywise Comprehensive Health Center.

1.1.18 Medical Staff and APC/AHP Staff will be notified within ten (10) days of Credentialing Committee decision of either approval or denial by the Governing Body of Valleywise Health.

SECTION TWO – REAPPOINTMENT/RE-CREDENTIALING PROCEDURES

2.1 All terms, conditions, requirements, and procedures relating to initial credentialing/appointment shall apply to continued appointment and re-credentialing/reappointment. Each staff member shall be sent an application for recredentialing/reappointment and notice of the date on which the appointment will expire (not to exceed two years from the last appointment/reappointment) in accordance with Medical Staff Credentials and Advanced Practice Clinicians and Allied Health Professionals Policies.

2.2 The MSS Department shall verify information since the time of the member's last appointment regarding professional and collegial activities, performance, clinical or technical skills and conduct. Such information will include but not be limited to:

2.2.1 At least two peer references

2.2.2 Within the last two years, any pending or completed professional action as specified in Section 1.1.5 of this policy.

2.2.3 Medical malpractice history over the past two years is required on the application and verified though NPDB.

2.2.4 All currently unrestricted professional licensures or certifications verified using primary source verification with the appropriate state agencies, and a current copy of the Drug Enforcement Administration (DEA) registration when applicable, with the date and number of each will be primary source verified with the U.S. Department of Justice Drug Enforcement Administration Diversion Control Division.

2.2.5 Primary source verification of Specialty or sub-specialty board certification, or recertification

2.2.6 All hospitals or health care organizations where the applicant had or has any association, employment, privileges or practice with the dates of each affiliation.

2.2.7 Health Status, Fitness for Duty, Immunization, and Communicable Disease Status information provided in response to pertinent questions about a LIP's physical and mental health status or chemical/substance dependency/abuse that may impair his/her ability to provide professional services reviewed at time of reappointment.

2.2.8 Medicare/Medicaid Sanctions (i.e., OIG and SAM) and Medicare Opt- Out Report will be reviewed at reappointment. If a LIP is identified they shall be deemed to not meet the qualifications for reappointment as outlined in the credentialing policies.

2.2.9 The Preclusion List will be provided by each health plan to be reviewed monthly and at time of re-credentialing/reappointment.

2.2.10 The Social Security Administration's "Death Master File Index" will be used to rescreen the applicant's social security number through the background check process for applicants undergoing the reappointment/recredentialing process.

2.2.11 The National Plan and Provider Enumeration System ("NPPES") National Provider Identifier ("NPI") Registry will be queried to reconfirm/reverify the applicant's individual "NPI" number at time of recredentialing/reappointment.

2.2.12 Current documentation of basic life support training will be re-verified and filed in the LIP's credential file (i.e., BLS, ACLS, PALS, NRP) at time of recredentialing/reappointment if applicant is practicing in the FQHC Clinic.

2.2.13 Current Level 1 Fingerprint Clearance card issued by the Arizona Department of Public Safety at time of reappointment/re-credentialing **OR** Record of fingerprinting clearance renewal application for an expiring fingerprint clearance card in process with the Arizona Department of Public Safety **and** copy of an updated Arizona Department of Health Services Bureau of Child Care Licensing Criminal History Affidavit, in accordance with Arizona Revised Statute ("ARS") §36-425.03 (Children's Behavioral Health Programs) R9-10-1006 (11.)(c.)(vi) in R910-1006 (11.)(c.)(vi), will be obtained and filed in LIP's credential file if the applicant is located or covering in a Valleywise Community Health Center or a Valleywise Comprehensive Health Center.

2.2.14 Medical Staff and APC/AHP Staff will be notified within ten (10) days of Credentialing Committee decision of either approval or denial by the Governing Body of Valleywise Health.

2.3 The sources used for verification will be the same as in the initial credentialing process.

SECTION THREE - NOTIFICATION AND STATUS OF APPLICATION

3.1 During the initial credentialing or re-credentialing process, the LIP will be given notice by the Valleywise Health credentialing staff of any conflicting information and be given an opportunity to reconcile such information in accordance with the Medical Staff and Allied Health Professional Credentials Policies.

3.2 LIPs receive a copy of the Medical Staff Bylaws, Medical Staff Credentialing Policy, or Allied Health Professional Credentialing Policy (if applicable) outlining their rights.

3.3 LIPs have the right to review information submitted to support their credentialing application in accordance with the **Practitioner Access to Credentialing Files Policy**.

SECTION FOUR - ONGOING VERIFICATION OF INFORMATION

4.1 Medicare/Medicaid Exclusions shall be verified on a monthly basis. Verification shall be accomplished through a sweep of the credentialing database matched against the OIG (Office of Inspector General) and SAM (System for Awards Management) websites.

4.2 Medicare/Medicaid Opt-Out Report - The Medicare Opt-Out Report will be reviewed on a quarterly basis; if a LIP is identified the health plan will be notified immediately.

4.3 Licensure - The applicant's current professional licensure shall also be verified at the time of license renewal and revision of privileges. During the interim period between reappointment cycles, the Credentials Committee shall review disciplinary actions identified, or other issues deemed to be significant. The Credentials Committee shall make recommendations on these matters, when deemed necessary. Any licensure revocation, suspension, restriction, or probation shall result in a like limitation of clinical privileges, as of the date such action becomes effective and throughout its term. Contracted health plans shall be notified immediately of any such actions.

4.4 Patient Complaints, Adverse Events, and Medical Record Review- The collection of and review of information obtained from complaints, adverse events, and medical record review is performed on a concurrent basis. Appropriate interventions are identified from adverse events through the confidential peer review mechanism.

4.5 Immunizations and communicable disease status are verified by the Valleywise Health Employee Health and Wellness Department at time of initial appointment and on an ongoing basis in accordance with Valleywise Health policies and procedures.

4.6 Level 1 Fingerprinting Clearance cards will be verified with the Arizona Department of Public Safety.

SECTION FIVE - REPORTING TO THE NATIONAL PRACTITIONER DATA BANK (NPDB), STATE LICENSING BOARD, AHCCCS CLINICAL QUALITY MANAGEMENT UNIT, OFFICE OF THE ATTORNEY GENERAL, AND LAW ENFORCEMENT AGENCY

5.1 It is the policy of Valleywise Health to comply with the required reporting of adverse actions taken against a Participating Practitioner to all regulatory agencies, including the **National Practitioner Data Bank** (NPDB) and the appropriate State of Arizona Licensing Board.

5.2 Following a formal peer review process, and at the time that Valleywise Health denies, reduces, revokes, terminates, or suspends the privileges of a LIP for a period of longer than thirty (30) calendar days, or accepts the Participating LIP's surrender of privileges while under investigation by Valleywise Health, Valleywise Health will notify the NPDB and the appropriate State of Arizona Licensing Board.

5.3 NPDB Reporting:

5.3.1 Valleywise Health will submit a report to the NPDB of the adverse action consistent with the NPDB timeliness requirements.

5.3.2 The NPDB report will be submitted electronically, in accordance with NPDB requirements via the NPDB website at www.npdb-hipdb.com

5.4 State of Arizona Licensing Board Reporting: The Report Verification Document that Valleywise Health received from the NPDB will be submitted to the appropriate State licensing board.

5.5 AHCCCS Clinical Quality Management Unit/Office of the Attorney General: A report shall be submitted within one business day of quality deficiencies that result in a LIP's suspension or termination from the Valleywise Health Medical Staff or Allied Health Professional Staff.

5.6 Law Enforcement Agency: Reports will be filed in accordance with Valleywise Health Policies and Procedures.

SECTION SIX – PROTECTION AGAINST DISCRIMINATION

6.1 In accordance with the Medical Staff and Allied Health Professional Credentials Policies, No individual shall be denied appointment or reappointment at the Hospital on the basis of gender, race, ethnic/national identity, ancestry, age, health status, sexual orientation, religion, veteran's status, marital status, handicap, or types of patients (e.g. Medicaid) in which the LIP specializes. Means used to prevent discrimination in the decision-making process includes:

6.1.1 The Credentials Committee will be comprised of a multi-disciplinary, heterogeneous group of practitioners to the degree feasible.

6.1.2 All members of the medical staff and allied health professional staff are required to attest to their willingness to abide by the Medical Staff Bylaws and associated documents. Discrimination is prohibited in the Medical Staff Credentialing Policy (section 2.A.5) and Allied Health Professional Credentialing Policy (Section 3.A.5).

6.1.3 Adverse recommendations must be supported by qualitative and quantitative data that is presented to the Credentials Committee blindly (i.e., using a numeric identifier in lieu of name, discipline, specialty, etc.).

6.1.4 All denial decisions will be handled in accordance with the Medical Staff Credentials Policy (Article 3.A.6-3.A.7) and Allied Health Professional Policy (Article 4.A.5-4.A.6) and potentials for discrimination shall be assessed through the respective (medical staff or allied health professional staff) Hearing and Appeal Process.

6.2 The Credentials Committee will conduct an annual review of credentialing decisions to ensure that practitioners are not discriminated against and each voting member will sign a Confidentiality and Non-Discrimination form at time of initial appointment to the committee and annually thereafter.

SECTION SEVEN – GENERAL PROVISIONS

7.1 Valleywise Health shall seek to verify all the data elements as set forth in this policy and the Medical Staff and Allied Health Professional Staff Credentialing Policies. Demonstration of verification of the data elements will be achieved with each verified element dated/initialed via electronic database/audit tool sheet by the professional of the MSS Department conducting the credentialing/verification.

7.2 Valleywise Health will conduct timely verification of information, as evidenced by approval (or denial) of a LIP for initial credentialing/appointment within sixty (60) days of receipt of a complete application. Each applicant is required to sign and attest to the accuracy of the information provided in the application. If the signature attestation exceeds sixty (60) calendar days before the credentialing decision, MSS shall update it with an attestation that the information on the application remains correct and complete.

7.3 Valleywise Health will conduct timely verification of information, as evidenced by approval (or denial) of a LIP for re-credentialing/reappointment within one hundred eighty (180) days of receipt of a complete application. Each applicant is required to sign and attest to the accuracy of the information provided in the re-credentialing/reappointment application. If the signature attestation exceeds one hundred eighty (180) days before the credentialing decision, MSS shall update it with an attestation that the information on the application remains correct and complete.

7.4 All members of the Medical Staff and APC/AHP Staff acknowledge that they agree to respect and maintain the confidentiality of all discussions, deliberations, proceedings, and activities of Medical Staff Committees and Departments which have the responsibility of evaluating and improving the quality of care in the Hospital. Members of the Credentials Committee and other Peer Review Committees may be required to sign a confidentiality statement.

7.5 Provisionally credentialed (clean file review) and approval is permitted in accordance with the criteria and process set forth in the Medical Staff Credentialing Policy (Section 4.B) and APC/AHP Professionals Policy (Section 4.C).

7.6 The health care plan and Valleywise Health will identify the LIPs who will participate in this agreement in a written list updated monthly. Any published directories are based on the information provided from the Credentials Office.

7.7 Valleywise Health will conform to the current requirements established by the NCQA.

7.8 For purpose of the "Federal Quality Health Care (FQHC)" delegated credentialing arrangements, a completed application is defined as the fully verified application that has been acted on favorably by the Valleywise Health Credentials Committee.

7.9 Any meeting of the Credentials Committee by way of a virtual meeting may only be conducted by either video or web-based conferencing with audio.

7.10 Valleywise Health will review and monitor LIP adverse events and complaints on a continuous ongoing basis in accordance with our Valleywise Health Medical Staff Peer Review Policy.

7.11 Valleywise Health Medical Staff Services will conduct a review of the CMS Preclusion List, as provided by the health plan, on a monthly basis, at time of initial credentialing, and recredentialing/reappointment. If a practitioner/applicant is confirmed to be on the Preclusion List, Valleywise Health will terminate its agreement with the practitioner and provide a notification letter to the practitioner/applicant of said termination. Also, Valleywise Health will provide notification to the health plan (MCO).

SECTION EIGHT – CREDENTIALING SYSTEM CONTROLS

8.1 **Primary Source Verification Information:** Credentialing information, including application, supporting documents, and primary source verification (PSV) of license, DEA, board certification, education/training, and professional liability claims are obtained/received from the applicant or appropriate verification entity via mail, email, electronic/online portal. When PSV is printed/received and is not automatically date stamped, the MSS professional (as defined under policy definitions) manually date stamps and initials the document to indicate when it was printed/received. All PSV documents are kept in each applicant's individual credentialing file. All credentialing files are stored in a locked cabinet/office

accessible only by the MSS professional or electronically within the credentialing database.

8.2 Tracking Modifications: Any modification(s) made to a completed application, supporting documentation, or a PSV will be documented by completion of the Application / Primary Source Verification (PSV) Update form in its entirety, which includes the applicant's name, specialty, document to update, explanation of update, the name of the person providing the update, the date the update was obtained, and the name of the MSS professional who obtained the update. When email or fax confirmation is obtained from the applicant or applicable/primary source, the MSS professional will attach to the completed Application / Primary Source Verification (PSV) Update form.

a. Inappropriate Modification: Altering any information on the application, and/or supporting documentation without providing an explanation/reason for the modification will be documented on the corresponding Valleywise Health Application Modification form. Examples of inappropriate modifications to credentialing information include but are not limited to:

- Altering credentialing approval dates
- Altering dates on verifications
- Whited out dates or signatures on hard copy documents
- Unauthorized deletion of provider files or documentation

b. Appropriate Modification: Making any modification on the application, and/or supporting documentation without providing an explanation/reason for the modification will be documented on the corresponding Valleywise Health Application Modification form. Examples of appropriate modifications to credentialing information include but are not limited to:

- Updates to expired licensure or other documents
- Changes/updates to education, training, or privileges
- To correct data entry errors
- Duplicate profiles
- Documents appended to incorrect provider profile

8.3 Authorization to Modify Information: Only authorized MSS professionals (i.e., Director, Manger, Medical Staff Coordinator) have the authority to access, modify, and/or delete information when circumstances for modification are appropriately

documented using the corresponding Valleywise Health Application Modification form.

8.4 Securing Information: All credentialing information is protected from unauthorized modification. The MSS professional maintains a database for all credentialed applicants that is password protected. Non-electronic credentialing information is stored in a locked cabinet/office accessible only by the MSS professional or electronically within the credentialing database.

8.5 Credentialing Process Audit: The credentialing processes in place by the organization are audited on an annual basis, at a minimum, by the Director of Medical Staff Services or designee. Credentialing files are randomly chosen and are reviewed to ensure PSV information was dated and initialed by the MSS professional, that any modified information on the credentialing application or PSV is appropriately documented, and that all information is secured in a locked cabinet/office. In addition, annual delegated credentialing audits are performed by the organization's delegated entities. The organization undergoes renewal of DNV accreditation on an annual basis wherein credentialing files are reviewed by a DNV surveyor, as well as operational site visits conducted by the Health Resources & Services Administration Health Center Program within their designated project/designation period.

a. ~~**a.**~~ Participating practitioners providing care in the FQHC clinic setting will be included in a report. The required 5% or 50 files, whichever is less, sampling methodology is based on the entire file universe of FQHC practitioners, not the credentialing cycle. The steps are as follows:

i. Determine FQHC file universe size – this includes all FQHC credential files with or without modifications and is not tied to a credential cycle.

ii. Determine sample size – this will be 5% or fifty (50) files (~~which ever~~whichever is less) as determined by the FQHC file universe size.

iii. Pull sample for auditing – this sample must include only files with modifications and include at least ten (10) initial credential files and ten (10) recredential files.

~~all modifiations within the system at any time during t~~The ~~look-back period~~ The audit will be conducted at least annually with a look-back period of the previous twelve (12) months.~~for the audit will be the previous twelve months and conducted during the designated frequency e.g., at least annually (modifications within 12 months)~~.

b. When an inappropriate modification has been identified, the responsible MSS professional will receive education/coaching to reiterate the correct modification procedure. Also, there will be a quarterly monitoring process implemented that will include both qualitative and quantitative analysis to assess the effectiveness of

actions on the findings identified. An action plan will be implemented to include monitoring of a minimum of five (5) credential files and corresponding documents for a minimum of three consecutive quarters.

SECTION NINE – CLINIC SITE VISITS

9.1 **Purpose**: To provide a mechanism for compliance with standards in regard to clinic site visits for Primary Care, Dental, Specialist, and Obstetrics/Gynecology providers related to clinic/practice site quality.

9.2 **Policy**: To ensure conformance with the standards of Valleywise Health, contracted managed care organizations, Det Norske Veritas ("DNV"), National Committee of Quality Assurance ("NCQA"), as well as Federal, State, and local regulatory requirements.

9.3 **Procedure:** In an effort to assess the quality, safety and accessibility of clinic sites where care is delivered, the Clinic Managers in collaboration with the Medical Staff Services Department will conduct the site review, forwarding the completed audit form to the Medical Staff Services Department for evaluation to determine whether additional action is required.

9.4 **Threshold:** A minimum score of 80% must be achieved to pass the review. If the clinic site fails to meet the threshold, an action plan will be requested addressing implementation for improvement. Deficient clinic sites will be re-reviewed at least every six (6) months until an acceptable score is achieved.

9.5 **Ongoing Review:** Complaints will continually be monitored by the clinic managers for all applicable clinic sites in accordance with this policy. A site visit will be conducted when two (2) complaints within a six (6) month period occur against one clinic site in any of the areas identified (i.e., physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and adequacy of treatment record keeping) and will be conducted within sixty (60) days of the second complaint received.

9.6 If acceptable to the health plan, contracted providers including licensed or certified behavioral health providers may be subject to an initial site visit as part of the credentialing process and/or a site review will be conducted for only new clinics or relocated clinic sites. Clinic site reviews will not be performed on established clinic sites/practices that are accredited by DNV, NCQA or any other recognized accrediting body. Appropriate documentation of accreditation will be maintained for those sites.

SECTION TEN – PRACTITIONER DIRECTORIES

10.1 The Valleywise Health Medical Staff Services Department will provide updated and corrected information within thirty (30) calendar days of receipt of updated or corrected information to all contracted health plans for use in practitioner directories.

References:

Valleywise Health Medical Staff Bylaws, Medical Staff Credentialing Policy, Advanced Practice Clinicians and Allied Health Professionals Policy, Practitioner Access to Credential Files, NCQA Standards CR 1- 12, Health Care Quality Improvement Act of 1986, HRSA-Health Center Program Compliance Manual (Chapter 5), AHCCCS Medical Policy Manual, Chapter 900.

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

POLICY RESPONSIBLE PARTY: Kristine Trulock, Director of Medical Staff Services
DEVELOPMENT TEAM(S): Credentialing Committee
Policy #:39026 T
Policy Title: Operational Credentialing Policy and Procedure

e-Signers:
Michael D. White, MD, MBA, EVP and Chief Clinical Officer

Place an X on the right side of applicable description:
New -
Retire - **Reviewed -X**

Revised with Minor Changes –

Revised with Major Changes -X

Please list revisions made below: (Other than grammatical changes or name and date changes) Updated the definitions and included language to align with regulatory requirements (i.e., NCQA).

List associated form(s): (If applicable)
Reviewed and Approved by in Addition to Responsible Party and E-Signer(s):
Committee: Credentials Committee
~~03/2023~~03/2024
Committee: Medical Executive Committee
~~03/2023~~03/2024
Reviewed for EPIC: 00/00
Other: Maricopa County Special Health Care District Board
~~03/2023~~03/2024
Other: 00/00
Other: 00/00

1.d.vi. Medical Staff - Nurse Practitioner Emergency Medicine Privileges and Practice Prerogatives

VALLEYWISE HEALTH
DEPARTMENT OF EMERGENCY MEDICINE
NURSE PRACTITIONER PRIVILEGES

_____
Name of Nurse Practitioner (Print)

To be eligible to apply for privileges as a Nurse Practitioner ("NP") in the Emergency Medicine Department, the applicant must currently possess Nurse Practitioner Core Privileges as a member of Valleywise Health Allied Health Professional ("AHP") Staff.

RESPONSIBLE PARTY:	Department Chair, or his/her designee
DEFINITION:	A Registered Nurse Practitioner (RNP) is an advanced practice nurse who provides primary health care and specialized health services to individuals and families. The Nurse Practitioner is employed or contracted to provide services to inpatients and outpatients in Valleywise Health. Collaboration – Means to establish a relationship for consultation or referral with one (1) or more physicians who have active, unrestricted licenses.
PRACTICE PREROGATIVES:	• Shall practice within his/her scope of practice, training and experience to independently assess, diagnose, plan, and treat illnesses by using and adhering to departmental protocols governing patient management, in accordance with Arizona Nursing Board, Arizona Statutes and Arizona Administrative Code. • Shall practice in collaboration with an Attending Physician who has unrestricted privileges and medical staff membership in good standing at Valleywise Health and seek appropriate consultation when necessary. • Shall participate in quality assurance review on a periodic basis, including systematic review of records and treatment plans • Shall make appropriate referrals to other health professionals and community agencies. • Shall participate in CME and other Department educational conferences. • Shall participate in discharge planning. • May write admitting orders on behalf of a member of the Valleywise Health Medical Staff to initiate a patient's entry into a Valleywise Health inpatient facility. • May prescribe and dispense medications within guidelines approved by the Arizona State Board of Nursing and the Drug Enforcement Administration and Arizona State Board of Pharmacy. • May assist in research activities within their respective Valleywise Health Department. • May not write orders relating to the patient's resuscitation status. • May not have on the job training to enhance their competencies**;** but may enhance their competencies by learning additional skills/procedures within their scope of practice through additional didactic education and supervised clinical practice (achieved through clinical experience in a formalized education/training program) as specified in the Arizona Administrative Code (A.A.C.-Chapter 19-Arizona State Board of Nursing).

Maricopa County Special Health Care District Board approval: 10/26/2016, 04/2017, 11/2017, 08/2018, 4/2019, 01/2020, 06/2020, 03/2024

DEPARTMENT OF EMERGENCY MEDICINE
NURSE PRACTITIONER PRIVILEGES

INITIAL APPLICANTS

To be eligible to apply for privileges as a NP in Emergency Medicine Department, the applicant must meet the following criteria:

- Completion of a master's, post-master's, or doctorate from a nurse practitioner program accredited by the Commission on the Collegiate of Nursing Education or the National League for Nursing Accrediting Commission with emphasis on the NP's specialty area.; **AND**
- Current certification by the American Nurses Credentialing Center, the American Academy of Nurse Practitioners or an equivalent body as determined by the Rules of the Arizona State Board of Nursing.
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in the state of Arizona (As per the Arizona State Board of Nursing, national certification prior to July 1, 2004 was not requirement for licensure); **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws, **AND**
- ACLS, PALS, and ATLS certifications

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Minimum of five (5) cases shall be reviewed in accordance with the Valleywise Health Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) to include evaluation of chief complaint; history & physical; use of ancillary services; appropriateness of diagnosis; and discharge/instruction.

EMERGENCY MEDICINE - NURSE PRACTITIONER CORE PRIVILEGES

Assess, evaluate, diagnose, and treat patients who present in the ED with any symptom, illness, injury, or condition, and provide services necessary to ameliorate minor illnesses or injuries (within their scope of practice). Stabilize patients with major illnesses or injuries and assess patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an inpatient basis. Nurse practitioners may write orders that include ongoing orders, discharge orders and admission orders on behalf of a member of the Valleywise Health Medical Staff. The core privileges in this specialty include the procedures on the Nurse Practitioner Core Privileges and such other procedures that are extensions of the same techniques and skills. Where appropriate, procedures may be performed with, or without ultrasound guidance.

CORE PRIVILEGES	Requested		Approved	Not Approved	Comment
Perform history and physical examination*					
Order and interpret laboratory studies. Order and perform preliminary interpretations of simple plain x-ray films with second reading by supervising physician (or radiologist) and apply results. Order and perform other diagnostic tests.					
Identify, develop, implement and evaluate a plan of care for a patient to promote, maintain, and restore health					
Manage ED Observation Patients: Familiarity with the rapid assessment, decision making, treatment, consultation from specialty services, and disposition of adult patients meeting adult observation status criteria					
Prescriptive Privileges for prescription of non-controlled substances and devices within scope of specialty practice (Prescribing & Dispensing Authority required)					
Prescriptive Privileges for schedule II, III, IV or V controlled substances within the confines of the Arizona statutes (DEA registration required)					
Oral and nasal airway placement					
CPR					
Defibrillation/Cardioversion					
Venipuncture/cannulation & Arterial puncture/cannulation					
Pelvic Examinations					
Bladder catheterization					
Slit Lamp Exam, Tonometry					
Reduction of joint dislocation - Finger(s)					
Local/digital anesthesia					
Splinting & immobilization techniques					
I & D abscess					
Foreign body removal (soft tissue, nose, ear, eye, rectum, and vagina)					

Maricopa County Special Health Care District Board approval: 10/26/2016, 04/2017, 11/2017, 08/2018, 4/2019, 01/2020, 06/2020, 03/2024

*Emergency Medicine history and physical examination are the responsibility of and require review and countersignature by a member of the Valleywise Health Medical Staff.

EMERGENCY MEDICINE - NURSE PRACTITIONER CORE PRIVILEGES - CONTINUED

CORE PRIVILEGES -continued	Requested		Approved	Not Approved	Comment
Superficial foreign body removal from cornea					
Treatment of anterior epistaxis					
Re-implantation of avulsed teeth					
Replacement of percutaneous feeding tube					
Intra-osseous Needle Device: Placement, medication administration, removal					
Wound repair (suturing/wound glue/staples) – Repair/Removal					

*Emergency Medicine history and physical examination are the responsibility of and require review and countersignature by a member of the Valleywise Health Medical Staff.

REAPPOINTMENT REQUIREMENTS

To be eligible to renew core privileges as a NP in Emergency Medicine, the applicant must meet the following criteria:

- An adequate volume of experience with acceptable results for the past 24 months and demonstrated current competence based on results of ongoing professional practice evaluation and outcomes. Experience must correlate to the privileges requested. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges; **AND**
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in the state of Arizona, **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws, **AND**
- ACLS, PALS, and ATLS certifications

EMERGENCY MEDICINE NURSE PRACTITIONER ADVANCED PRIVILEGES (see specific criteria)

Noncore privileges are requested individually in addition to requesting the core. Each individual requesting advanced privileges must meet the specific threshold criteria as applicable to the initial applicant or re-applicant. Each time a new privilege is requested, it may be requested by the Nurse Practitioner and recommended by the collaborating physician and forwarded to the Valleywise Health Medical Staff Office to be approved and appended to the advanced list of privileges. Where appropriate, procedures may be performed with, or without ultrasound guidance.

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Minimum of two (2) cases shall be reviewed in accordance with the Valleywise Health Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) for each like/same scope of practice advanced procedure/privilege requested.

Emergency Medicine Advanced Privileges – The applicant must provide written documentation of current competence (as noted below) for all procedures requested:

a) **Recent graduate (within the past two years)** – A list of requested procedures performed within the educational program, signed by a representative of the program, attesting to competence.

b) **All Others** – The applicant must provide written documentation of completion of an approved, accredited training course for advanced procedures to include didactic and hands on skills training within the previous two (2) years **AND** Performance of the requisite number of procedures described below for the initial appointment within the previous two (2) years.

OR

The applicant may provide documentation of current credentialing for the requested advanced procedure(s) **AND** Documentation of performance of the requisite number of procedures below for reappointment within the previous two (2) years.

VALLEYWISE HEALTH
DEPARTMENT OF EMERGENCY MEDICINE
NURSE PRACTITIONER
ADVANCED PRIVILEGES

ADVANCED PRIVILEGES	Requested		Initial Appointment	Reappointment	Approved	Not Approved	Comment
Orotracheal intubation			10	2			1
Central venous access			10	2			2
Reduction of joint dislocation – Shoulder*			5	1			2
Reduction of joint dislocation – Hip*			5	1			2
Lumbar puncture**			10	2			2
Arthrocentesis**			5	1			2
Thoracentesis**			5	1			1
Paracentesis**			10	2			2
Procedural Sedation (*1- Under Personal Supervision only (A physician must be in the room during the performance of procedural sedation.) 1. Initial Request: Must have completed a Valleywise Health approved training course (APEX documentation required) and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 2. Maintenance of privilege: Maintain ACLS certification and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 3. The APEX training course can be found at http://apex.valleywisehealth.org			10	2			1

*Like/same scope of practice for reduction procedures. **Like/same scope of practice for needle guided procedures.

Comments:
1) Under Personal Supervision only (A physician must be in the room during the performance of the procedures.)
2) Must consult with attending physician prior to procedure

Acknowledgement of Applicant

I have requested only those practice prerogatives for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Valleywise Health, and I understand that:

a. In exercising any practice prerogatives granted, I am constrained by Hospital and Medical Staff/Allied Health Professional Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the practice prerogatives granted to me is waived in an emergent situation and in such situation; my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

Applicant

1.d.vii. Medical Staff - Physician Assistant Emergency Medicine Privileges and Practice Prerogatives

VALLEYWISE HEALTH
DEPARTMENT OF EMERGENCY MEDICINE
Physician Assistant Privileges

_____
Name of Physician Assistant (Print)

To be eligible to apply for privileges as a Physician Assistant in the Emergency Medicine Department, the applicant must meet Valleywise Health Allied Health Professional (AHP) Staff membership requirements as outlined in the AHP Manual and the following privileging criteria:

RESPONSIBLE PARTY:	Department Chair/designee, or Sponsorship by physician(s) who is/are member(s) in good standing of Valleywise Health.
DEFINITION:	Physician Assistants provide medical care under the guidance of a physician supervisor at the Valleywise Comprehensive Health Centers, Valleywise Community Centers, other Valleywise Health owned or operated ambulatory settings, Valleywise Health Medical Center and Valleywise Emergency -Phoenix and Maryvale.
SUPERVISION:	Under direction and supervision of a sponsoring physician, in accordance with Arizona statutes and regulations. Direct Supervision: Physician on site that can intervene when necessary.

PRACTICE PREROGATIVES:

- Shall be members of the Allied Health Professional staff assigned to a Clinical Department.
- Shall provide inpatient and/or outpatient medical care to patients, in accordance with Arizona statutes, rules and regulations, and guidelines.
- Shall triage patients as well as assist nursing staff in triage.
- Shall maintain accurate, complete and legible patient records.
- Shall monitor the effectiveness of therapeutic interventions.
- Shall initiate emergency care when needed.
- Shall advise families and patients regarding types of services available and provide counseling for general health problems.
- Shall participate in the Department's peer review and QI processes.
- May prescribe medications in accordance with the rules and regulations of the Arizona Board of Medical Examiners, the Arizona State Board of Pharmacy and the Drug Enforcement Administration.
- Shall agree to abide by applicable policies and procedures established by the Medical Staff and Valleywise Health
- May participate on various committees within Valleywise Health or as designated by the Department Chairman.
- May perform invasive procedures as delineated by the applicable clinical department based on demonstrated clinical competence and training and delegated by supervising physician.

INITIAL APPLICANTS

To be eligible to apply for privileges as a Physician Assistant in Emergency Medicine, the applicant must meet the following criteria:

- Graduate of an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)-approved program (prior to January 2001, completion of a Commission on Accreditation of Allied Health Education Programs-approved program); AND
- Current Arizona license issued by the State of Arizona's Joint Board on the Regulation of Physician Assistants; AND Drug Enforcement Administration (DEA) Certification, if applicable; **AND**
- Current National Certification (NCCPA) re-registration and re-certification required as specified by the National Commission on Certification of Physicians Assistants *(For those Physicians Assistants practicing at VALLEYWISE HEALTH prior to May 2001, current NCCPA certification is preferred, but not a condition for appointment to the AHP staff. Any non-certified Physician Assistant "grandfathered-in" will be required to attain certification in the ensuing two-year period.);* Current active licensure to practice as physician assistant in the state of Arizona; **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the VALLEYWISE HEALTH Allied Health Professionals Policy/Medical Staff Bylaws; **AND**
- ACLS, PALS, and ATLS certifications

Maricopa County Special Health Care District Board approval: 10/26/2016, 04/26/2017, 11/2017, 8/2018, 01/2020, 06/2020, 03/2024

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Minimum of five (5) cases shall be reviewed in accordance with the Valleywise Health Medical Staff Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) to include evaluation of chief complaint; history & physical; use of ancillary services; appropriateness of diagnosis; and discharge/instruction.

EMERGENCY MEDICINE – PHYSICIAN ASSISTANT CORE PRIVILEGES

Assess, evaluate, diagnose, and treat patients who present in the ED with any symptom, illness, injury, or condition, and provide services necessary to ameliorate minor illnesses or injuries. Stabilize patients with major illnesses or injuries and assess patients to determine if additional care is necessary. Privileges do not include long-term care of patients on an inpatient basis. Physician assistants may write orders that include ongoing orders, discharge orders and admission orders. The core privileges in this specialty include the procedures on the Physician Assistant Core Privileges and such other procedures that are extensions of the same techniques and skills. Where appropriate, procedures may be performed with, or without ultrasound guidance.

CORE PRIVILEGES	Requested		Approved	Not Approved	Comment
Perform history and physical examination*					
Order and interpret laboratory studies. Order and perform preliminary interpretations of simple plain x-ray films with second reading by supervising physician (or radiologist) and apply results. Order and perform other diagnostic tests.					
Identify, develop, implement and evaluate a plan of care for the patient to promote, maintain and restore health under appropriate physician supervision					
Prescriptive Privileges for Prescription of non-controlled substances And devices, within the scope of practice (Prescribing and Dispensing Authority required)					
Prescribe privileges for schedule II, III, IV, or V controlled substances, Within the confines of the Arizona statutes (DEA registration required)					
Oral and nasal airway placement					
Manage ED Observation Patients: Familiarity with the rapid assessment, decision making, treatment, consultation from specialty services, and disposition of adult patients meeting adult observation status criteria.					
CPR					
Defibrillation/Cardioversion					
Venipuncture/cannulation & Arterial puncture/cannulation					
Pelvic Examinations					
Bladder catherization					
Slit lamp exam/Tonometry					
Reduction of join dislocation - Finger					
Local/digital anesthesia					
Splinting & Immobilization techniques					
I & D Abscess					
Foreign body removal (soft tissue, nose, ear, eye, rectum, vagina)					
Treatment of anterior epistaxis					
Re-implantation of avulsed teeth					
Replacement of percutaneous feeding tube					
Intra-osseous Needle Device: Placement, medication administration, removal					
Wound repair (suturing/stapling/glue) – Repair/removal					

*Emergency Medicine history and physical examination are the responsibility of and require review and countersignature by a member of the VALLEYWISE HEALTH Medical Staff.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges as a Physician Assistant in Emergency Medicine, the applicant must meet the following criteria:

- An adequate volume of experience with acceptable results for the past 24 months and demonstrated current competence based on results of ongoing professional practice evaluation and outcomes. Experience must correlate to the privileges requested. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges, **AND**
- Current active licensure to practice as a physician assistant in the state of Arizona, **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws, **AND**
- ACLS, PALS, and ATLS certifications

ADVANCED PRIVILEGES (see specific criteria)

Noncore privileges are requested individually in addition to requesting the core. Each individual requesting advanced privileges must meet the specific threshold criteria as applicable to the initial applicant or re-applicant. Each time a new privilege is requested, it may be requested by the physician assistant and recommended by the supervising physician and forwarded to the Valleywise Health Medical Staff Office to be approved and appended to the advanced list of privileges. Where appropriate, procedures may be performed with, or without ultrasound guidance.

FOCUSED PROFESSIONAL PRACTICE EVALUATION

Minimum of two (2) cases shall be reviewed in accordance with the Valleywise Health Medical Staff Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) for each like/same scope of practice advanced procedure/privilege requested.

Advanced Privileges – The applicant must provide written documentation of current competence (as noted below) for all procedures requested (procedures will require supervision as described below):

a) **Recent graduate (within the past two years)** – A list of requested procedures performed within the educational program, signed by a representative of the program, attesting to competence.

b) **All Others** – The applicant must provide documented completion of an approved training course for advanced procedures to include didactic and hands on skills training within the previous two (2) years **AND** Performance of the requisite number of procedures described below for the initial appointment within the previous two (2) years; **OR**

The applicant may provide documentation of current credentialing for the requested advanced procedure AND Performance of the requisite number of procedures described below for reappointment within the previous two (2) years; **OR**

A signed statement from a supervising physician confirming that he/she has personally observed that the applicant has successfully performed the requisite number of procedures described below AND that he/she can attest to his/her competence.

c) **If none of the above requirements can be met**, the applicant may request temporary approval to perform the procedure(s) under personal supervision until such time as the above noted attestation can be submitted OR successful completion of the requisite number of procedures described below. This request must be co-signed by the collaborating physician.

ADVANCED PRIVILEGES	Requested		Initial Appointment	Reappointment	Approved	Not Approved	Comment
Orotracheal intubation			10	2			1
Central venous access			10	2			2
Reduction of joint dislocation – Shoulder*			5	1			2
Reduction of joint dislocation – Hip*			5	1			2
Lumbar puncture**			10	2			2
Arthrocentesis**			5	1			2
Thoracentesis**			5	1			1
Paracentesis**			10	2			2

Maricopa County Special Health Care District Board approval: 10/26/2016, 04/26/2017, 11/2017, 8/2018, 01/2020, 06/2020, 03/2024

ADVANCED PRIVILEGES	Requested		Initial Appointment	Reappointment	Approved	Not Approved	Comment
Procedural Sedation (*1- Under Personal Supervision only (A physician must be in the room during the performance of procedural sedation.) 1. Initial Request: Must have completed a VALLEYWISE HEALTH approved training course (APEX documentation required) and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 2. Maintenance of privilege: Maintain ACLS certification and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 3. The APEX training course can be found at http://apex.Valleywise Health.org			10	2			1

*****Like/same scope of practice for reduction procedures. ******Like/same scope of practice for needle guided procedures.

Comments:
1) Under Personal Supervision only (A physician must be in the room during the performance of the procedures.)
2) Must consult with attending physician prior to procedure

Acknowledgement of Applicant

I have requested only those practice prerogatives for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Valleywise Health, and I understand that:

a. In exercising any practice prerogatives granted, I am constrained by Hospital and Medical Staff/Allied Health Professional Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the practice prerogatives granted to me is waived in an emergent situation and in such situation; my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed:_____ ***Date***_____

Applicant

SPONSORING/SUPERVISING PHYSICIAN

As sponsoring/supervising physician of the applicant, I understand it is my responsibility to ensure the applicant abides by the Medical Staff Bylaws, Rules & Regulations, Department Rules & Regulations, any policies and procedures established by the Valleywise Health, and practices within the scope of his/her license/certification/registration and practice prerogatives. Furthermore, I understand that it is my responsibility to provide support, supervision, and oversight as may be required, depending on the skills of the Physician's Assistant and the patient population being treated.

_____ _____ _____

Signature of Sponsoring Physician Sponsoring Physician Specialty Date

Maricopa County Special Health Care District Board approval: 10/26/2016, 04/26/2017, 11/2017, 8/2018, 01/2020, 06/2020, 03/2024

1.d.viii. Medical Staff - Nurse Practitioner Surgery Privileges and Practice Prerogatives

DEPARTMENT OF SURGERY
NURSE PRACTITIONER GENERAL SURGERY /TRAUMA SURGERY PRIVILEGES

_____
Name of Nurse Practitioner (Print)

To be eligible to apply for privileges in the Department of Surgery, the applicant must meet Valleywise Health Allied Health Professional (AHP) Staff membership requirements as outlined in the AHP Manual and the following privileging criteria:

RESPONSIBLE PARTY: Department Chair, or his/her designee

DEFINITION: A Registered Nurse Practitioner (RNP), a Category II Practitioner, is an advanced practice nurse who provides primary health care and specialized health services to individuals and families. The Nurse Practitioner is employed or contracted to provide services to inpatients and outpatients within Valleywise Health.

"COLLABORATION" means the collaboration with (or supervision of) a Category II practitioner by a Collaborating Physician, that may or may not require the actual presence of the Collaborating Physician, but that does require, at a minimum, that the Collaborating Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II practitioner is credentialed.

"SUPERVISION" means under the general supervision of an attending physician unless otherwise instructed.

PREROGATIVES:

- Shall practice within his/her scope of practice, training and experience to independently assess, diagnose, plan, and treat illnesses by using and adhering to departmental protocols governing patient management, in accordance with Arizona Nursing Board, Arizona Statutes and Arizona Administrative Code.
- Shall practice in collaboration with an Attending Physician who has unrestricted critical care privileges and medical staff membership in good standing at Valleywise Health and seek appropriate consultation when necessary.
- Shall participate in quality assurance review on a periodic basis, including systematic review of records and treatment plans
- Shall make appropriate referrals to other health professionals and community agencies.
- Shall participate in CME and other Department educational conferences.
- May write admitting orders on behalf of a critical care attending physician to initiate a patient's entry into a Valleywise Health inpatient facility. All admitting orders must be authenticated by the designated critical care attending physician.
- May prescribe and dispense medications within guidelines approved by the Arizona State Board of Nursing and the Drug Enforcement Administration and Arizona State Board of Pharmacy.
- May assist in research activities within their respective Valleywise Health Department.
- May write 'Do Not Resuscitate or Discontinue Life Support' orders after goals of care discussion with patient and/or patient's medical decision making surrogate and critical care attending physician.
- May not have on the job training to enhance their competencies; **but** may enhance their competencies by learning additional skills/procedures within their scope of practice through additional didactic education and supervised clinical practice (achieved through clinical experience in a formalized education/training program) as specified in the Arizona Administrative Code (A.A.C.-Chapter 19-Arizona State Board of Nursing).

VALLEYWISE HEALTH
NURSE PRACTITIONER – GENERAL SURGERY /TRAUMA SURGERY PRIVILEGES

INITIAL APPLICANTS

To be eligible to apply for privileges as a NP in Surgery Department, the applicant must meet the following criteria:

- Completion of a master's, post-master's, or doctorate from a nurse practitioner program accredited by the Commission on the Collegiate of Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC) with emphasis on the NP's specialty area (specifically satisfy the qualification requirements for acute care nurse practitioner); **AND**
- Current certification by the American Nurses Credentialing Center, the American Academy of Nurse Practitioners or an equivalent body as determined by the Rules of the Arizona State Board of Nursing.
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in the state of Arizona (As per the Arizona State Board of Nursing, national certification prior to July 1, 2004 was not requirement for licensure); **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws, **AND**
- Demonstrate Current Clinical Activity: Applicants for initial appointment must be able to demonstrate provision of care, treatment, and services reflective of the scope of privileges requested for at least **50 patients** during the past 12 months in a setting similar in scope and complexity to Valleywise Health; or demonstrate successful completion of an accredited college or university formal masters program or a post-masters program in nursing with a concentration in an advanced practice registered nursing category and specialty (as defined under R4-19-501 of the "Rules of the State Board of Nursing") within the past 12 months.
- Hold current Advanced Life Support (ACLS) and Advanced Trauma Life Support (ATLS) certifications (ATLS required if requesting/maintaining Advanced Non-Core Surgical Privileges as pertaining to treating Trauma/Burn patients)
-

FOCUSED PROFESSIONAL PRACTICE EVALUATION: Minimum of 5 representative cases shall be reviewed (additional records may be reviewed to assess the scope of practice has been covered) and completed in accordance with the Valleywise Health Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy.

FOCUSED PROFESSIONAL PRACTICE EVALUATION FOR NON-CORE SPECIAL PROCEDURS: Retrospective review of a minimum of two (2) cases (additional records may be reviewed to assess the scope of practice has been covered) in accordance with the Valleywise Health Initial Evaluation to Confirm Practititioner Competence Policy and Procedure.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew core privileges as a surgical NP, the applicant must meet the following criteria:

- Current demonstrated competence and current experience with acceptable results for thirty (30) patients reflective of the scope of privileges requested for the past 24 months as a result of ongoing professional practice evaluation activities and outcomes; **AND**
- Current active licensure to practice as an advanced practice registered nurse in the practitioner category in the state of Arizona, **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws, **AND**
- Hold current Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) certifications (ATLS required if requesting/maintaining Advanced Non-Core Surgical Privileges as pertaining to treating Trauma/Burn patients)

SURGICAL CLINCAL CORE PRIVILEGES

Evaluate, diagnose, and provide pre-, intra- and postoperative care, treatment, and services consistent with surgical practice, including the performance of physical exams, diagnosing conditions, the development of treatment plans, health counseling, prescribing medications, and assisting in surgery for patients within the age group of patients seen by the collaborating/supervising physician. NPs may not admit patients to the hospital. May provide care to patients in the surgical intensive care setting in conformance with unit policies. The core privileges in this specialty include the procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills. Where appropriate, procedures may be performed with, or without ultrasound guidance. ***If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.***

VALLEYWISE HEALTH
NURSE PRACTITIONER – GENERAL SURGERY /TRAUMA SURGERY PRIVILEGES

SURGICAL CLINICAL CORE PRIVILEGES	Requested		Approved	Not Approved	Comment
1. Perform history and physical examination*					
2. Order and interpret laboratory studies. Order and perform preliminary interpretations of simple plain x-ray films with second reading by supervising physician (or radiologist) and apply results. Order and perform other diagnostic tests.					
3. Develop, implement and evaluate a plan of care for a patient to promote, maintain, and restore health					
4. Perform rectal and pelvic examinations as indicated *					
5. Perform superficial wound irrigation and wound debridement					
6. Suturing surgical incisions and lacerations, and general care for superficial wounds and minor superficial surgical procedures					
7. Perform incision and drainage of superficial abscesses					
8. Removal of superficial foreign bodies, percutaneous surgical hardware					
9. Removal of drains					
10. Removal of sutures					
11. Perform field infiltrations of anesthetic solutions					
12. Insertion and removal of packing					
13. Discontinuation of chest tube					
14. Insert and remove nasogastric tubes					
15. Provide hemostatis					
16. Splinting/casting of extremities					
17. Removal and/or biopsy of external superficial skin subcutaneous lesions					
18. Select and apply appropriate wound dressings, including liquid or spray occlusive materials, absorbent material affixed with tape or circumferential wrapping, immobilizing dressing (soft or rigid), or medicated dressings; use of liquid nitrogen; cryotherapy					
19. Write admitting orders on behalf of a member of the Medical Staff to initiate a patient's entry into a Valleywise Health inpatient facility. Obtain and record medical/social history and perform physical examinations including rectal and pelvic examinations as indicated					
20. Prescriptive Privileges for non-controlled substances and devices with scope of specialty practice (Prescribing & Dispensing Authority required)					
21. Prescriptive Privileges for controlled substances (DEA registrati required)					

*History and physical examination for surgical inpatient and procedures, or surgery that require anesthesia or procedural sedation are the responsibility of and **require** review and countersignature by a member of the Valleywise Health Medical Staff.

Special Non-Core Privileges

FIRST SURGICAL ASSIST PRIVILEGES	Requested		Approved	Not Approved	Comment
Includes: Assist in surgery to include, but not limited to, first assist, deep and simplified tissue closures, application of appliances, perform incision and drainage of deep abscesses (supervising physician immediately available in the operating suite). ***Required education and experience***: Applicant must qualify for Nurse Practitioner surgical core privileges and have successfully completed an accredited "registered nurse first assistant" training course and have demonstrated current competence and evidence of the performance of at least 15 procedures in the past 12 months, or personal supervision of the first 15 procedures. **Focused Professional Practice Evaluation** for Non-Core Special Procedures – Refer to Page 2: ~~Retrospective review of a minimum of two (2) cases in accordance with the Valleywise Health Initial Evaluation to Confirm Practitioner Competence Policy and Procedure.~~ **Reappointment Criteria:** Demonstrated current competence and the performance of at least 15 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.]					

ADVANCED SKIN GRAFTING PRIVILEGES	Requested		Approved	Not Approved	Comment
Includes: Harvesting, grafting and debridement/excision and coverage using various biological/artificial materials of burn and/or complex wounds (supervising physician immediately available in the operating suite). ***Required education and experience***: Applicant must qualify for Nurse Practitioner surgical core and first assist privileges and have successfully completed an accredited "registered nurse first assistant" training course; a minumum of 1 year's experience of practice in Burn Care; and personal supervision is required for the first 30 procedures. **Focused Professional Practice Evaluation:** Retrospective review of a minimum of two (2) cases in accordance with the Valleywise Health Professional Practice Evaluation Policy. **Reappointment Criteria:** Demonstrated current competence and the performance of at least 15 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.]					

High Resolution Anoscopy (HRA) with biopsies, infrared coagulation and hyfrecation treatment	Requested		Approved	Not Approved	Comment
Required education and experience: Applicants must have documentation of completion of training for high resolution anoscocpy with biopsies, infrared coagulation and hyfrecation during an accredited residency training, OR ASCCCP official continuing medical education course with practicum; **AND** ♦ Demonstrated current competence and evidence of performance of at least five (5) anosocopies with biopsies, 3 IRC treatments and 3 hyfrecation treatments in the past 12 months with acceptable results. Focused Professional Practice Evaluation for Non-Core Spec Procedures – Refer to Page 2: ~~**Retrospective review of minimum of two (2) cases in accordance with the Valleywi Health Professional Practice Evaluation Policy.**~~ **Reappointment Criteria:** Demonstrated current competence and the performance of at least ten (10) in the past 24 months based on results ongoing professional practice evaluation and outcomes.					

VALLEYWISE HEALTH
NURSE PRACTITIONER – GENERAL SURGERY /TRAUMA SURGERY PRIVILEGES

Special Non-Core Privileges

ADVANCED SURGICAL CLINICAL PRIVILEGES	Requested		Approved	Not Approved	Comment
1. Saphenous / Internal Mammary/ Radial Artery Vein Harvest Nurse Practitioner's may request to perform Saphenous / Internal Mammary / Radial Artery Vein Harvesting if the following conditions are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) harvests, **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience in vein harvesting with submission of documentation of having performed ten (10) harvests.					
2. Placement of Thoracostomy Tube** (see below criteria)					
3. Insertion of Arterial / Central Venous / Swan-Ganz Catheter** (see below criteria) **(Only performed on patients older than 14 years of age)**					
4. Sternotomy** (see below criteria)					
5. Sternal Closure** (see below criteria)					
6. Thoracentesis** (see below criteria)					
** Nurse Practitioner's may request to perform Placement of Thoracostomy Tube, Insertion of Arterial / Central Venous / Swan-Ganz Catheter, Sternotomy, Sternal Closure, and Thoracentesis if the following conditions are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience with submission of documentation of having performed ten (10) procedures (for each procedure requested). **Focused Professional Practice Evaluation for Non-Core Special Procedures – Refer to Page 2:** ~~Minimum of two (2) representative cases for each procedure requested shall be reviewed (additional records may be reviewed to assess the scope of practice has been covered) and completed in accordance with the Valleywise Health Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy.~~ **Reappointment Criteria:** Demonstrated current competence and the performance of at least ten (10) in the past 24 months based on results of ongoing professional practice evaluation and outcomes.					
Procedural Sedation (*1- Under Personal Supervision only (A physician must be in the room during the performance of procedural sedation.) 1. Initial Request: Must have completed a Valleywise Health approved training course (APEX documentation required) and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 2. Maintenance of privilege: Maintain ACLS certification and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 3. The APEX training course can be found at http://apex.valleywisehealth.org **Focused Professional Practice Evaluation for Non-Core Special Procedures – Refer to Page 2** **Reappointment Criteria:** Demonstrated current competence and the performance of at least ten (10) in the past 24 months based on results of **ongoing professional practice evaluation and outcomes.**					#1

***Comments:**
1) Under Personal Supervision only (A physician must be in the room during the performance of the procedures.)
2) Must consult with attending physician prior to procedure
3) General Supervision

Acknowledgement of Applicant

I have requested only those clinical privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at [hospital name], and I understand that:

a. In exercising any clinical privileges granted and in carrying out the responsibilities assigned to me, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the policies governing privileged allied health professionals.

Signed_____ ***Date***_____

Applicant

1.d.ix. Medical Staff - Physician Assistant Surgery Privileges and Practice Prerogatives

DEPARTMENT OF SURGERY
PHYSICIAN ASSISTANT SURGERY/TRAUMA-BURN PRIVILEGES AND PRACTICE PREROGATIVES

_____
Name of Physician Assistant (Print)

To be eligible to apply for core privileges in General Surgery, the applicant must meet Valleywise Health Allied Health Professional (AHP) Staff membership requirements as outlined in the AHP Manual and the following privileging criteria:

RESPONSIBLE PARTY:	Department Chair/designee, or Sponsorship by physician(s) who is/are member(s) in good standing of Valleywise Health.
DEFINITION:	Physician Assistant, a Category II practitioner, provides medical care under the guidance of a physician supervisor at the Valleywise Community Health Centers, Valleywise Comprehensive Health Centers, other Valleywise Health owned or operated ambulatory settings, and Valleywise Health Medical Center.
SUPERVISION:	Under direction and supervision of a sponsoring physician, in accordance with Arizona statutes and regulations. Direct Supervision: Physician on site that can intervene when necessary.

PRACTICE PREROGATIVES:

- Shall be members of the Allied Health Professional staff assigned to a Clinical Department.
- Shall provide inpatient and/or outpatient medical care to patients, in accordance with Arizona statutes, rules and regulations, and guidelines.
- Shall triage patients as well as assist nursing staff in triage.
- Shall maintain accurate, complete and legible patient records.
- Shall monitor the effectiveness of therapeutic interventions.
- Shall initiate emergency care when needed.
- Shall advise families and patients regarding types of services available and provide counseling in relation to care provided.
- Shall participate in the Department's peer review and QI processes.
- May prescribe medications in accordance with the rules and regulations of the Arizona Board of Medical Examiners, the Arizona State Board of Pharmacy and the Drug Enforcement Administration.
- Shall agree to abide by applicable policies and procedures established by the Medical Staff and Valleywise Health.
- May participate on various committees within Valleywise Health or as designated by the Department Chairman.
- May perform invasive procedures as delineated by the applicable clinical department based on demonstrated clinical competence and training and delegated by supervising physician.

INITIAL APPLICANTS

To be eligible to apply for privileges as a Physician Assistant in the Department of Surgery the applicant must meet the following criteria:

- Graduate of an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)-approved program (prior to January 2001, completion of a Commission on Accreditation of Allied Health Education Programs-approved program); AND
- Current Arizona license issued by the State of Arizona's Joint Board on the Regulation of Physician Assistants; AND Drug Enforcement Administration (DEA) Certification, if applicable; **AND**
- Current National Certification (NCCPA) re-registration and re-certification required as specified by the National Commission on Certification of Physicians Assistants *(For those Physicians Assistants practicing at Valleywise Health prior to May 2001, current NCCPA certification is preferred, but not a condition for appointment to the AHP staff. Any non-certified Physician Assistant "grandfathered-in" will be required to attain certification in the ensuing two-year period.);* Current active licensure to practice as physician assistant in the state of Arizona; **AND**
- Professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Valleywise Health Allied Health Professionals Policy/Medical Staff Bylaws.
- Demonstrate Current Clinical Activity: Applicants for initial appointment must be able to demonstrate provision of care, treatment, and services reflective of the scope of privileges requested for at least **50 patients** during the past 12 months in a setting similar in scope and complexity to Valleywise Health; or demonstrate successful completion from an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA)-approved program (prior to January 2001, completion of a Commission on Accreditation of Allied Health Education Programs-approved program).
- Hold current Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Support (ATLS) certifications (ATLS required if requesting/maintaining Advanced Non-Core Burn/Trauma Privileges)

Maricopa County Special Health Care District Board approval: 05/2018, 04/2021, 11/2021, 3/2022, 08/2022, 03/2024

DEPARTMENT OF SURGERY
PHYSICIAN ASSISTANT SURGERY/TRAUMA-BURN PRIVILEGES AND PRACTICE PREROGATIVES

FOCUSED PROFESSIONAL PRACTICE EVALUATION
Minimum of five (5) cases shall be reviewed in accordance with the Valleywise Health Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) to include evaluation of chief complaint; history & physical; use of ancillary services; appropriateness of diagnosis; and discharge/instruction.

SURGICAL CLINICAL – PHYSICIAN ASSISTANT CORE PRIVILEGES
Evaluate, diagnose, and provide pre-, intra- and postoperative care, treatment, and services consistent with surgical practice, including the performance of physical exams, diagnosing conditions, the development of treatment plans, health counseling, prescribing medications, and assisting in surgery for patients within the age group of patients seen by the collaborating/supervising physician. PAs may not admit patients to the hospital. May provide care to patients in the surgical intensive care setting in conformance with unit policies. The core privileges in this specialty include the procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills. Where appropriate, procedures may be performed with, or without ultrasound guidance. ***If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.***

SURGICAL CLINICAL BASIC CORE PRIVILEGES	Requested		Approved	Not Approved	Comment
Perform history and physical examination*					
Order and interpret laboratory studies. Order and perform preliminary interpretations of simple plain x-ray films with second reading by supervising physician (or radiologist) and apply results. Order and perform other diagnostic tests.					
Identify, develop, implement and evaluate a plan of care for the patient to promote, maintain and restore health under appropriate physician supervision					
Prescription drugs/Non-controlled Substances, within the confines of the Arizona statutes					
Prescribe schedule II, III, IV or V controlled substances, within the confines of the Arizona statutes (DEA registration required)					

*History and physical examination for surgical inpatient and procedures, or surgery that require anesthesia or procedural sedation are the responsibility of and **require** review and countersignature by a member of the Valleywise Health Medical Staff.

SURGICAL CLINICAL CORE PRIVILEGES	Requested		Approved	Not Approved	Comment
1. Perform rectal and pelvic examinations as indicated					
2. Perform superficial wound irrigation and wound debridement					
3. Suturing surgical incisions and lacerations, and general care for superficial wounds and minor superficial surgical procedures					
4. Perform incision and drainage of superficial abscesses					
5. Removal of superficial foreign bodies, percutaneous surgical hardware					
6. Removal of drains					
7. Removal of sutures					
8. Perform field infiltrations of anesthetic solutions					
9. Insertion and removal of packing					
10. Discontinuation of chest tube					
11. Insert and remove nasogastric tubes					
12. Provide hemostatis					
13. Splinting/casting of extremities					
14. Removal and/or biopsy of external superficial skin subcutaneous lesions					

Maricopa County Special Health Care District Board approval: 05/2018, 04/2021, 11/2021, 3/2022, 08/2022, 03/2024

SURGICAL CLINICAL CORE PRIVILEGES -CONTINUED	Requested		Approved	Not Approved	Comment
15. Select and apply appropriate wound dressings, including liquid or spray occlusive materials, absorbent material affixed with tape or circumferential wrapping, immobilizing dressing (soft or rigid), or medicated dressings; use of liquid nitrogen; cryotherapy					
16. Make daily rounds on hospitalized patients with or at the direction of the collaborating/supervising physician.					
17. Make preoperative and postoperative teaching visits with patients					
18. Monitor and manage stable acute and chronic illnesses of population served					
19. Write admitting orders on behalf of a member of the Medical Staff to initiate a patient's entry into a Valleywise Health inpatient facility. Obtain and record medical/social history and perform physical examinations including rectal and pelvic examinations as indicated					
20. Participate in volume replacement or autotransfusion techniques as appropriate					

ADVANCED SURGICAL CLINICAL CORE PROCEDURAL PRIVILEGES (see specific criteria)

Advanced Core Privileges are requested individually in addition to requesting the basic core. Each individual requesting advanced privileges must meet the specific threshold criteria as applicable to the initial applicant or re-applicant. Each time a new privilege is requested, it may be requested by the physician assistant and recommended by the supervising physician and forwarded to the Valleywise Health Medical Staff Office to be approved and appended to the advanced list of privileges. Where appropriate, procedures may be performed with, or without ultrasound guidance.

Advanced Non-Core Burn/Trauma and Advanced Surgical Core and Privileges – The applicant must provide written documentation of current competence (as noted below) for all procedures requested (procedures will require supervision as described below):

a) **Recent graduate (within the past two years)** – A list of requested procedures performed within the educational program, signed by a representative of the program, attesting to competence.

b) **All Others** – The applicant must provide documented completion of an approved training course for advanced procedures to include didactic and hands on skills training with the previous two (2) year **AND** Performance of procedures described below for the initial appointment within the previous two (2) years; **OR** the applicant may provide documentation of current credentialing for the requested advanced procedure(s) **AND** Performance of the procedure(s) described below for reappointment with the previous two (2) years; **OR a** signed statement from the supervising physician confirming that he/she has personally observed the applicant successfully perform the procedure(s) and can attest to his/her competence.

c) **If none of the above requirements can be met**, the applicant may request approval to perform the procedure(s) under "Personal Supervision". This request must be co-signed by the supervising physician.

Focused Professional Practice Evaluation: Minimum of two (2) cases shall be reviewed in accordance with the Valleywise Health Medical Staff Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) for each advanced procedure/privilege requested with like/same scope of practice.

Reappointment Criteria: Demonstrated current competence and the performance of at least 15 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.

DEPARTMENT OF SURGERY
PHYSICIAN ASSISTANT SURGERY/TRAUMA-BURN PRIVILEGES AND PRACTICE PREROGATIVES

ADVANCED NON-CORE – BURN AND TRAUMA PROCEDURES (TO BE ONLY PERFORMED ON PATIENTS OLDER THAN 14 YEARD OF AGE)	Requested		Approved	Not Approved	Comment
Cricothyroidotomy					
Endotracheal & Nasotracheal Intubation					
Chest Tube Insertion					
Swan-Ganz Catheter Insertion					
Central Line Insertion					
Arterial Line Insertion					
Bronchoscopy with/without Lavage					

Physician Assistants may request to perform the above Burn/Trauma Procedures if the following Initial Criteria Requirements are met:

1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR**
2) Attended an approved post-graduate course inclusive of didactic and hands-on experience with submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR**
3) If none of the above requirements can be met, the applicant may request approval to perform the procedure(s) under "Personal Supervision". This request must be co-signed by the supervising physician.

ADVANCED NON-CORE BURN AND TRAUMA SURGERY PROCEDURES ALL AGES:	Requested		Approved	Not Approved	Comment
Escharotomy/Fasciotomy of: ▪ Hands/Fingers/Chest/Upper Extremity ▪ Lower Extremity/Neck/Chest/Abdomen/Foot/Toes Physician Assistants may request to perform the above Burn/Trauma Procedures if the following Initial Criteria Requirements are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience with submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 3) If none of the above requirements can be met, the applicant may request approval to perform the procedure(s) under "Personal Supervision". This request must be co-signed by the supervising physician.					
Debridement, Tangential & Fascial Excisions of burn wounds with placement of graft material. Physician Assistants may request to perform the above Burn/Trauma Procedures if the following **Initial Criteria Requirements** are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience with submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 3) If none of the above requirements can be met, the applicant may request approval to perform the procedure(s) under "Personal Supervision". This request must be co-signed by the supervising physician.					

ADVANCED SURGICAL CORE PROCEDURAL PRIVILEGES

SURGICAL FIRST ASSIST PRIVILEGES	Requested		Approved	Not Approved	Comment
Includes: Assist in surgery to include, but not limited to, first assist, deep and simplified tissue closures, application of appliances, perform incision and drainage of deep abscesses (supervising physician immediately available in the operating suite). ***Initial Criteria Requirements***: Applicant must qualify for Physician Assistant surgical core privileges and have successfully completed an accredited "first assistant" training course and have demonstrated current competence and evidence of the performance of at least 15 procedures in the past 12 months, or personal supervision of the first 15 procedures. **Focused Professional Practice Evaluation:** Retrospective review of a minimum of two (2) cases in accordance with the Valleywise Health Initial Evaluation to Confirm Practitioner Competence Policy and Procedure. **Reappointment Criteria:** Demonstrated current competence and the performance of at least 15 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.					

ADVANCED SKIN GRAFTING PRIVILEGES	Requested		Approved	Not Approved	Comment
Includes: Harvesting, grafting and debridement/excision and coverage using various biological/artificial materials of burn and/or complex wounds (supervising physician immediately available in the operating suite). ***Initial Criteria Requirements***: Applicant must qualify for Physician Assistant surgical core privileges and have demonstrated current competence and evidence of the performance of at least 15 procedures in the past 12 months, or personal supervision of the first 15 procedures. **Focused Professional Practice Evaluation:** Retrospective review of a minimum of two (2) cases in accordance with the Valleywise Health Initial Evaluation to Confirm Practitioner Competence Policy and Procedure. **Reappointment Criteria:** Demonstrated current competence and the performance of at least 15 procedures in the past 24 months based on results of ongoing professional practice evaluation and outcomes.					

ADVANCED SURGICAL CORE PROCEDURAL PRIVILEGES

High Resolution Anoscopy (HRA) with biopsies, infrared coagulation a hyfrecation treatment	Requested		Approved	Not Approved	Comment
Required education and experience: Applicants must have documentation of completion of training for high resolution anoscocpy with biopsies, infrared coagulation and hyfrecation during an accredited residency training, OR ASCCCP official continuing medical education course with practicum; **AND** ♦ Demonstrated current competence and evidence of performance of at least five (5) anosocopies with biopsies, 3 IRC treatments and 3 hyfrecation treatments in the past 12 months with acceptable results. **FPPE Required** **Reappointment Criteria:** Current demonstrated competence and performance of at least ten (10) procedures with acceptable results and reflective of the scope of privileges requested for the past 24 months based on results of ongoing professional practice evaluation and outcomes.					

Physician Assistant Advanced Non-Core Surgical Clinical Privileges

Focused Professional Practice Evaluation: Minimum of two (2) cases shall be reviewed in accordance with the Valleywise Health Medical Staff Focused Professional Practice Evaluation to Confirm Practitioner Competence Policy (additional records may be reviewed to assess the scope of practice has been covered) for each advanced procedure/privilege requested with like/same scope of practice.

REAPPOINTMENT REQUIREMENTS: To be eligible to renew Advanced Non-Core Surgical Clinical Privileges in the Department of Surgery the applicant must meet the following criteria:

- An adequate volume of experience with acceptable results for the past 24 months and demonstrated current competence based on results of ongoing professional practice evaluation and outcomes. Experience must correlate to the privileges requested. Evidence of current ability to perform privileges requested is required of all applicants for renewal of privileges

ADVANCED NON-CORE SURGICAL CLINICAL PRIVILEGES	Requested		Approved	Not Approved	Comment
1. Saphenous / Internal Mammary/ Radial Artery Vein Harvest Physician Assistant may request to perform Saphenous / Internal Mammary / Radial Artery Vein Harvesting if the following conditions are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) harvests; **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience in vein harvesting with submission of documentation of having performed ten (10) harvests.					
2. Sternotomy** (see below criteria)					
3. Sternal Closure** (see below criteria)					
4. Thoracentesis** (see below criteria)					

Physician Assistant Advanced Non-Core Surgical Clinical Privileges - CONTINUED

ADVANCED NON-CORE SURGICAL CLINICAL PRIVILEGES	Requested		Approved	Not Approved	Comment
5. Physician Assistants may request to perform Placement of Thoracostomy Tube, Insertion of Arterial / Central Venous / Swan-Ganz Catheter, Sternotomy, Sternal Closure, and Thoracentesis if the following conditions are met: 1) Provided documentation of having satisfactorily completed didactic and hands-on experience in original assistant training with the submission of documentation of having performed ten (10) procedures (for each procedure requested); **OR** 2) Attended an approved post-graduate course inclusive of didactic and hands-on experience with submission of documentation of having performed ten (10) procedures (for each procedure requested).					

☐ Requested BOTOX INJECTIONS FOR CHRONIC MIGRAINES/HEADACHES	Requested		Approved	Not Approved	Comment
Performing Botox injections for the management of migraines/headaches. Physician Assistant may request to perform Botulinum Toxin Injections for the Treatment of Migraines/Headaches if the following conditions are met: **1)** Provided documentation of having satisfactorily completed didactic and hands-on experience in original training program with the submission of documentation of having performed **five (5)** Botulinum Toxin Injections for the Treatment of Migraines/Headaches **in the past twelve (12) months, OR** 2) Attended a post-graduate course inclusive of didactic and hands-on experience in **Botulinum Toxin Injections for the Treatment of Migraines/Headaches** with submission of documentation of having successfully completed the course; **AND** 3) First five (5) trigger point injections to be under Personal supervision of an attending with like privileges. Once completed the APC may request a change in level of supervision in performing said procedure with a letter submitted to the Medical Services Department by the supervising attending of the successful completion of proctoring.					
Procedural Sedation (*1- Under Personal Supervision only (A physician must be in the room during the performance of procedural sedation.) 1. Initial Request: Must have completed a Valleywise Health approved training course (APEX documentation required) and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 2. Maintenance of privilege: Maintain ACLS certification and Successful completion of "Hands On" Basic Airway Management Training Course within the past two (2) years 3. The APEX training course can be found at http://apex.valleywisehealth.org **Focused Professional Practice Evaluation for Non-Core Special Procedures – See Above** **Reappointment Criteria:** Demonstrated current competence and the performance of at least ten (10) in the past 24 months based on results of **ongoing professional practice evaluation and outcomes.**					#1

***Comments:**
1) Under Personal Supervision only (A physician must be in the room during the performance of the procedures.)
2) Must consult with attending physician prior to procedure
3) General Supervision

Acknowledgement of Applicant

I have requested only those practice prerogatives for which by education, training, current experience, and demonstrated performance I am qualified to perform and for which I wish to exercise at Valleywise Health, and I understand that:

a. In exercising any practice prerogatives granted, I am constrained by Hospital and Medical Staff/Allied Health Professional Staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the practice prerogatives granted to me is waived in an emergent situation and in such situation; my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signed_____ ***Date***_____

Applicant

SPONSORING/SUPERVISING PHYSICIAN

As sponsoring/supervising physician of the applicant, I understand it is my responsibility to ensure the applicant abides by the Medical Staff Bylaws, Rules & Regulations, Department Rules & Regulations, any policies and procedures established by the Valleywise Health, and practices within the scope of his/her license/certification/registration and practice prerogatives. Furthermore, I understand that it is my responsibility to provide support, supervision, and oversight as may be required, depending on the skills of the Physician's Assistant and the patient population being treated.

Signature of Sponsoring Physician	Sponsoring Physician Specialty	Date

General Supervision (GS)	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.
Direct Supervision (DS)	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.
Personal Supervision (PS)	A physician must be in the room during the performance of the procedure.

2. Valleywise Health's Workplace Violence Committee

3/27/2024

Valleywise Health WorkPlace Violence (WPV)

Presented by: Crystal Garcia, VP of Specialty Svcs, Quality and Patient Safety
Parts of Presentation prepared by: Olivia Davis, Quality Analyst

Scope: Inpatient Acute, Behavioral Health & Ambulatory

- Problem: Workers are increasingly facing WorkPlace Violence (WPV) in healthcare settings impacting staff injury, missed work, burnout/turnover, and disillusionment with their professions and healthcare organization. It is important we analyze our current state in order to assess our level of prevention, reporting and response and build toward the future state.

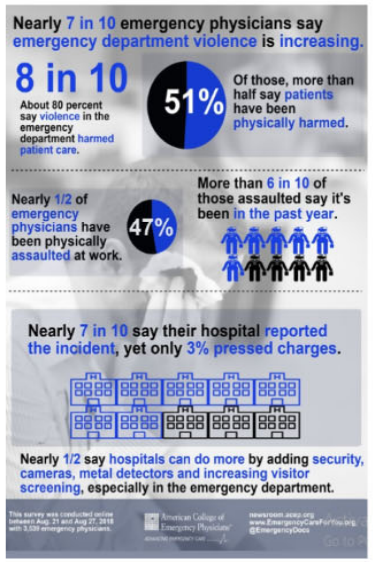
- Future State: A Workplace Violence Plan with reliable data, robust reporting, use of post incident debrief, effective staff training, use of a risk assessment in EPIC, conspicuous public postings & review and evaluation to correct hazards/risks with an annual review of the plan.

- Measures of Success:
  - Reduction in reportable and non reportable injuries related to WPV
  - Compliance with AZ SB 1311
  - Compliance with training requirements

Workplace Violence Statistics:

Workplace Violence—Statistics

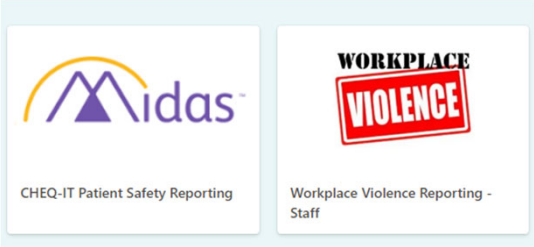
- The Occupational Safety and Health Administration (OSHA) reports that nearly 90% of health care workers will experience workplace violence during their employment.
  - Heath care workers are 12 times more likely to encounter workplace violence than the overall workforce.
- The National Institute for Occupational Safety and Health (NIOSH) reports that 70% of all non-fatal workplace violence occurs in the health care and social services sectors.
  - However, it is estimated that less than 60% of health care workers report non-fatal workplace violence.
    - Reporting is more likely when the health care worker experiences physical injury, has fewer years of work experience, or a higher level of education and licensure.



Ogletree Deakins

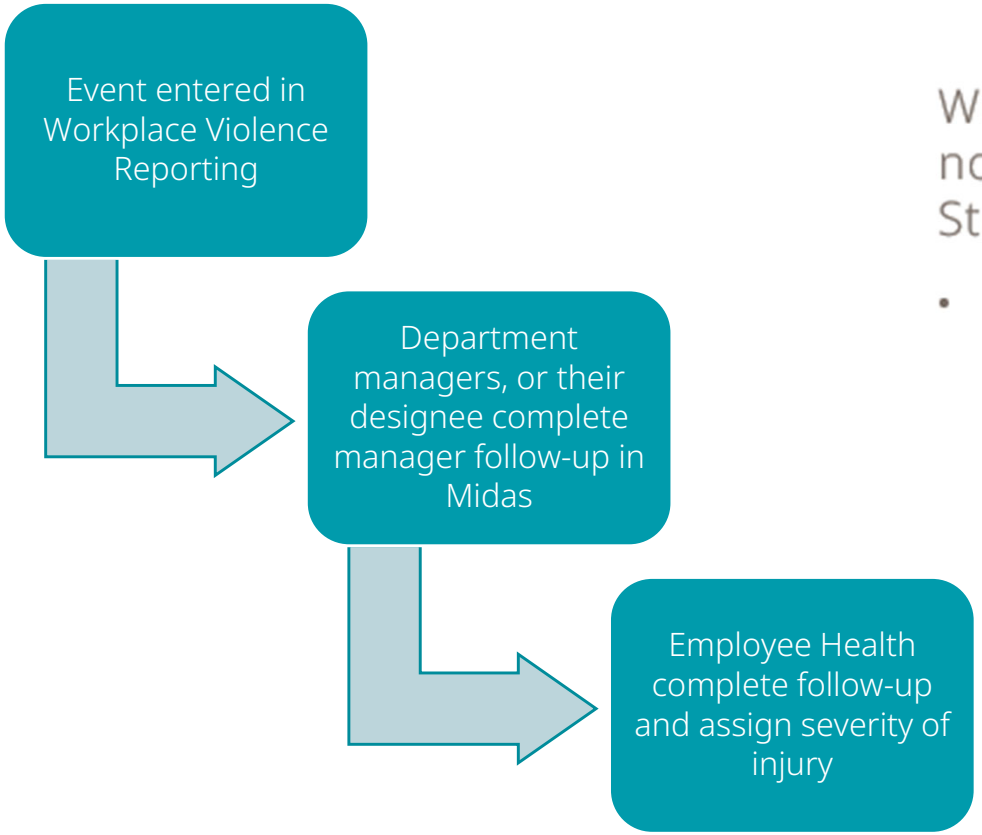
Action Items from Committee:

- Created a Workplace Violence Focus Study in the electronic reporting system Midas which includes the Post Assault Huddle.
- Education provided on the importance of separating the Workplace Violence reporting for staff from patient safety event reports.



  - Policy 15705S was developed and implemented that meets all of the following requirements:
    - Identifies the individual who is responsible for implementing and overseeing the plan
    - Requires the conspicuous posting of signs in public areas
    - Includes reporting, incident response and post incident investigation procedures
    - Provide training and education
    - Evaluate the implementation and effectiveness of the plan on an annual basis

Workplace Violence Reporting



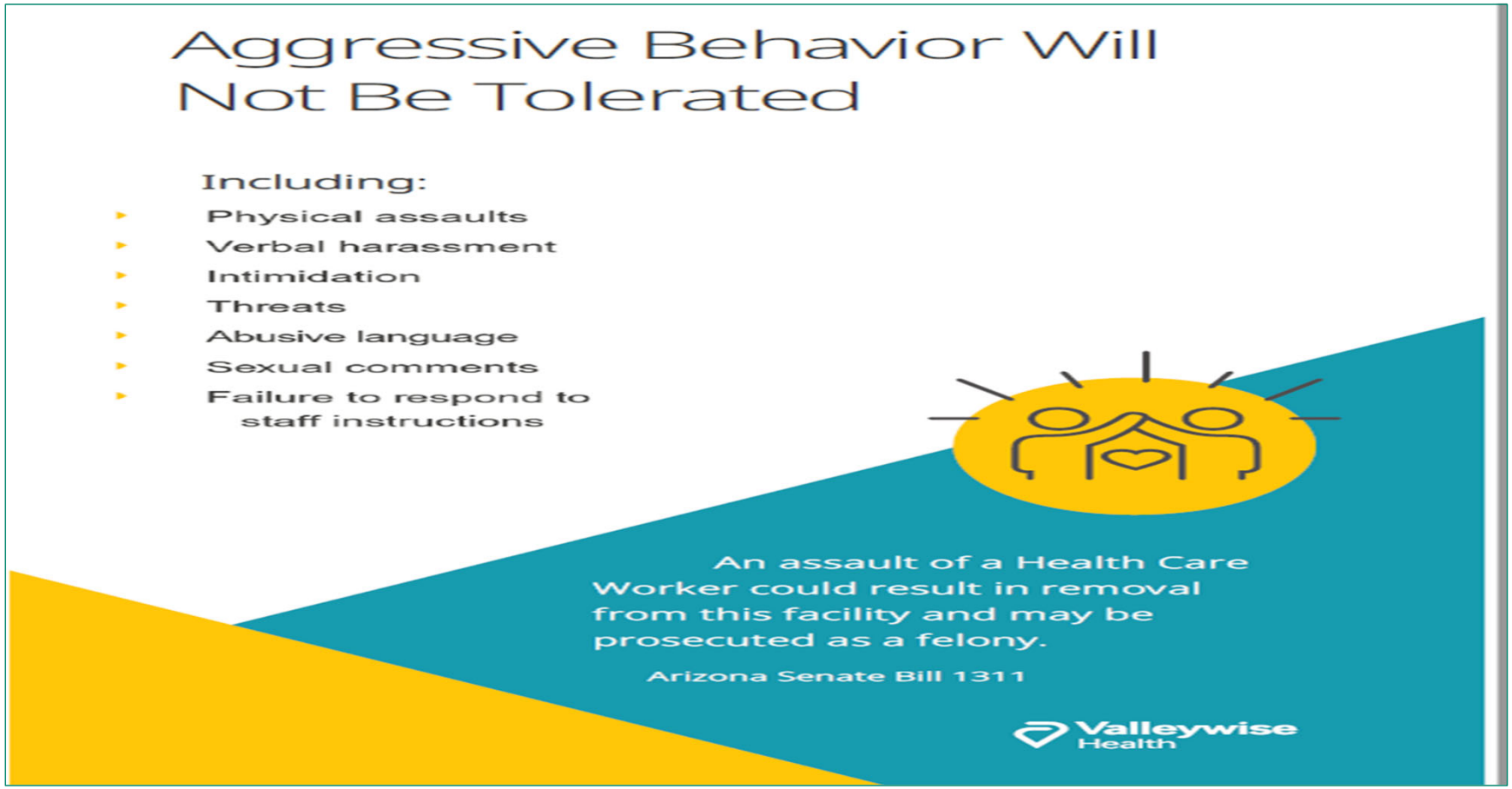
Workplace Violence towards staff now reported in Midas Focus Study

- First event reported on July 11, 2023, in Workplace Violence Midas Focus Study

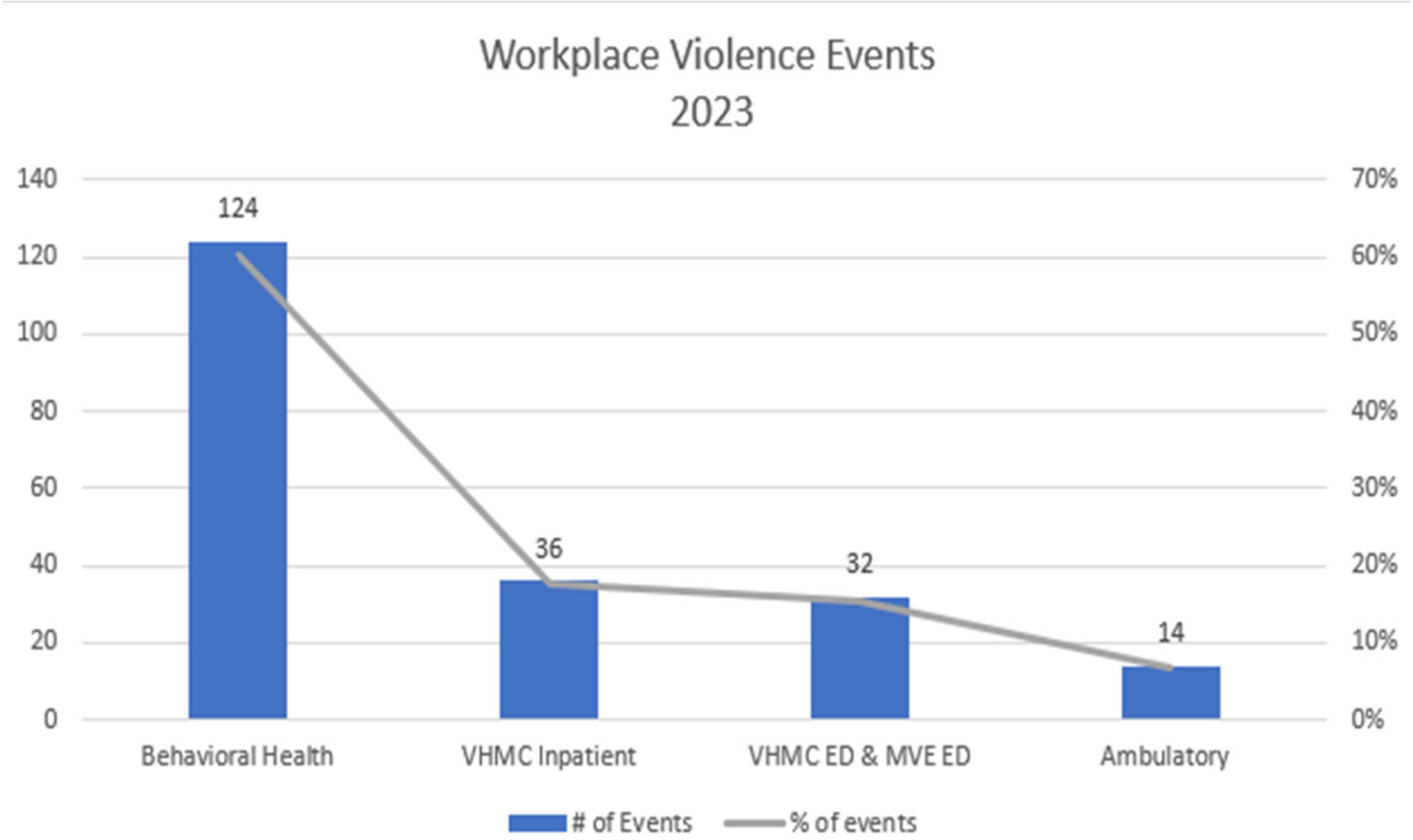
Action Items from Committee:

- CPI Risk Assessment and Implementation for all staff across the organization.
    - APEX lesson was assigned to employees.
- Post assault huddle documentation by staff involved in assault incident. Clinical leadership to review, and close loop on any discrepancies.
- Quality Analyst follows up with the responsible manager to ensure manager is following up with staff involved and completing the focus study within 7 days.
- EPIC Banner Implementation throughout organization. Banner will alert users of patient history of violence.
- Monthly review of incidents. Follow-up by WPV Committee, on after-actions, and closing the loop.

Placement of Signage (English/Spanish):



Workplace Violence Events Reported



206 total events from July 2023 to December 2023.

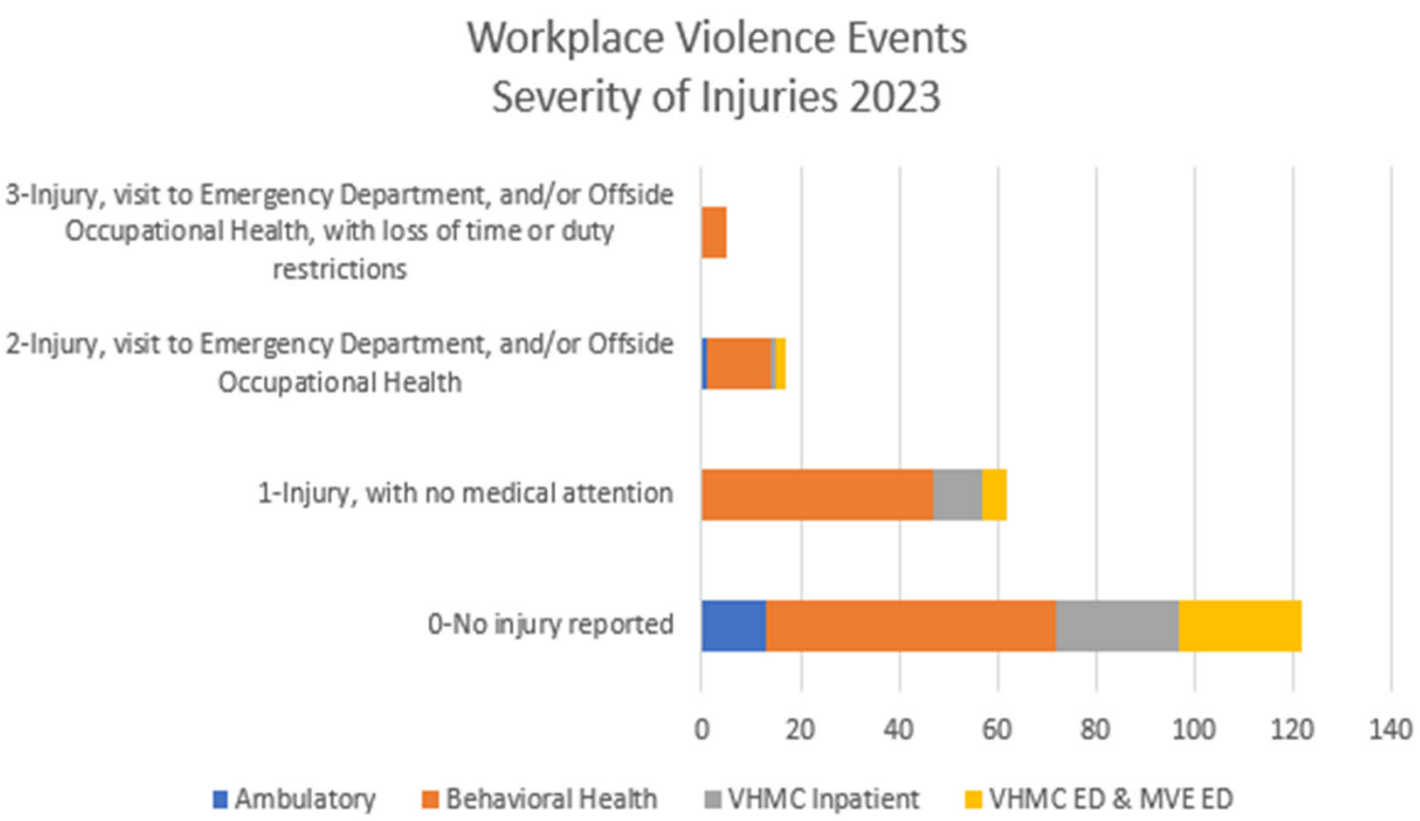
- 60% of events occurred in Behavioral Health.

Top three types of incidents included:

- Punching/Slapping
- Verbal Abuse
- Kicking

Events from July 2023 to December 2023

Severity of Injuries



59% (122/206) of events resulted with no injury reported.

41% events resulted with injury:

- Majority of the events with an injury are in Behavioral Health.
- Five events resulted with an injury and visit to ED, and/or Offside Occupational Health, with loss of time or duty restrictions

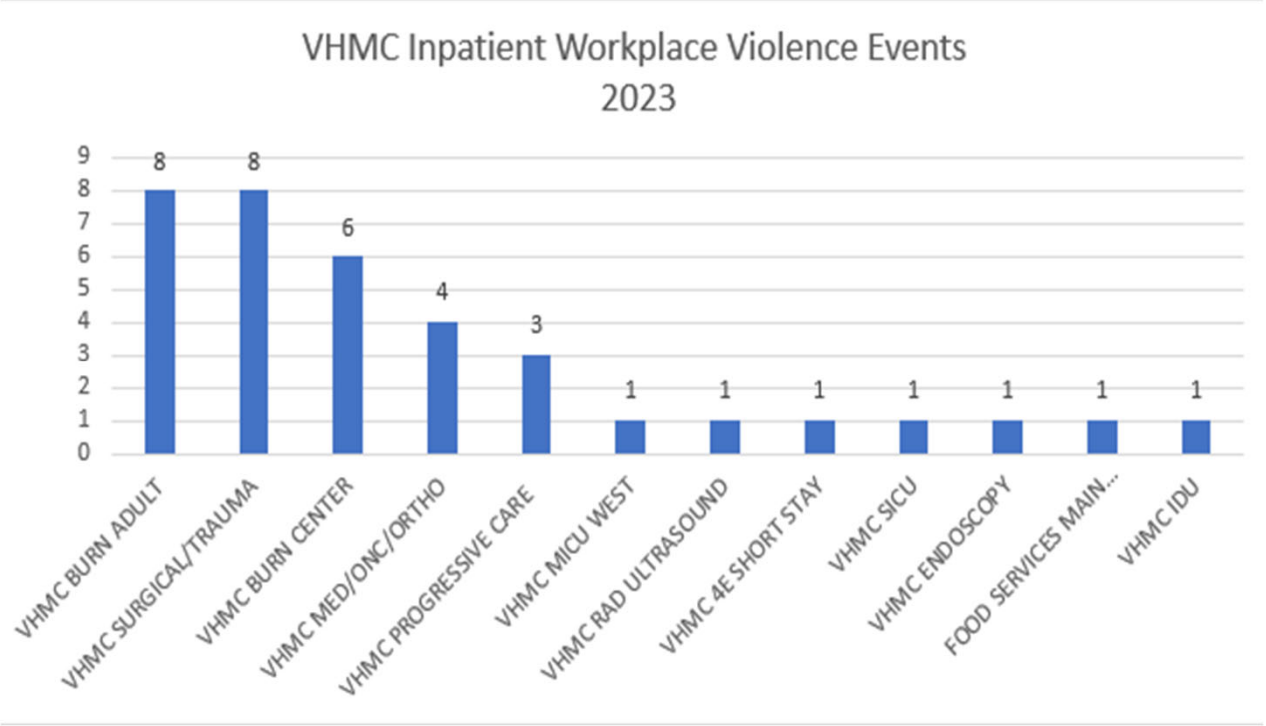
Events from July 2023 to December 2023

Behavioral Health Events

124 workplace violence events reported in Behavioral Health units

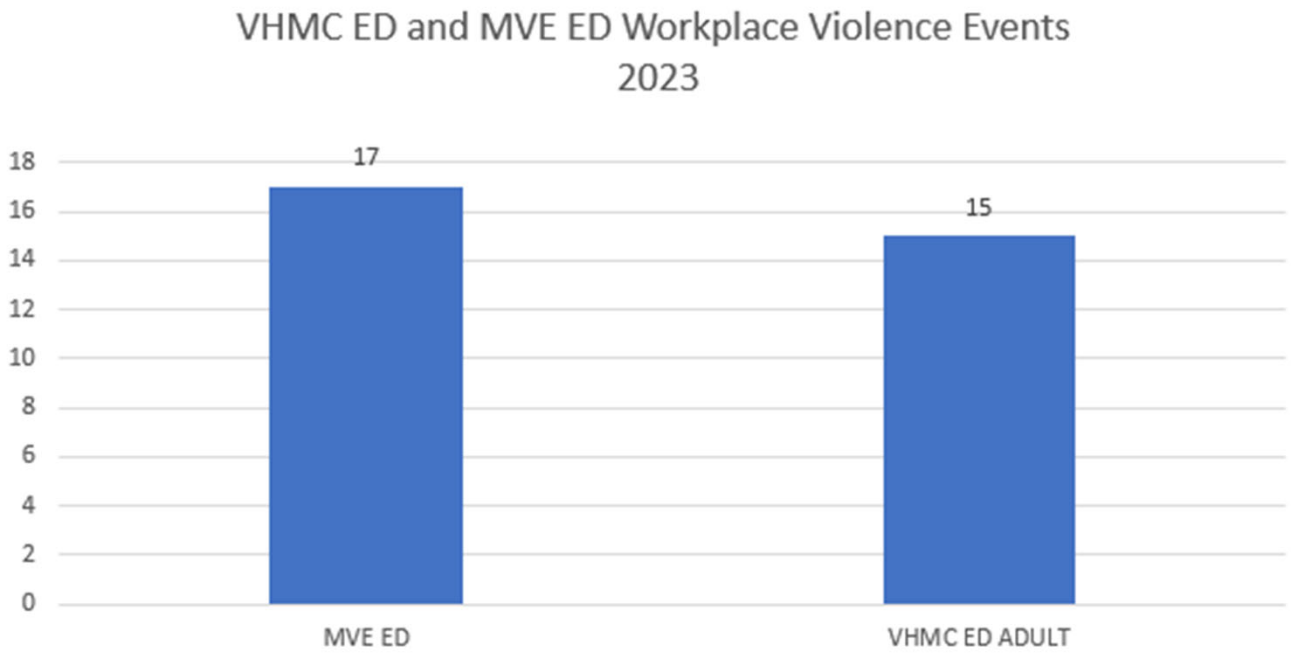
- MVB UNIT 402 had the most events, followed by MVB UNIT 601, MVB UNIT 602, MVB UNIT 502.

VHMC Inpatient Events



There was 36 workplace violence events reported for VHMC Inpatient units

VHMC ED and MVE ED Events



32 workplace violence events reported in VHMC ED and MVE ED.

Thank you!

3. Valleywise Health's 2024 Legislative Agenda

Valleywise Health

March 27, 2024

Legislative & Governmental Relations

Michael Fronske
Director of Legislative and Government Affairs

Current Statistics of Session

Day	80
Bills posted	1629
Bills passed	18
Bills vetoed	2
Bills signed	7
Resolutions passed	10

Legislative Deadlines

JANUARY 2024

Monday 1/8 Session Begins

~~Thursday 1/11 House 7-bill Introduction Limit Begins at (5:00 p.m.)~~

~~Tuesday 1/16 Senate Bill Request Deadline (5:00 p.m.)~~

~~Monday 1/22 Senate Bill Intro Set Preparation Deadline (5:00 p.m.)~~

~~Monday 1/29 Senate Bill Introduction Deadline (5:00 p.m.)~~

FEBRUARY 2024

~~Friday 2/2 House Bill Request Deadline (5:00 p.m.)~~

~~Monday 2/5 House Bill Introduction Deadline (5:00 p.m.)~~

~~Friday 2/16 Last Day to Hear SBs in Senate Committees~~

~~Friday 2/16 Last Day to Hear HBs in House Committees~~

MARCH 2024

~~Friday 3/22 Last Day to Hear SBs in House Committees~~

~~Friday 3/22 Last Day to Hear HBs in Senate Committees~~

APRIL 2024

Friday 4/12 Last Day for Conference Committees (By Senate and House Rule)

Tuesday 4/16 100th Day of Session

State Legislation and Issues

Budget Process

The Executive predicts a $900M deficit, JLBC predicts a $1.7B deficit

The Governor's $16B Budget was released on January 12th

The Legislature is currently working from a Baseline Budget

- No budget bills have been introduced; appropriation bills are being heard

State Legislation and Issues

66 Bills Sent Out for Comment (35 Moving)
50 Bills on Monitor List

Bills We Are Tracking Closely:

- SB 1037 AHCCCS; comprehensive dental care (Never Heard in the House)
- HB 2035 Insurance; claims; appeals; provider credentialing(Passed Senate Approps)
- SB 1402 Healthcare; costs; reimbursement (Awaiting House Rules)
- HB 2744 Involuntary treatment; guardians; agents; rights (Amended in the Senate)
- SB 1578 Involuntary treatment; substance abuse (Never Heard in the House)
- SB 1609 NOW Behavioral health; AHCCCS; health facilities (Amended in the House)
- SB 1731 Public meetings; comments; members (Awaiting House Rules)

Action Items

Request to Support or Oppose Bills and Amendments with Timely Feedback to the Board

Request to Oppose:

HB 2504 Forced organ harvesting; insurance; prohibition (Passed the House 31-28 Passed Senate FICO 4-3)

SB 1655 NOW Behavioral health entities; regulation (Failed in House HHS 3-7)

SB 1216 NOW Government employees; online use (Passed the Senate 17-1, Amended in House Government)

Federal Issues

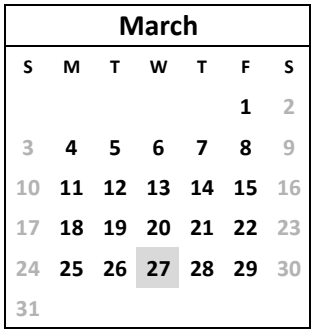
Continue to work with our Congressional Delegation on these key issues:

- Support H.R. 7397 Reinforcing Essential Health Systems for Communities Act which includes a designation for Essential Hospitals that was introduced February 15th
- Continue to protect 340B funding, and protect against hospital site-neutral payment cut proposals


Valleywise
Health

4. Fiscal Year 2025 Budget Calendar

FY 2025 Planning and Budget Calendar – District Board



March						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

March

27 - Maricopa County Special Health Care District Board of Directors (District Board) budget hearing – Review calendar.

April

24 - District Board budget hearing – Review preliminary patient volumes and capital target.

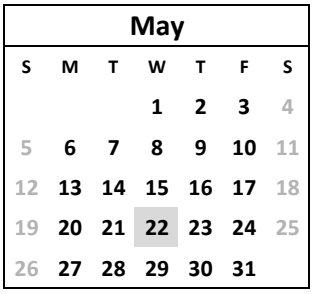
May

22 - District Board budget hearing– Review capital, volumes, revenue, expenses, and other assumptions.

June

20 - District Board budget hearing – Review of the FY2025 Operating and Capital Budget.

26 - District Board budget hearing – Consideration of the FY2025 Operating and Capital Budget for approval.



May						
S	M	T	W	T	F	S
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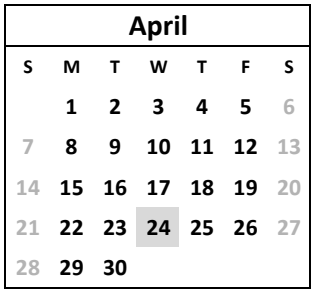
19	20	21	22	23	24	25
26	27	28	29	30	31	



April						
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	1	2	3	4	5	6
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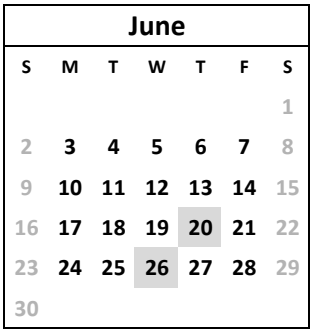
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				



June						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

5. February 2024 Financials and Statistical Information

Valleywise Health

Financial and Statistical Information

for the month ending

February 29, 2024

Valleywise Health

Table of Contents

Financial Highlights – February 2024

Patient Activity

Total admissions in February were 9.3% under budget and 12.5% higher than February of last year. Inpatient acute admissions for the month were 12.6% under budget and 6.8% higher than last February. Behavioral health admissions were 1.6% over budget for the month and 32.3% higher than February 2023. Emergency department visits were 1.6% under budget for the month and 6.5% higher than February of last year. Ambulatory visits were 1.5% under budget for the month and 9.1% higher than the same month in the prior year.

Operating Revenue

Net patient service revenues were 5.4% under budget for the month and were 1.3% lower on a year-to-date basis. Other revenues were 38.5% over budget for the month, primarily in revenues related to Health II program, sales at retail pharmacies, and grant/research & foundation program revenues. Overall total operating revenues were 5.3% over budget primarily in other revenues.

Operating Expense

Total operating expenses were 3.7% over budget for February. Labor expense, which includes salaries, benefits, and contract labor, were 9.1% over budget for the month. Majority of negative variances were in employee benefits due to a large increase in medical claims paid during the month. Net medical service fees were 0.8% under budget for the month primarily due to higher than budgeted collections. Supplies were 23.0% over budget primarily in surgery related medical supplies (implants) due to increase surgery cases, laboratory supplies, pharmaceuticals (specialty drugs), radiology related supplies, and repairs & maintenance supplies. Purchased services were 16.9% over budget primarily in management fees, consulting & management, attorney & legal fees and advertising services. Lastly, all other expenses excluding depreciation were 6.4% over budget for the month primarily in risk management related expenses, medical equipment rental, and utilities expenses.

Non–Operating Revenue (Expense)

In total, net non-operating revenues and expenses were 21.4% under budget for the month of February, primarily due to local match program expenses and capital related grant revenue.

Cash and Cash Equivalents (including investments)

	February 24	June 23
Operating / General Fund	$126.5M	$241.2M
Bond related – Restricted	$77.0M	$166.5M
Total cash and cash equivalents (including investments)	$203.5M	$407.7M

Select Ratios

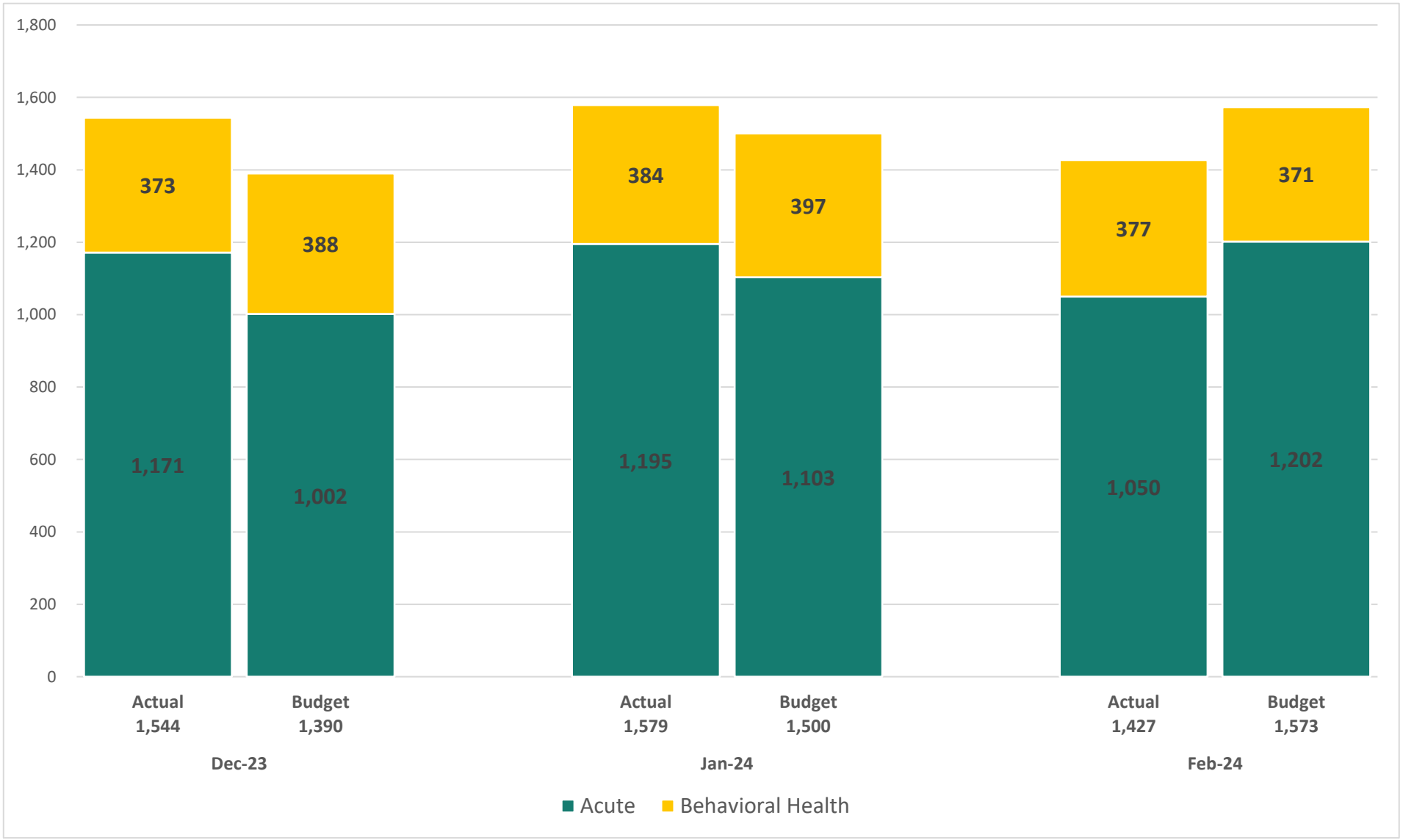
	FY2024 YTD Actual	FY2024 YTD Budget
Liquidity		
Days cash on hand (unrestricted)	54.8	89.7
Days in Accounts Receivable	75.3	60
Current Ratio (excludes Bond funds)	2.0	3.7

	FY2024 YTD Actual	FY2024 YTD Budget
Profitability		
Operating Margin (%)	(30.5)	(29.8)
Excess Margin – normalized (%)	(8.6)	(7.7)
Productivity		
FTE/AOB w/o Residents	4.17	4.26

If you have any questions, please do not hesitate to contact Melanie Talbot or Claire Agnew, CFO.

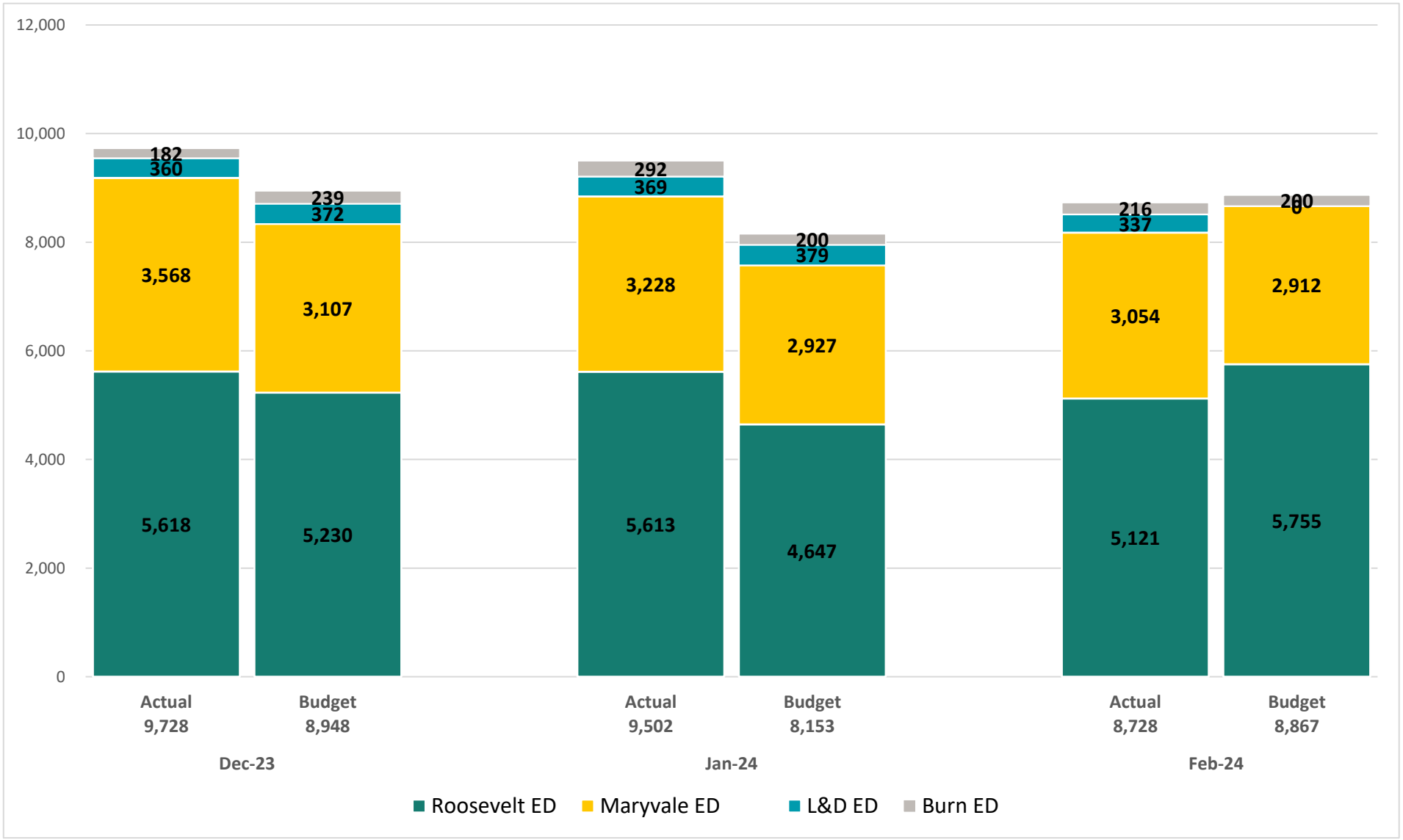
Valleywise Health

Fiscal Year 2024
Admissions



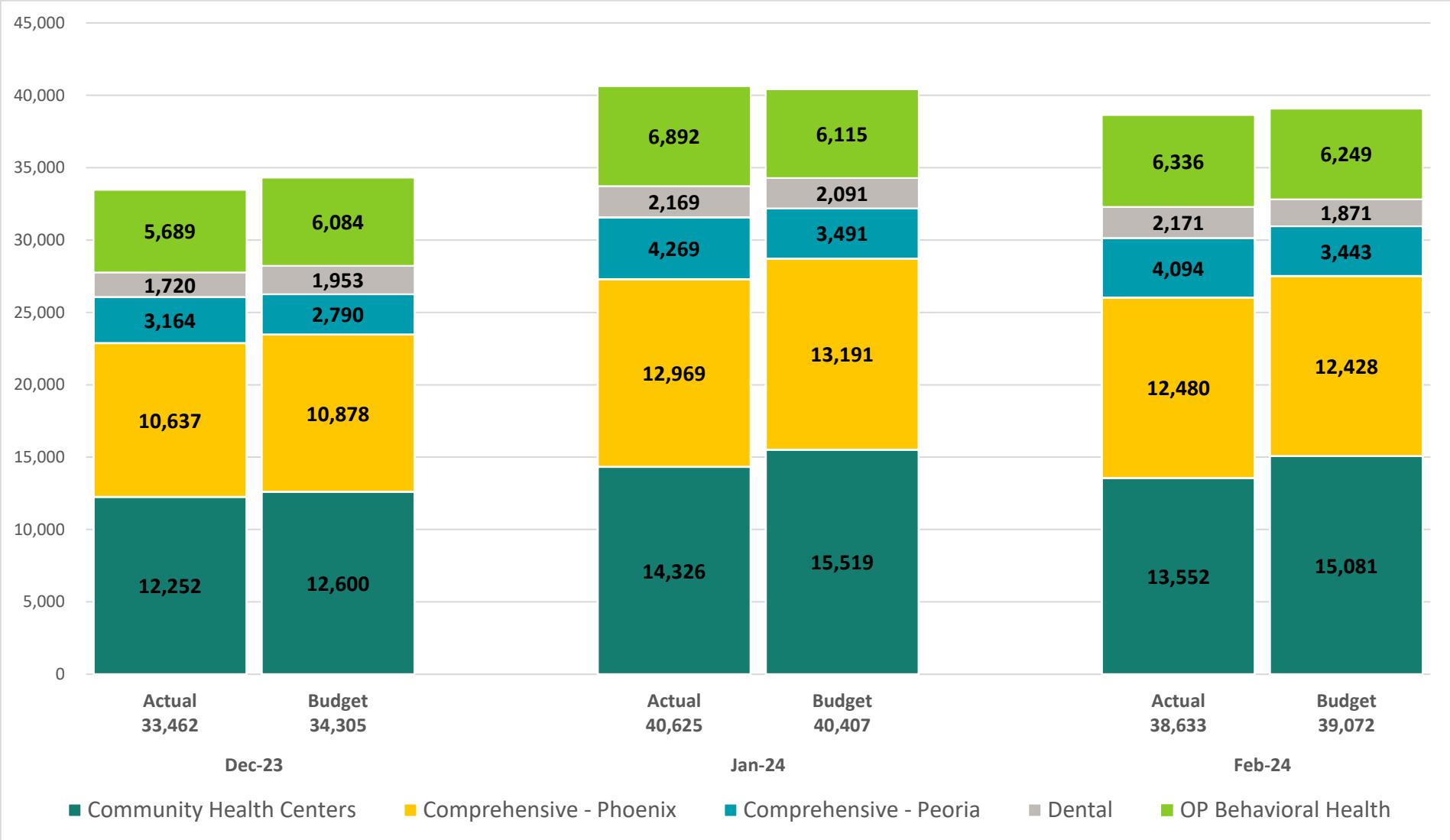
Valleywise Health

Fiscal Year 2024
Emergency Department Visits



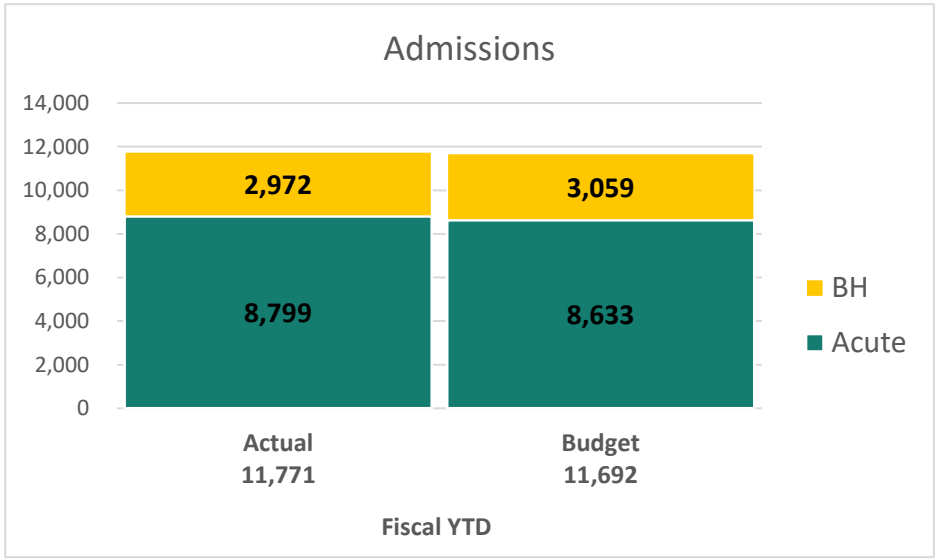
Valleywise Health

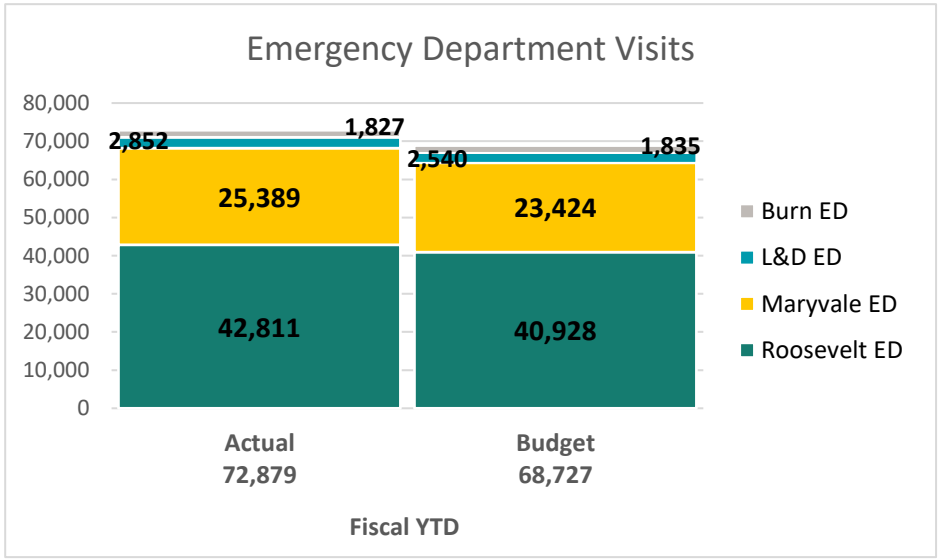
Fiscal Year 2024
Ambulatory Visits

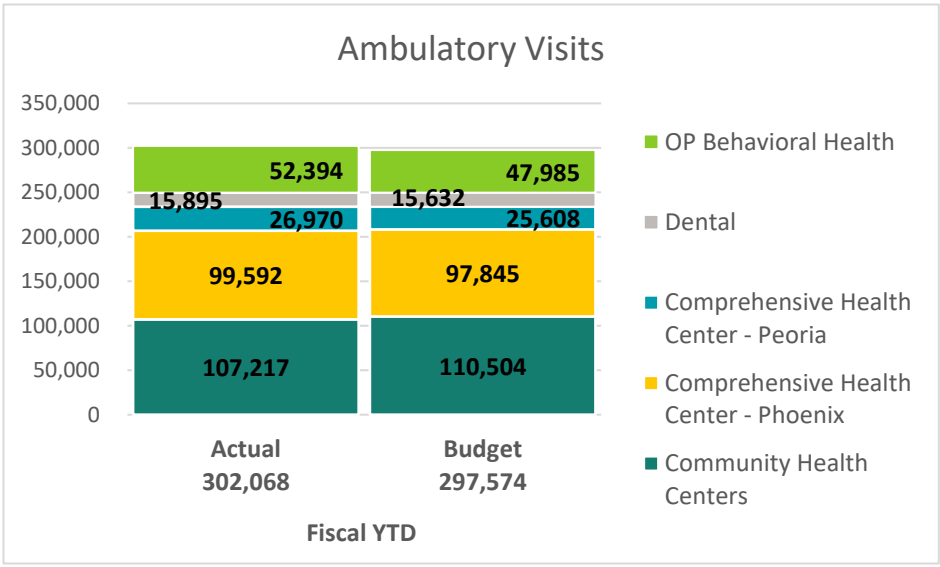


* Includes Telehealth visits -- 4,200 (December 2023) || 5,093 (January 2024) || 4,746 (February 2024)

Fiscal Year 2024
Year-to-Date Volume Summary



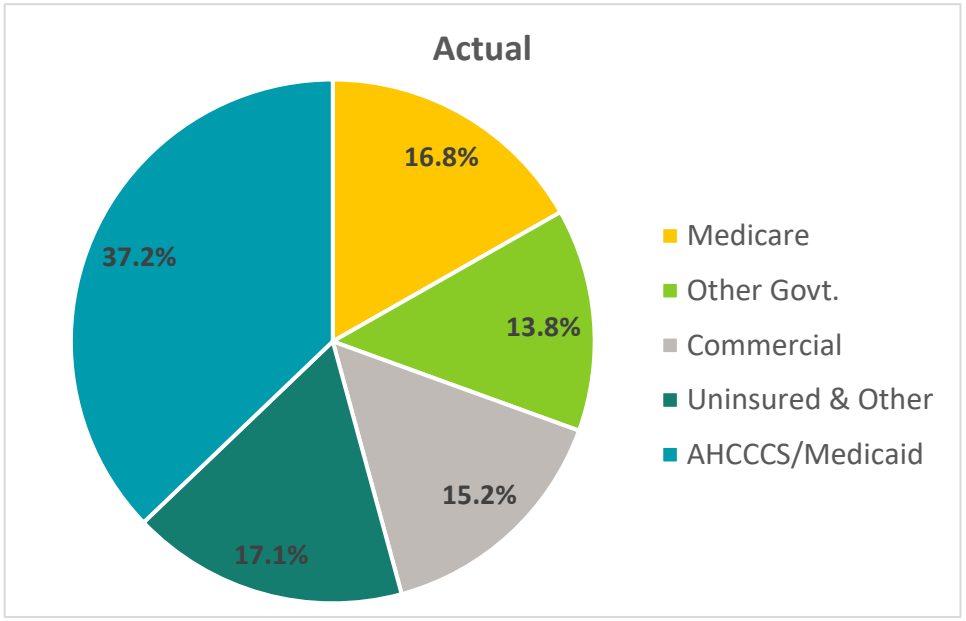




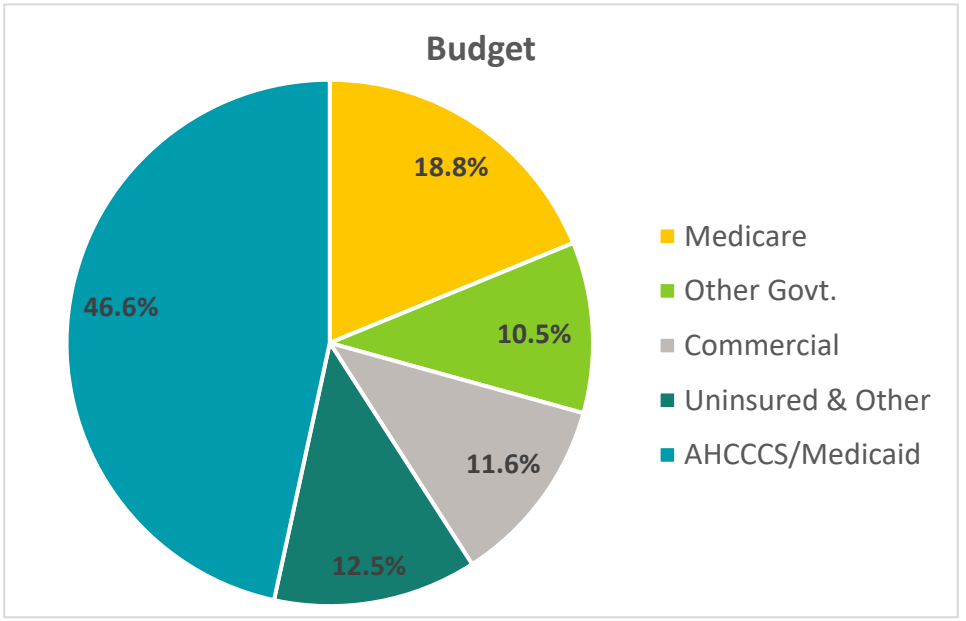
* Includes 37,401 Telehealth visits in FY 2024

Valleywise Health

Fiscal Year 2024
Patient Revenue Source by Gross Revenue

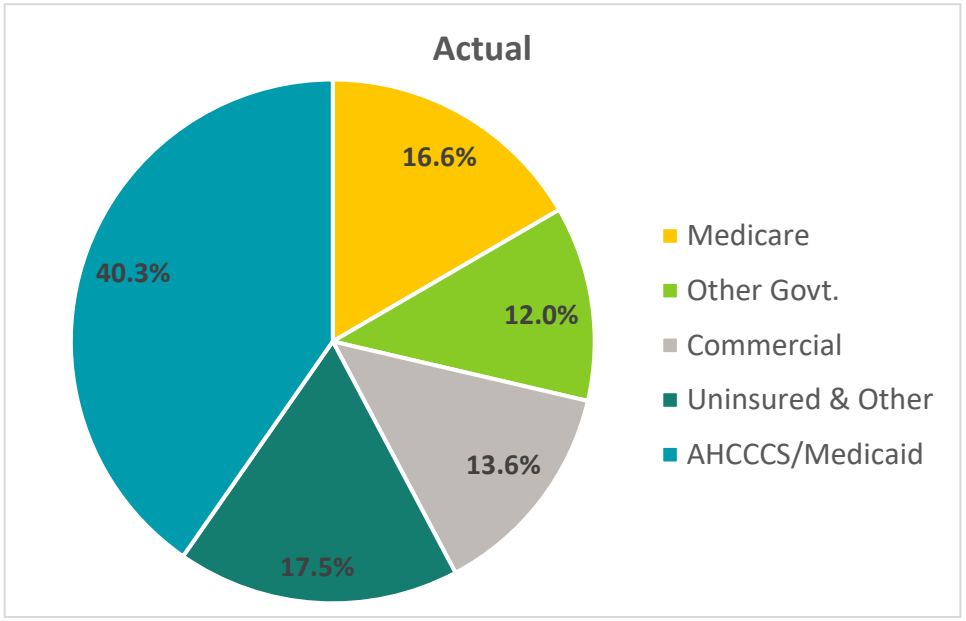


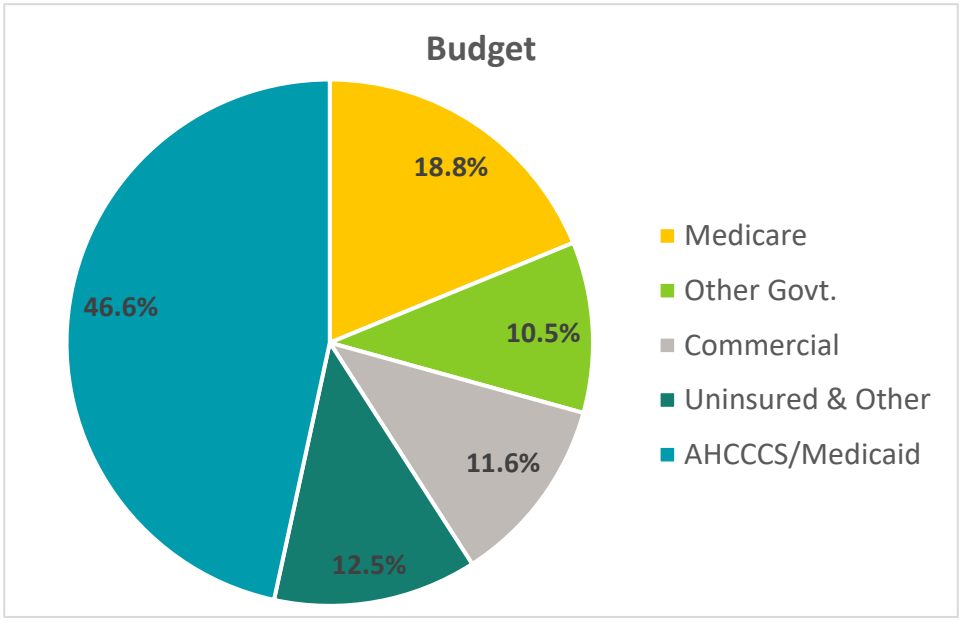
Actual Gross Revenue is
month of February 29, 2024

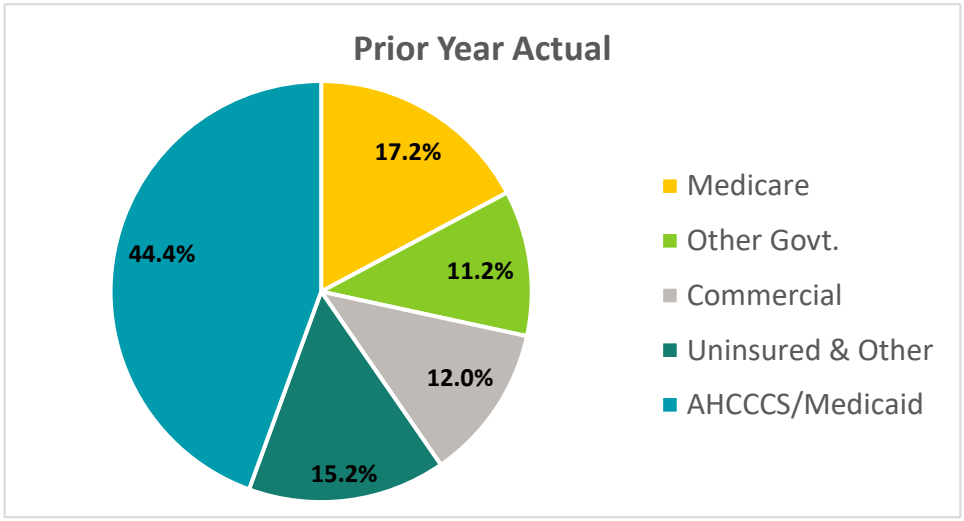


Valleywise Health

Fiscal Year 2024
Patient Revenue Source by Gross Revenue







Actual Gross Revenue is YTD as of February 29, 2024

Prior Year Gross Revenue is all of fiscal year 2023

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
STATEMENT OF REVENUES AND EXPENSES
For the Period Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month Variance	Prior Year Same Month % Change
Net Patient Service Revenue	**$ 38,013,251**	**$ 40,188,148**	**$ (2,174,897)**	**(5.4 %)**	**$ 39,717,717**	**$ (1,704,465)**	**(4.3 %)**
Other Revenue	17,906,471	12,933,070	4,973,400	38.5 %	14,811,565	3,094,906	20.9 %
Total Operating Revenue	55,919,722	53,121,219	2,798,503	5.3 %	54,529,281	1,390,441	2.5 %
OPERATING EXPENSES							
Salaries and Wages	26,020,405	25,396,135	(624,270)	(2.5 %)	21,934,559	(4,085,846)	(18.6 %)
Contract Labor	6,490,254	5,649,494	(840,760)	(14.9 %)	7,449,419	959,165	12.9 %
Employee Benefits	9,604,900	7,543,877	(2,061,023)	(27.3 %)	6,883,484	(2,721,416)	(39.5 %)
Medical Service Fees	9,605,201	9,679,827	74,626	0.8 %	9,133,589	(471,612)	(5.2 %)
Supplies	9,321,982	7,577,690	(1,744,292)	(23.0 %)	7,180,075	(2,141,907)	(29.8 %)
Purchased Services	5,339,744	4,569,235	(770,509)	(16.9 %)	4,299,010	(1,040,735)	(24.2 %)
Repair and Maintenance	1,408,497	1,834,249	425,752	23.2 %	1,520,426	111,929	7.4 %
Utilities	858,230	603,810	(254,420)	(42.1 %)	550,117	(308,113)	(56.0 %)
Rent	741,969	509,140	(232,829)	(45.7 %)	535,218	(206,750)	(38.6 %)
Other Expenses	2,499,925	2,229,081	(270,844)	(12.2 %)	1,816,203	(683,722)	(37.6 %)
Provider Assessment	0	0	0	0.0 %	0	0	0.0 %
Depreciation	2,244,333	5,874,371	3,630,038	61.8 %	3,672,085	1,427,753	38.9 %
Total Operating Expense	74,135,440	71,466,908	(2,668,531)	(3.7 %)	64,974,185	(9,161,254)	(14.1 %)
Operating Income (Loss)	**(18,215,718)**	**(18,345,690)**	**129,972**	**0.7 %**	**(10,444,904)**	**(7,770,814)**	**(74.4 %)**
NONOPERATING REVENUES (EXPENSES)							
NonCapital Grants	121,605	459,203	(337,598)	(73.5 %)	379,101	(257,496)	(67.9 %)
NonCapital Transfers from County/State	295,658	295,658	0	0.0 %	295,658	0	0.0 %
Investment Income	548,485	577,742	(29,258)	(5.1 %)	653,252	(104,768)	(16.0 %)
Other NonOperating Revenues (Expenses)	(731,822)	1,976,950	(2,708,772)	(137.0 %)	1,300,654	(2,032,476)	(156.3 %)
Interest Expense	(1,416,729)	(1,416,729)	0	0.0 %	(2,453,383)	1,036,654	42.3 %
Tax Levy	12,452,350	12,452,350	0	0.0 %	10,767,838	1,684,513	15.6 %
Total NonOperating Revenues (Expenses)	11,269,547	14,345,174	(3,075,627)	(21.4 %)	10,943,120	326,427	3.0 %

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
STATEMENT OF REVENUES AND EXPENSES
For the Period Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month Variance	Prior Year Same Month % Change
Excess of Revenues over Expenses	**$ (6,946,171)**	**$ (4,000,515)**	**$ (2,945,656)**	**(73.6 %)**	**$ 498,216**	**$ (7,444,386)**	**(1494.2 %)**
Bond-Related Revenues and Expenses	(3,244,615)	(3,356,776)	112,160	3.3 %	(1,001,383)	(2,243,232)	(224.0 %)
Increase (Decrease) in Net Assets (normalized)	$ (10,190,786)	$ (7,357,291)	$ (2,833,496)	(38.5 %)	$ (503,168)	$ (9,687,619)	(1925.3 %)

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
STATEMENT OF REVENUES AND EXPENSES
For the Eight Periods Ending February 29, 2024

	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year Variance	YTD Prior Year % Change
Net Patient Service Revenue	**$ 338,276,906**	**$ 342,856,606**	**$ (4,579,701)**	**(1.3 %)**	**$ 327,920,618**	**$ 10,356,288**	**3.2 %**
Other Revenue	120,423,697	103,845,100	16,578,596	16.0 %	102,614,841	17,808,855	17.4 %
Total Operating Revenue	458,700,602	446,701,706	11,998,896	2.7 %	430,535,459	28,165,143	6.5 %
OPERATING EXPENSES							
Salaries and Wages	217,805,862	208,022,411	(9,783,451)	(4.7 %)	194,278,603	(23,527,259)	(12.1 %)
Contract Labor	48,321,569	50,963,919	2,642,351	5.2 %	56,968,448	8,646,880	15.2 %
Employee Benefits	66,801,302	61,445,744	(5,355,559)	(8.7 %)	57,815,322	(8,985,980)	(15.5 %)
Medical Service Fees	67,951,733	76,595,270	8,643,537	11.3 %	70,006,765	2,055,033	2.9 %
Supplies	77,456,552	64,686,691	(12,769,861)	(19.7 %)	64,293,677	(13,162,875)	(20.5 %)
Purchased Services	40,027,671	37,721,017	(2,306,653)	(6.1 %)	35,518,855	(4,508,816)	(12.7 %)
Repair and Maintenance	14,686,869	14,541,661	(145,209)	(1.0 %)	14,332,396	(354,474)	(2.5 %)
Utilities	6,252,201	5,508,788	(743,414)	(13.5 %)	5,643,301	(608,901)	(10.8 %)
Rent	4,758,685	3,819,957	(938,728)	(24.6 %)	4,097,639	(661,047)	(16.1 %)
Other Expenses	19,770,626	18,346,721	(1,423,905)	(7.8 %)	14,952,480	(4,818,146)	(32.2 %)
Provider Assessment	0	0	0	0.0 %	5,891,876	5,891,876	100.0 %
Depreciation	34,721,647	38,351,685	3,630,038	9.5 %	28,892,631	(5,829,015)	(20.2 %)
Total Operating Expense	598,554,716	580,003,862	(18,550,854)	(3.2 %)	552,691,993	(45,862,724)	(8.3 %)
Operating Income (Loss)	**(139,854,114)**	**(133,302,156)**	**(6,551,959)**	**(4.9 %)**	**(122,156,534)**	**(17,697,581)**	**(14.5 %)**
NONOPERATING REVENUES (EXPENSES)							
NonCapital Grants	6,960,225	5,797,343	1,162,882	20.1 %	3,655,009	3,305,216	90.4 %
NonCapital Transfers from County/State	2,365,264	2,365,264	0	0.0 %	2,365,264	0	0.0 %
Investment Income	5,692,437	4,621,938	1,070,499	23.2 %	4,438,577	1,253,860	28.2 %
Other NonOperating Revenues (Expenses)	(2,623,918)	(2,072,456)	(551,462)	(26.6 %)	(5,183,775)	2,559,857	49.4 %
Interest Expense	(11,380,410)	(11,380,410)	(0)	(0.0 %)	(19,600,900)	8,220,489	41.9 %
Tax Levy	99,618,804	99,618,803	0	0.0 %	87,158,285	12,460,518	14.3 %
Total NonOperating Revenues (Expenses)	100,632,401	98,950,482	1,681,919	1.7 %	72,832,461	27,799,940	38.2 %

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
STATEMENT OF REVENUES AND EXPENSES
For the Eight Periods Ending February 29, 2024

	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year Variance	YTD Prior Year % Change
Excess of Revenues over Expenses	**$ (39,221,713)**	**$ (34,351,674)**	**$ (4,870,040)**	**(14.2 %)**	**$ (49,324,073)**	**$ 10,102,360**	**20.5 %**
Bond-Related Revenues and Expenses	(26,594,028)	(26,807,629)	213,602	0.8 %	(8,049,064)	(18,544,964)	(230.4 %)
Increase (Decrease) in Net Assets (normalized)	$ (65,815,741)	$ (61,159,303)	$ (4,656,438)	(7.6 %)	$ (57,373,136)	$ (8,442,605)	(14.7 %)

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

STATEMENT OF NET POSITION

February 29, 2024

	2/29/2024	6/30/2023
ASSETS		
Current Assets		
Cash and Cash Equivalents		
Cash - Care System	$ 126,526,435	$ 241,214,127
Cash and Short-Term Investment	126,526,435	241,214,127
Cash - Bond	76,990,726	166,504,192
Cash and Short-Term Investment - Bond	76,990,726	166,504,192
Total Cash and Cash Equivalents	203,517,161	407,718,319
Patient A/R, Net of Allowances	102,646,896	85,709,368
Other Receivables and Prepaid Items	59,020,287	42,225,086
Estimated Amounts Due from Third-Party Payors	104,524,501	50,640,640
Due from Related Parties	6,917,173	3,376,279
Other Current Assets	2,516,402	2,516,402
Total Current Assets	479,142,419	592,186,093
Capital Assets, Net	830,207,449	796,596,154
Other Assets		
Long-Term Portion - Right to use Assets	5,005,017	5,005,017
Total Other Assets	5,005,017	5,005,017
Total Assets	1,314,354,886	1,393,787,264
Deferred Outflows	56,462,313	56,462,313
Total Assets and Deferred Outflows	**$ 1,370,817,199**	**$ 1,450,249,577**

Valleywise Health

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

STATEMENT OF NET POSITION

February 29, 2024

	2/29/2024	6/30/2023
LIABILITIES AND NET POSITION		
Current Liabilities		
Current Maturities of Long-Term Debt	$ 37,225,419	$ 43,216,702
Accounts Payable	74,876,374	75,381,153
Accrued Payroll and Expenses	37,187,978	28,158,703
Medical Claims Payable	18,255,175	18,892,539
Due to Related Parties	(2,605,604)	1,434
Other Current Liabilities	78,670,450	80,724,270
Total Current Liabilities	243,609,793	246,374,801
Long-Term Debt		
Bonds Payable	603,300,622	640,746,278
Other Long-Term Debt	5,005,017	5,005,017
Total Long-Term Debt	608,305,639	645,751,296
Long-Term Liabilities	356,444,644	356,444,644
Total Liabilities	1,208,360,076	1,248,570,741
Deferred Inflows	18,778,412	18,778,412
Net Position		
Invested in Capital Assets, Net of Related Debt	787,977,013	748,374,435
Temporarily Restricted	47,867,232	49,521,120
Unrestricted	(692,165,534)	(614,995,130)
Total Net Position	143,678,711	182,900,424
Total Liabilities, Deferred Inflows, and Net Position	**$ 1,370,817,199**	**$ 1,450,249,577**

Valleywise Health

Supplemental Information

Valleywise Health
Financial and Statistical Information
29-Feb-24

Legend
Greater than or equal to 100% of Budget
Within 95% to 100% of Budget
Less than 95% of Budget

	Current Month				Fiscal Year to Date				Prior Fiscal Year to Date		
	Actual	Budget	Variance	Var %	Actual	Budget	Variance	Var %	Actual	Variance	Var %
Acute											
Admissions	1,050	1,202	(152)	(12.6%)	8,799	8,633	166	1.9%	8,670	129	1.5%
Length of Stay (LOS)	5.3	3.9	(1.5)	(38.1%)	5.4	5.1	(0.3)	(5.2%)	5.2	(0.1)	(2.8%)
Patient Days	5,591	4,635	956	20.6%	47,304	44,101	3,203	7.3%	45,352	1,952	4.3%
Acute - Observation Days and Admits											
Observation Days	588	495	93	18.8%	5,367	4,616	751	16.3%	4,986	380	7.6%
Observation Admission - Transfer to Inpatient	213	186	27	14.5%	1,699	1,698	1	0.1%	1,795	(96)	(5.3%)
Observation Admission Only	355	306	49	16.0%	2,986	2,796	190	6.8%	2,958	28	0.9%
Total Admissions - Acute plus Observation Only	1,405	1,508	(103)	(6.8%)	11,785	11,429	356	3.1%	11,628	157	1.4%
Behavioral Health											
Admissions	377	371	6	1.6%	2,972	3,059	(87)	(2.8%)	2,588	384	14.8%
Length of Stay (LOS)	22.6	23.3	0.6	2.7%	23.8	23.5	(0.3)	(1.3%)	24.8	1.0	4.1%
Patient Days	8,529	8,630	(101)	(1.2%)	70,788	71,894	(1,106)	(1.5%)	64,306	6,482	10.1%
Valleywise Behavioral Health Center-Phoenix	2,477	1,954	523	26.8%	19,444	16,761	2,683	16.0%	14,185	5,259	37.1%
Valleywise Behavioral Health Center-Mesa	3,003	3,205	(202)	(6.3%)	24,742	27,718	(2,976)	(10.7%)	25,266	(524)	(2.1%)
Valleywise Behavioral Health Center-Maryvale	3,049	3,471	(422)	(12.2%)	26,602	27,415	(813)	(3.0%)	24,855	1,747	7.0%
Combined (Acute + Behavioral Health)											
Adjusted Admissions	2,947	3,128	(181)	(5.8%)	23,342	22,172	1,170	5.3%	21,531	1,811	8.4%
Adjusted Patient Days	29,163	26,382	2,781	10.5%	234,178	219,966	14,212	6.5%	209,724	24,454	11.7%
Case Mix Index											
Total Hospital	1.68	1.55	0.13	8.6%	1.57	1.55	0.02	1.0%	1.57	(0.00)	(0.3%)
Acute (Excluding Newborns)	1.82	1.75	0.07	3.8%	1.68	1.75	(0.07)	(4.0%)	1.79	(0.11)	(6.2%)
Behavioral Health	1.34	1.26	0.08	6.7%	1.30	1.26	0.04	3.0%	1.25	0.05	3.9%
Medicare	2.19	2.10	0.09	4.2%	2.04	2.10	(0.06)	(2.7%)	2.16	(0.12)	(5.4%)
AHCCCS	1.74	1.82	(0.08)	(4.7%)	1.68	1.82	(0.14)	(7.7%)	1.83	(0.15)	(8.2%)
Ambulatory											
Valleywise Community Health Centers Visits	13,552	15,081	(1,529)	(10.1%)	107,217	110,504	(3,287)	(3.0%)	112,586	(5,369)	(4.8%)
Valleywise Comprehensive Health Center-Phoenix Visits	12,480	12,428	52	0.4%	99,592	97,845	1,747	1.8%	96,598	2,994	3.1%
Valleywise Comprehensive Health Center-Peoria Visits	4,094	3,443	651	18.9%	26,970	25,608	1,362	5.3%	24,589	2,381	9.7%
Dental Clinics Visits	2,171	1,871	300	16.0%	15,895	15,632	263	1.7%	15,371	524	3.4%
OP Behavioral Health Visits	6,336	6,249	87	1.4%	52,394	47,985	4,409	9.2%	43,881	8,513	19.4%
Total Ambulatory Visits :	**38,633**	**39,072**	**(439)**	**(1.1%)**	**302,068**	**297,574**	**4,494**	**1.5%**	**293,025**	**9,043**	**3.1%**

Valleywise Health
Financial and Statistical Information
29-Feb-24

Legend
Greater than or equal to 100% of Budget
Within 95% to 100% of Budget
Less than 95% of Budget

	Current Month				Fiscal Year to Date				Prior Fiscal Year to Date		
	Actual	Budget	Variance	Var %	Actual	Budget	Variance	Var %	Actual	Variance	Var %
Other											
Operating Room Utilization	72%	70%	2.4%	3.4%	72%	70%	1.6%	2.2%	70%	1.2%	1.7%
Total Main OR Surgical Minutes - Roosevelt	71,190	83,924	(12,734)	(15.2%)	601,125	563,490	37,635	6.7%	582,435	18,690	3.2%
Main OR Minutes per Case - Roosevelt	114	115	1.2	1.1%	115	115	(0.2)	(0.2%)	114	(1.7)	(1.5%)
Total Main OR Surgeries - Roosevelt	626	730	(104)	(14.2%)	5,218	4,901	317	6.5%	5,131	87	1.7%
OP Surgeries - Peoria	111	102	9	8.8%	671	733	(62)	(8.5%)	331	340	102.7%
Total Surgeries - Roosevelt (Main OR) and Peoria	**737**	**832**	**(95)**	**(11.4%)**	**5,889**	**5,634**	**255**	**4.5%**	**5,462**	**427**	**7.8%**
Endoscopy Procedures - Roosevelt	247	259	(12)	(4.6%)	2,065	2,368	(303)	(12.8%)	2,173	(108)	(5.0%)
Endoscopy Procedures - Peoria	167	119	48	40.4%	933	798	135	16.9%	866	67	7.7%
Total Endoscopy Procedures - Roosevelt and Peoria	**414**	**378**	**36**	**9.6%**	**2,998**	**3,166**	**(168)**	**(5.3%)**	**3,039**	**(41)**	**(1.3%)**
Deliveries	588	179	409	228.5%	1,772	1,622	150	9.2%	1,656	116	7.0%
Trauma Visits (subset of ED Visits)	153	175	(22)	(12.6%)	1,223	1,335	(112)	(8.4%)	1,330	(107)	(8.0%)
Emergency Department (ED)	**8,728**	**8,867**	**(139)**	**(1.6%)**	**72,879**	**68,727**	**4,152**	**6.0%**	**68,986**	**3,893**	**5.6%**
Roosevelt ED	5,121	5,755	(634)	(11.0%)	42,811	40,928	1,883	4.6%	40,409	2,402	5.9%
Maryvale ED	3,054	2,912	142	4.9%	25,389	23,424	1,965	8.4%	23,966	1,423	5.9%
L&D ED	337	-	337	100.0%	2,852	2,540	312	12.3%	2,771	81	2.9%
Burn ED	216	200	16	8.0%	1,827	1,835	(8)	(0.4%)	1,840	(13)	(0.7%)
% of Total ED Visits Resulting in Admission Roosevelt	12.6%	14.3%	(1.7%)	(12.1%)	12.4%	12.9%	(0.5%)	(4.0%)	12.3%	0.1%	0.5%
% of Total ED Visits Resulting in Admission Maryvale	5.3%	5.2%	0.1%	2.3%	5.1%	5.0%	0.1%	1.8%	5.0%	0.1%	2.7%
% of Acute Patients Admitted Through the ED	92.1%	84.1%	8.0%	9.5%	91.4%	91.0%	0.4%	0.5%	88.3%	3.1%	3.5%
Left Without Treatment (LWOT) ROOSEVELT	1.3%	<3%	1.7%	56.4%	1.4%	<3%	1.6%	53.3%	1.4%	(0.0%)	(0.7%)
Left Without Treatment (LWOT) MARYVALE	0.9%	<3%	2.1%	71.6%	1.1%	<3%	1.9%	64.0%	1.1%	0.1%	(5.3%)
Overall ED Median Length of Stay (minutes) ROOSEVELT	225	<240	15	6.3%	226	<240	14	5.8%	220	(6)	(2.7%)
Overall ED Median Length of Stay (minutes) MARYVALE	153	<220	67	30.5%	157	<220	63	28.6%	181	24	(13.3%)
PSYCH ED Median LOS (minutes) ROOSEVELT	635	<240	(635)	(164.6%)	602	<240	(602)	(150.8%)	628	26	4.1%
PSYCH ED Median LOS (minutes) MARYVALE	662	<240	(662)	(175.6%)	808	<240	(808)	(236.7%)	549	(259)	(47.2%)
Median Time to Treatment (MTT) (minutes) ROOSEVELT	28	<30	2	6.7%	28	<30	2	6.7%	29	1	3.4%
Median Time to Treatment (MTT) (minutes) MARYVALE	23	<30	7	23.3%	24	<30	6	20.0%	28	4	(14.3%)
Cath Lab Utilization - Room 1	15%	45%	(29.6%)	(65.8%)	22%	45%	(22.9%)	(50.9%)	22%	0.3%	1.2%
Cath Lab Utilization - Room 2	21%	45%	(23.7%)	(52.6%)	19%	45%	(26.3%)	(58.4%)	25%	(6.3%)	(25.3%)
Cath Lab Utilization - IR	119%	65%	54.0%	83.0%	103%	65%	38.2%	58.7%	95%	8.3%	8.7%
CCTA/Calcium Score	16	15	1	6.7%	141	120	21	17.5%	129	12	9.3%
Pediatric ED Visits at Maryvale (under age 18)	611				4,786				4,942	(156)	(3.2%)
Adult ED Visits at Maryvale (age 18 and over)	2,443				20,603				19,024	1,579	8.3%
Maryvale ED to Inpatient OR (under age 18)	2				26				29	(3)	(10.3%)
Maryvale ED to Inpatient OR (Total)	45				389				247	142	57.5%
Pediatric ED Visits at Roosevelt (under age 18)	796				6,230				7,093	(863)	(12.2%)
Adult ED Visits at Roosevelt (age 18 and over)	4,325				36,580				33,316	3,264	9.8%

Valleywise Health
Financial and Statistical Information
29-Feb-24

Legend
Greater than or equal to 100% of Budget
Within 95% to 100% of Budget
Less than 95% of Budget

	Current Month				Fiscal Year to Date				Prior Fiscal Year to Date		
	Actual	Budget	Variance	Var %	Actual	Budget	Variance	Var %	Actual	Variance	Var %
Operating Income / (Loss) in 000s											
Valleywise Health	$ (18,216)	$ (18,346)	$ 130	0.7%	$ (139,854)	$ (133,302)	$ (6,552)	(4.9%)	$ (122,157)	$ (17,698)	(14.5%)
Net Income / (Loss) in 000s											
Valleywise Health	$ (6,946)	$ (4,001)	$ (2,946)	(73.6%)	$ (39,222)	$ (34,352)	$ (4,870)	(14.2%)	$ (49,324)	$ 10,102	20.5%
Net Income / (Loss) in 000s Normalized											
Valleywise Health	$ (10,191)	$ (7,357)	$ (2,833)	(38.5%)	$ (65,816)	$ (61,159)	$ (4,656)	(7.6%)	$ (57,373)	$ (8,443)	(14.7%)

			Prior Fiscal Year End		
RATIOS:			Actual	Variance	Var %
Liquidity					
Total Cash and Investments (000s)	$ 126.5		$ 241.9	$ (115.4)	(47.7%)
Total Days Cash on Hand	54.8		109.2	(54.4)	(49.8%)
Current Ratio	2.0		2.6	(0.6)	(23.1%)
Current Ratio without Bond-related Assets & Liabilities	1.7		2.3	(0.6)	(26.1%)
Days in Accounts Receivable (Hospital only)	75.2		57.7	(17.5)	(30.3%)
Capital Structure					
EBIDA Debt Service Coverage	0.02		0.70	(0.68)	(97.1%)
Profitability					
Operating Margin	(30.5%)	(13.8%) (16.7%) (121%)	(24.3%)	(6.2%)	(25.5%)
Labor					
FTE/AOB WO Residents	4.17	4.26 0.10 2.3%	4.35	0.19	4.3%

	Current Month				Rolling Last Twelve Months			
	Actual	Prior Year	Variance	Var %	Actual	Prior Year	Variance	Var %
Turnover Rate - Voluntary	1.18%	1.21%	0.03%	2.48%	14.93%	19.81%	4.88%	24.63%
Turnover Rate - Involuntary	0.44%	0.51%	0.07%	13.73%	4.41%	4.77%	0.36%	7.55%
Turnover Rate - Uncontrollable	0.38%	0.51%	0.13%	25.49%	5.00%	4.96%	(0.04%)	(0.81%)
Turnover Rate - Total	**2.00%**	**2.24%**	**0.24%**	**10.71%**	**24.34%**	**29.54%**	**5.20%**	**17.60%**

Appendix A
Definition of Financial Indicators

Indicator	Definition				Desired Position Relative to Trend	Desired Position Relative to Median
Total Days Cash on Hand	= Cash + Short-Term Investments / (Operating Expenses Less - Depreciation) / YTD Days				Up	Above
Days in Accounts Receivable	= Net Patient Accounts Receivable (including Due/From) / Net Patient Service Revenue / YTD Days				Down	Below
Cushion Ratio	= Cash + Short-Term Investments / Principal + Interest Expenses				Up	Above
Cash to Debt	= Cash + Short-Term Investments / Long Term Debt	X	100		Up	Above
EBITDA Debt Service Coverage	= EBITDA / Principal + Interest Expenses				Up	Above
Debt to Net Assets	= Long Term Debt / Long Term Debt + Unrestricted Assets	X	100		Down	Below
Operating Margin	= Operating Income (Loss) / Operating Revenues	X	100		Up	Above
EBITDA Margin	= EBITDA / Operating Revenues + Non Operating Revenues	X	100		Up	Above
Excess Margin	= Net Income / Operating Revenues + Non Operating Revenues	X	100		Up	Above
Case Mix Index - Total Hospital	= All discharged accounts. Includes normal newborns (DRG 795). Includes discharges with a Behavioral Health patient type.				Up	Above
Case Mix Index - Acute (Excluding Newborns)	= Discharged accounts. Excludes normal newborns (DRG 795). Excludes discharges with a Behavioral Health patient type.				Up	Above
Case Mix Index - Behavioral Health	= Discharges with a Behavioral Health patient type.				Up	Above
Case Mix Index - Medicare	= Discharged accounts with a financial class of Medicare or Medicare Managed Care. Excludes normal newborns (DRG 795). Excludes discharges with a Behavioral Health patient type.				Up	Above
Case Mix Index - AHCCCS	= Discharged accounts with a financial class of AHCCCS or Maricopa Health Plan. Excludes normal newborns (DRG 795). Excludes discharges with a Behavioral Health patient type.				Up	Above

For ALL Case Mix values -- only Patient Types of Inpatient, Behavioral Health and Newborn are counted (as appropriate). Patient Types of Observation, Outpatient and Emergency are excluded from all CMI calculations at all times.

New individual MS-DRG weights are issued by CMS each year, with an effective date of October 1st.

Valleywise Health

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

VOLUMES

For the Eight Periods Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month % Change	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year % Change
ADMISSIONS												
Acute	1,050	1,202	(152)	(12.6 %)	983	6.8 %	8,799	8,633	166	1.9 %	8,670	1.5 %
Behavioral Health	377	371	6	1.6 %	285	32.3 %	2,972	3,059	(87)	(2.8 %)	2,588	14.8 %
Valleywise Behavioral Health Center-Phoenix	92	83	9	10.8 %	42	119.0 %	633	703	(70)	(10.0 %)	432	46.5 %
Valleywise Behavioral Health Center-Mesa	125	139	(14)	(10.1 %)	136	(8.1 %)	1,155	1,189	(34)	(2.9 %)	1,160	(0.4 %)
Valleywise Behavioral Health Center-Maryvale	160	149	11	7.4 %	107	49.5 %	1,184	1,167	17	1.5 %	996	18.9 %
Total	1,427	1,573	(146)	(9.3 %)	1,268	12.5 %	11,771	11,692	79	0.7 %	11,258	4.6 %
OBSERVATION ADMISSIONS												
Transferred to Inpatient *	213	186	27	14.5 %	230	(7.4 %)	1,699	1,698	1	0.1 %	1,795	(5.3 %)
Observation Admission Only	355	306	49	16.0 %	383	(7.3 %)	2,986	2,796	190	6.8 %	2,958	0.9 %
Total Observation Admissions	568	492	76	15.4 %	613	(7.3 %)	4,685	4,494	191	4.3 %	4,753	(1.4 %)
TOTAL ADMISSIONS AND OBSERVATION ONLY												
Total	1,782	1,879	(97)	(5.2 %)	1,651	7.9 %	14,757	14,488	269	1.9 %	14,216	3.8 %
ADJUSTED ADMISSIONS												
Total	2,947	3,128	(181)	(5.8 %)	2,495	18.1 %	23,342	22,172	1,170	5.3 %	21,531	8.4 %
PATIENT DAYS												
Acute	5,591	4,635	956	20.6 %	5,120	9.2 %	47,304	44,101	3,203	7.3 %	45,352	4.3 %
Behavioral Health	8,529	8,630	(101)	(1.2 %)	7,985	6.8 %	70,788	71,894	(1,106)	(1.5 %)	64,306	10.1 %
Valleywise Behavioral Health Center-Phoenix	2,477	1,954	523	26.8 %	1,894	30.8 %	19,444	16,761	2,683	16.0 %	14,185	37.1 %
Valleywise Behavioral Health Center-Mesa	3,003	3,205	(202)	(6.3 %)	3,014	(0.4 %)	24,742	27,718	(2,976)	(10.7 %)	25,266	(2.1 %)
Valleywise Behavioral Health Center-Maryvale	3,049	3,471	(422)	(12.2 %)	3,077	(0.9 %)	26,602	27,415	(813)	(3.0 %)	24,855	7.0 %
Total	14,120	13,265	855	6.4 %	13,105	7.7 %	118,092	115,995	2,097	1.8 %	109,658	7.7 %
AVERAGE DAILY CENSUS												
Acute	193	160	33	20.6 %	183	5.4 %	194	181	13	7.3 %	187	3.9 %
Behavioral Health	294	298	(3)	(1.2 %)	285	3.1 %	290	295	(5)	(1.5 %)	265	9.6 %
Valleywise Behavioral Health Center-Phoenix	85	67	18	26.8 %	68	26.3 %	80	69	11	16.0 %	58	36.5 %
Valleywise Behavioral Health Center-Mesa	104	111	(7)	(6.3 %)	108	(3.8 %)	101	114	(12)	(10.7 %)	104	(2.5 %)
Valleywise Behavioral Health Center-Maryvale	105	120	(15)	(12.2 %)	110	(4.3 %)	109	112	(3)	(3.0 %)	102	6.6 %
Total	487	457	29	6.4 %	468	4.0 %	484	475	9	1.8 %	451	7.2 %
ADJUSTED PATIENT DAYS												
Total	29,163	26,382	2,781	10.5 %	25,784	13.1 %	234,178	219,966	14,212	6.5 %	209,724	11.7 %

** Already included in 'Acute Admissions'.*

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

VOLUMES

For the Eight Periods Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month % Change	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year % Change
OPERATING ROOM SURGERIES - ROOSEVELT												
Inpatient	345	429	(84)	(19.6 %)	344	0.3 %	2,919	2,879	40	1.4 %	3,013	(3.1 %)
Outpatient	281	301	(20)	(6.6 %)	256	9.8 %	2,299	2,022	277	13.7 %	2,118	8.5 %
Total	626	730	(104)	(14.2 %)	600	4.3 %	5,218	4,901	317	6.5 %	5,131	1.7 %
Inpatient Minutes	42,000	52,853	(10,853)	(20.5 %)	44,445	(5.5 %)	363,270	354,868	8,402	2.4 %	355,785	2.1 %
Outpatient Minutes	29,190	31,071	(1,881)	(6.1 %)	26,490	10.2 %	237,855	208,622	29,233	14.0 %	226,650	4.9 %
Total	71,190	83,924	(12,734)	(15.2 %)	70,935	0.4 %	601,125	563,490	37,635	6.7 %	582,435	3.2 %
OPERATING ROOM SURGERIES - PEORIA												
Outpatient	111	102	9	8.8 %	48	131.3 %	671	733	(62)	(8.5 %)	331	102.7 %
Outpatient Minutes	7,755	5,933	1,822	30.7 %	3,660	111.9 %	48,840	39,625	9,215	23.3 %	29,850	63.6 %
ENDOSCOPY PROCEDURES - ROOSEVELT												
Inpatient	65	80	(15)	(19.2 %)	105	(38.1 %)	620	735	(115)	(15.7 %)	699	(11.3 %)
Outpatient	182	179	3	1.9 %	177	2.8 %	1,445	1,633	(188)	(11.5 %)	1,474	(2.0 %)
Total	247	259	(12)	(4.6 %)	282	(12.4 %)	2,065	2,368	(303)	(12.8 %)	2,173	(5.0 %)
ENDOSCOPY PROCEDURES - PEORIA												
Outpatient	167	119	48	40.4 %	123	35.8 %	933	798	135	16.9 %	866	7.7 %
DELIVERIES												
Total	588	179	409	228.5 %	195	201.5 %	1,772	1,622	150	9.2 %	1,656	7.0 %
ED VISITS												
Roosevelt	5,121	5,755	(634)	(11.0 %)	4,832	6.0 %	42,811	40,928	1,883	4.6 %	40,409	5.9 %
Maryvale	3,054	2,912	142	4.9 %	2,885	5.9 %	25,389	23,424	1,965	8.4 %	23,966	5.9 %
Labor & Delivery	337	0	337	100.0 %	296	13.9 %	2,852	2,540	312	12.3 %	2,771	2.9 %
Burn	216	200	16	8.0 %	186	16.1 %	1,827	1,835	(8)	(0.4 %)	1,840	(0.7 %)
Total	8,728	8,867	(139)	(1.6 %)	8,199	6.5 %	72,879	68,727	4,152	6.0 %	68,986	5.6 %
AMBULATORY VISITS												
Valleywise Community Health Centers	13,552	15,081	(1,529)	(10.1 %)	13,394	1.2 %	107,217	110,504	(3,287)	(3.0 %)	112,586	(4.8 %)
Valleywise Comprehensive Health Center-Phoenix	12,480	12,428	52	0.4 %	11,872	5.1 %	99,592	97,845	1,747	1.8 %	96,598	3.1 %
Valleywise Comprehensive Health Center-Peoria	4,094	3,443	651	18.9 %	3,019	35.6 %	26,970	25,608	1,362	5.3 %	24,589	9.7 %
Outpatient Behavioral Health	6,336	6,249	87	1.4 %	5,142	23.2 %	52,394	47,985	4,409	9.2 %	43,881	19.4 %
Dental	2,171	1,871	300	16.0 %	1,937	12.1 %	15,895	15,632	263	1.7 %	15,371	3.4 %
Total	38,633	39,072	(439)	(1.1 %)	35,364	9.2 %	302,068	297,574	4,494	1.5 %	293,025	3.1 %

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

FINANCIAL INDICATORS

For the Period Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month Variance	Prior Year Same Month % Change
Net Patient Service Revenue per APD	$ 1,303	$ 1,523	($ 220)	(14.4 %)	$ 1,540	($ 237)	(15.4 %)
Salaries	$ 26,020,405	$ 25,396,135	($ 624,270)	(2.5 %)	$ 21,934,559	($ 4,085,846)	(18.6 %)
Benefits	9,604,900	7,543,877	(2,061,023)	(27.3 %)	6,883,484	(2,721,416)	(39.5 %)
Contract Labor	6,490,254	5,649,494	(840,760)	(14.9 %)	7,449,419	959,165	12.9 %
Total Labor Costs	$ 42,115,559	$ 38,589,506	($ 3,526,053)	(9.1 %)	$ 36,267,463	($ 5,848,097)	(16.1 %)
Supplies	$ 9,321,982	$ 7,577,690	($ 1,744,292)	(23.0 %)	$ 7,180,075	($ 2,141,907)	(29.8 %)
Medical Service Fees	9,605,201	9,679,827	74,626	0.8 %	9,133,589	(471,612)	(5.2 %)
All Other *	12,996,916	9,185,295	(3,811,622)	(41.5 %)	9,873,703	(3,123,213)	(31.6 %)
Total	$ 31,924,099	$ 26,442,811	($ 5,481,288)	(20.7 %)	$ 26,187,367	($ 5,736,732)	(21.9 %)
Total Operating and Non-Operating Expenses *	$ 74,039,658	$ 65,032,317	($ 9,007,341)	(13.9 %)	$ 62,454,829	($ 11,584,829)	(18.5 %)
* Excludes Depreciation							
Tax Levy							
Property Tax	$ 8,018,745	$ 8,018,745	$ 0	0.0 %	$ 7,673,441	$ 345,305	4.5 %
Bonds	4,433,605	4,433,605	0	0.0 %	3,094,397	1,339,208	43.3 %
Total Tax Levy	$ 12,452,350	$ 12,452,350	$ 0	0.0 %	$ 10,767,838	$ 1,684,513	15.6 %
Patient Days - Acute	5,591	4,635	956	20.6 %	5,120	471	9.2 %
Patient Days - Behavioral Health	8,529	8,630	(101)	(1.2 %)	7,985	544	6.8 %
Patient Days - Total	14,120	13,265	855	6.4 %	13,105	1,015	7.7 %
Adjusted Patient Days	29,163	26,382	2,781	10.5 %	25,784	3,379	13.1 %
APD Ratio	2.07	1.99	0.08	3.8 %	1.97	0.10	5.0 %
Admissions - Acute	1,050	1,202	(152)	(12.6 %)	983	67	6.8 %
Admissions - Behavioral Health	377	371	6	1.6 %	285	92	32.3 %
Admissions - Total	1,427	1,573	(146)	(9.3 %)	1,268	159	12.5 %
Adjusted Admissions	2,947	3,128	(181)	(5.8 %)	2,495	452	18.1 %

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

FINANCIAL INDICATORS

For the Period Ending February 29, 2024

	Feb-24 Actual	Feb-24 Budget	Feb-24 Variance	Feb-24 % Change	Prior Year Same Month Feb-23	Prior Year Same Month Variance	Prior Year Same Month % Change
Average Daily Census - Acute	193	160	33	20.6 %	183	10	5.4 %
Average Daily Census - Behavioral Health	294	298	(3)	(1.2 %)	285	9	3.1 %
Average Daily Census - Total	487	457	29	6.4 %	468	19	4.0 %
Adjusted Occupied Beds - Acute	398	318	80	25.3 %	360	38	10.7 %
Adjusted Occupied Beds - Behavioral Health	607	592	16	2.6 %	561	46	8.3 %
Adjusted Occupied Beds - Total	1,006	910	96	10.5 %	921	85	9.2 %
Paid FTEs - Payroll	3,690	3,633	(57)	(1.6 %)	3,338	(353)	(10.6 %)
Paid FTEs - Contract Labor	475	449	(26)	(5.8 %)	543	68	12.5 %
Paid FTEs - Total	4,165	4,083	(83)	(2.0 %)	3,881	(285)	(7.3 %)
FTEs per AOB	4.14	4.49	0.35	7.7 %	4.21	0.07	1.7 %
FTEs per AOB (w/o Residents)	3.94	4.27	0.33	7.7 %	4.01	0.07	1.8 %
Benefits as a % of Salaries	36.9 %	29.7 %	(7.2 %)	(24.3 %)	31.4 %	(5.5 %)	(17.6 %)
Labor Costs as a % of Net Patient Revenue	110.8 %	96.0 %	(14.8 %)	(15.4 %)	91.3 %	(19.5 %)	(21.3 %)
Salaries and Contract Labor per APD	$ 1,115	$ 1,177	$ 62	5.3 %	$ 1,140	$ 25	2.2 %
Benefits per APD	329	286	(43)	(15.2 %)	267	(62)	(23.4 %)
Supplies per APD	320	287	(32)	(11.3 %)	278	(41)	(14.8 %)
Medical Service Fees per APD	329	367	38	10.2 %	354	25	7.0 %
All Other Expenses per APD *	446	348	(98)	(28.0 %)	383	(63)	(16.4 %)
Total Expenses per APD *	$ 2,539	$ 2,465	($ 74)	(3.0 %)	$ 2,422	($ 117)	(4.8 %)
Salaries and Contract Labor per Adj. Admission	$ 11,031	$ 9,924	($ 1,107)	(11.2 %)	$ 11,778	$ 747	6.3 %
Benefits per Adj. Admission	3,259	2,411	(848)	(35.1 %)	2,759	(500)	(18.1 %)
Supplies per Adj. Admission	3,163	2,422	(741)	(30.6 %)	2,878	(285)	(9.9 %)
Medical Service Fees per Adj. Admission	3,259	3,094	(165)	(5.3 %)	3,661	402	11.0 %
All Other Expenses per Adj. Admission *	4,410	2,936	(1,474)	(50.2 %)	3,958	(452)	(11.4 %)
Total Expenses per Adj. Admission *	$ 25,121	$ 20,787	($ 4,334)	(20.9 %)	$ 25,034	($ 88)	(0.3 %)

* Excludes Depreciation

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

FINANCIAL INDICATORS

For the Eight Periods Ending February 29, 2024

	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year Variance	YTD Prior Year % Change
Net Patient Service Revenue per APD	$ 1,445	$ 1,559	($ 114)	(7.3 %)	$ 1,564	($ 119)	(7.6 %)
Salaries	$ 217,805,862	$ 208,022,411	($ 9,783,451)	(4.7 %)	$ 194,278,603	($ 23,527,259)	(12.1 %)
Benefits	66,801,302	61,445,744	(5,355,559)	(8.7 %)	57,815,322	(8,985,980)	(15.5 %)
Contract Labor	48,321,569	50,963,919	2,642,351	5.2 %	56,968,448	8,646,880	15.2 %
Total Labor Costs	$ 332,928,733	$ 320,432,074	($ 12,496,659)	(3.9 %)	$ 309,062,373	($ 23,866,359)	(7.7 %)
Supplies	$ 77,456,552	$ 64,686,691	($ 12,769,861)	(19.7 %)	$ 64,293,677	($ 13,162,875)	(20.5 %)
Medical Service Fees	67,951,733	76,595,270	8,643,537	11.3 %	70,006,765	2,055,033	2.9 %
All Other *	99,500,381	93,391,010	(6,109,371)	(6.5 %)	105,221,221	5,720,840	5.4 %
Total	$ 244,908,665	$ 234,672,971	($ 10,235,695)	(4.4 %)	$ 239,521,663	($ 5,387,003)	(2.2 %)
Total Operating and Non-Operating Expenses *	$ 577,837,398	$ 555,105,044	($ 22,732,354)	(4.1 %)	$ 548,584,036	($ 29,253,362)	(5.3 %)
* Excludes Depreciation							
Tax Levy							
Property Tax	$ 64,149,963	$ 64,149,963	$ 0	0.0 %	$ 62,111,249	$ 2,038,714	3.3 %
Bonds	35,468,840	35,468,840	0	0.0 %	25,047,036	10,421,804	41.6 %
Total Tax Levy	$ 99,618,804	$ 99,618,803	$ 0	0.0 %	$ 87,158,285	$ 12,460,518	14.3 %
Patient Days - Acute	47,304	44,101	3,203	7.3 %	45,352	1,952	4.3 %
Patient Days - Behavioral Health	70,788	71,894	(1,106)	(1.5 %)	64,306	6,482	10.1 %
Patient Days - Total	118,092	115,995	2,097	1.8 %	109,658	8,434	7.7 %
Adjusted Patient Days	234,178	219,966	14,212	6.5 %	209,724	24,454	11.7 %
APD Ratio	1.98	1.90	0.09	4.6 %	1.91	0.07	3.7 %
Admissions - Acute	8,799	8,633	166	1.9 %	8,670	129	1.5 %
Admissions - Behavioral Health	2,972	3,059	(87)	(2.8 %)	2,588	384	14.8 %
Admissions - Total	11,771	11,692	79	0.7 %	11,258	513	4.6 %
Adjusted Admissions	23,342	22,172	1,170	5.3 %	21,531	1,811	8.4 %

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT

VALLEYWISE HEALTH (COMBINED CARE SYSTEM)

FINANCIAL INDICATORS

For the Eight Periods Ending February 29, 2024

	Feb-24 YTD Actual	Feb-24 YTD Budget	Feb-24 YTD Variance	YTD Feb-24 % Change	YTD Prior Year Feb-23	YTD Prior Year Variance	YTD Prior Year % Change
Average Daily Census - Acute	194	181	13	7.3 %	187	7	3.9 %
Average Daily Census - Behavioral Health	290	295	(5)	(1.5 %)	265	25	9.6 %
Average Daily Census - Total	484	475	9	1.8 %	451	33	7.2 %
Adjusted Occupied Beds - Acute	384	343	42	12.2 %	357	28	7.7 %
Adjusted Occupied Beds - Behavioral Health	575	559	17	3.0 %	506	69	13.7 %
Adjusted Occupied Beds - Total	960	901	58	6.5 %	863	97	11.2 %
Paid FTEs - Payroll	3,735	3,569	(166)	(4.7 %)	3,441	(294)	(8.5 %)
Paid FTEs - Contract Labor	460	477	17	3.5 %	503	42	8.4 %
Paid FTEs - Total	4,195	4,046	(150)	(3.7 %)	3,944	(252)	(6.4 %)
FTEs per AOB	4.37	4.49	0.12	2.6 %	4.57	0.20	4.3 %
FTEs per AOB (w/o Residents)	4.17	4.26	0.10	2.3 %	4.35	0.19	4.3 %
Benefits as a % of Salaries	30.7 %	29.5 %	(1.1 %)	(3.8 %)	29.8 %	(0.9 %)	(3.1 %)
Labor Costs as a % of Net Patient Revenue	98.4 %	93.5 %	(5.0 %)	(5.3 %)	94.2 %	(4.2 %)	(4.4 %)
Salaries and Contract Labor per APD	$ 1,136	$ 1,177	$ 41	3.5 %	$ 1,198	$ 62	5.1 %
Benefits per APD	285	279	(6)	(2.1 %)	276	(10)	(3.5 %)
Supplies per APD	331	294	(37)	(12.5 %)	307	(24)	(7.9 %)
Medical Service Fees per APD	290	348	58	16.7 %	334	44	13.1 %
All Other Expenses per APD *	425	425	(0)	(0.1 %)	502	77	15.3 %
Total Expenses per APD *	$ 2,468	$ 2,524	$ 56	2.2 %	$ 2,616	$ 148	5.7 %
Salaries and Contract Labor per Adj. Admission	$ 11,401	$ 11,681	$ 280	2.4 %	$ 11,669	$ 268	2.3 %
Benefits per Adj. Admission	2,862	2,771	(91)	(3.3 %)	2,685	(177)	(6.6 %)
Supplies per Adj. Admission	3,318	2,917	(401)	(13.7 %)	2,986	(332)	(11.1 %)
Medical Service Fees per Adj. Admission	2,911	3,455	543	15.7 %	3,251	340	10.5 %
All Other Expenses per Adj. Admission *	4,263	4,212	(51)	(1.2 %)	4,887	624	12.8 %
Total Expenses per Adj. Admission *	$ 24,755	$ 25,036	$ 281	1.1 %	$ 25,478	$ 723	2.8 %

* Excludes Depreciation

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

OPERATING REVENUE

Patient Days, Admissions and Adjusted Patient Days

Acute Care	**Actual**	**Budget**	**Variance**	**%Variance**
MTD - Patient Days	**5,591**	**4,635**	**956**	**20.6%**
YTD - Patient Days	**47,304**	**44,101**	**3,203**	**7.3%**
MTD - Admissions	**1,050**	**1,202**	**(152)**	**-12.6%**
YTD - Admissions	**8,799**	**8,633**	**166**	**1.9%**
MTD - Average Length of Stay (ALOS)	**5.3**	**3.9**	**(1.5)**	**-38.1%**
YTD - Average Length of Stay (ALOS)	**5.4**	**5.1**	**(0.3)**	**-5.2%**
MTD - Average Daily Census (ADC)	**200**	**166**	**34**	**20.6%**
YTD - Average Daily Census (ADC)	**195**	**181**	**13**	**7.3%**

Behavioral Health	**Actual**	**Budget**	**Variance**	**%Variance**
MTD - Patient Days	**8,529**	**8,630**	**(101)**	**-1.2%**
YTD - Patient Days	**70,788**	**71,894**	**(1,106)**	**-1.5%**
MTD - Admissions	**377**	**371**	**6**	**1.6%**
YTD - Admissions	**2,972**	**3,059**	**(87)**	**-2.8%**
MTD - Average Length of Stay (ALOS)	**22.6**	**23.3**	**0.6**	**2.7%**
YTD - Average Length of Stay (ALOS)	**23.8**	**23.5**	**(0.3)**	**-1.3%**
MTD - Average Daily Census (ADC)	**305**	**308**	**(4)**	**-1.2%**
YTD - Average Daily Census (ADC)	**291**	**296**	**(4)**	**-1.4%**

Adjusted Patient Days (APD)	**Actual**	**Budget**	**Variance**	**%Variance**
Month-to-Date	**29,163**	**26,382**	**2,781**	**10.5%**
Year-to-Date	**234,178**	**219,966**	**14,212**	**6.5%**

Net patient service revenue

	Actual	**Budget**	**Variance**	**%Variance**
Month-to-Date	**$ 38,013,251**	**$ 40,188,148**	**$ (2,174,897)**	**-5.4%**
Year-to-Date	**$ 338,276,906**	**$ 342,856,606**	**$ (4,579,701)**	**-1.3%**
Month-to-Date Per APD	**$ 1,303**	**$ 1,523**	**$ (220)**	**-14.4%**
Year-to-Date Per APD	**$ 1,445**	**$ 1,559**	**$ (114)**	**-7.3%**

Other operating revenue

	Actual	**Budget**	**Variance**	**%Variance**
Month-to-Date	**$ 17,906,471**	**$ 12,933,070**	**$ 4,973,400**	**38.5%**
Year-to-Date	**$ 120,423,697**	**$ 103,845,100**	**$ 16,578,596**	**16.0%**

The majority of the positive variances are in Health II, retail pharmacies revenues, other incentives, offsetting revenue grants/research & foundation, and value-based incentive revenue; while the majority of the negative variances for the month are in the 340(b) program, and other miscellaneous operating revenue.

Total operating revenues

	Actual	**Budget**	**Variance**	**%Variance**
Month-to-Date	**$ 55,919,722**	**$ 53,121,219**	**$ 2,798,503**	**5.3%**
Year-to-Date	**$ 458,700,602**	**$ 446,701,706**	**$ 11,998,896**	**2.7%**

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

OPERATING EXPENSES

Salaries and wages

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 26,020,405	$ 25,396,135	$ (624,270)	-2.5%
Year-to-Date	$ 217,805,862	$ 208,022,411	$ (9,783,451)	-4.7%

	Actual	Budget	Variance	%Variance
Paid FTE's - Payroll	3,690	3,633	(57)	-1.6%

	Actual	Budget	Variance	%Variance
Paid FTE's - Payroll (w/o Residents)	3,687	3,629	(58)	-1.6%

	Actual	Budget	Variance	%Variance
Salaries per FTE's - Payroll	$ 7,051	$ 6,990	$ (61)	-0.9%

Contract labor

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 6,490,254	$ 5,649,494	$ (840,760)	-14.9%
Year-to-Date	$ 48,321,569	$ 50,963,919	$ 2,642,351	5.2%

	Actual	Budget	Variance	%Variance
FTE's - Contract Labor incl Outsource	475	449	(26)	-5.8%

FTE's - Contract Labor	Actual	Budget	Variance	%Variance
Nursing operations - Acute	121	134	12	9.0%
Revenue Cycle	-	-	-	-100.0%
Behavioral Health	72	31	(41)	-134.1%
Information Technology	-	-	-	-100.0%
Support Services	15	9	(6)	-63.2%
Interns & Residents	206	202	(3)	-1.5%

	Actual	Budget	Variance	%Variance
Paid FTE's - Payroll & Contract Labor	4,165	4,083	(83)	-2.0%

	Actual	Budget	Variance	%Variance
Adjusted Occupied Beds (AOB)	1,042	942	99	10.5%

	Actual	Budget	Variance	%Variance
Paid FTE's per AOB	4.00	4.33	0.33	7.7%

	Actual	Budget	Variance	%Variance
Paid FTE's per AOB (w/o Residents)	3.80	4.11	0.32	7.7%

Employee benefits

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 9,604,900	$ 7,543,877	$ (2,061,023)	-27.3%
Year-to-Date	$ 66,801,302	$ 61,445,744	$ (5,355,559)	-8.7%

The primary negative variances for the month are in the net medical expenses, and the paid leave accrual.

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

Benefits as a % of salaries

	Actual	Budget	Variance	%Variance
Month-to-Date	36.9%	29.7%	-7.2%	-24.3%
Year-to-Date	30.7%	29.5%	-1.1%	-3.8%

Medical service fees

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 9,605,201	$ 9,679,827	$ 74,626	0.8%
Year-to-Date	$ 67,951,733	$ 76,595,270	$ 8,643,537	11.3%

The majority of the positive variance for the month is in higher than anticipated DMG collections; while the majority of the negative variance for the month is in DMG staffing fees.

Supplies

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 9,321,982	$ 7,577,690	$ (1,744,292)	-23.0%
Year-to-Date	$ 77,456,552	$ 64,686,691	$ (12,769,861)	-19.7%

The negative variances for the month are primarily in surgery related medical supplies (implants), pharmaceuticals, radiology supplies, laboratory supplies, and repairs & maintenance supplies; while the positive variance for the month is in GPO rebates.

Purchased services

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 5,339,744	$ 4,569,235	$ (770,509)	-16.9%
Year-to-Date	$ 40,027,671	$ 37,721,017	$ (2,306,653)	-6.1%

The major negative variances for the month are in management fees, consulting & management fees, attorney & legal fees, advertising services, and translation & interpreting services. The major positive variances for the month are in laundry & dry cleaning services, other professional services, and other services.

Other expenses

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 5,508,621	$ 5,176,280	$ (332,341)	-6.4%
Year-to-Date	$ 45,468,382	$ 42,217,126	$ (3,251,256)	-7.7%

The major negative variances for the month are in risk management expenses, utilities, and rent expense. The major positive variance for the month is in other miscellaneous expenses and software subscriptions.

Depreciation

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 2,244,333	$ 5,874,371	$ 3,630,038	61.8%
Year-to-Date	$ 17,911,582	$ 38,351,685	$ 20,440,103	53.3%

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

Total operating expenses

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 74,135,440	$ 71,466,908	$ (2,668,531)	-3.7%
Year-to-Date	$ 581,744,652	$ 580,003,862	$ (1,740,790)	-0.3%

Operating income (loss)

	Actual	Budget	Variance	%Variance
Month-to-Date	$ (18,215,718)	$ (18,345,690)	$ 129,972	0.7%
Year-to-Date	$ (123,044,050)	$ (133,302,156)	$ 10,258,106	7.7%

Non-operating revenues (expenses)

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 11,269,547	$ 14,345,174	$ (3,075,627)	-21.4%
Year-to-Date	$ 100,632,401	$ 98,950,482	$ 1,681,919	1.7%

The majority of the negative variances are in local match related expenses, and capital related grant revenues.

Excess of revenues over expenses

	Actual	Budget	Variance	%Variance
Month-to-Date	$ (6,946,171)	$ (4,000,515)	$ (2,945,656)	73.6%
Year-to-Date	$ (22,411,648)	$ (34,351,674)	$ 11,940,025	-34.8%

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

ASSETS

Cash and cash equivalents - Delivery system

Feb-24	Jun-23	Change	% change
$ 126,526,435	$ 241,214,127	$ (114,687,692)	-47.5%

Cash and cash equivalents - Bond (restricted)

Feb-24	Jun-23	Change	% change
$ 76,990,726	$ 166,504,192	$ (89,513,467)	-53.8%

Paid $40.7M in principal and interest in July 2023 related to the 3rd and 4th bond offerings.

Patient A/R, net of allowances

Feb-24	Jun-23	Change	% change
$ 102,646,896	$ 85,709,368	$ 16,937,528	19.8%

Other receivables and prepaid items

Feb-24	Jun-23	Change	% change
$ 59,020,287	$ 42,225,086	$ 16,795,201	39.8%

FY24 other receivables / prepaids includes:
$19.2M in prepaids/deposits
$12.4M in inventories
$10.3M receivables from grants & research sponsors
$5.6M in Health II
$3.0M due from other receivables
$4.1M in Psych subsidy
$1.6M due from Wellpartner/340B program
$1.4M in retail pharmacy receivable
$699K due from other hospital - resident rotation
$603K due from Home Assist Health
$208K due from Health Foundation

Estimated amounts due from third party payors

Feb-24	Jun-23	Change	% change
$ 104,524,501	$ 50,640,640	$ 53,883,862	106.4%

FY24 due from third party payors includes:
$101.3M due from AHCCCS for GME - FY2024
$2.8M due from AHCCCS for DSH - FY2024
$387K due from First Things First

Due from related parties

Feb-24	Jun-23	Change	% change
$ 6,917,173	$ 3,376,279	$ 3,540,894	104.9%

FY24 due from related parties includes:
$4.8M due from Maricopa County for tax levy collection
$2.1M due from Public Health Ryan White Part A programs

Other Current Assets

Feb-24	Jun-23	Change	% change
$ 2,516,402	$ 2,516,402	$ -	0.0%

Capital Assets, net

Feb-24	Jun-23	Change	% change
$ 830,207,449	$ 796,596,154	$ 33,611,296	4.2%

Other Assets

Feb-24	Jun-23	Change	% change
$ 5,005,017	$ 5,005,017	$ -	0.0%

Deferred outflows

Feb-24	Jun-23	Change	% change
$ 56,462,313	$ 56,462,313	$ -	0.0%

LIABILITIES AND NET POSITION

Current maturities of long-term debt

Feb-24	Jun-23	Change	% change
$ 37,225,419	$ 43,216,702	$ (5,991,283)	-13.9%

FY24 current maturities includes:
$34.7M in Bond current portion and interest payable
$2.5M in current portion - Lease Liability

Accounts payable

Feb-24	Jun-23	Change	% change
$ 74,876,374	$ 75,381,153	$ (504,779)	-0.7%

FY24 accounts payable includes:
$38.8M in vendor related expense accruals/estimates
$21.6M in vendor approved payments
$14.5M due to DMG for annual recon and pass thru payments

Accrued payroll and expenses

Feb-24	Jun-23	Change	% change
$ 37,187,978	$ 28,158,703	$ 9,029,275	32.1%

Medical claims payable

Feb-24	Jun-23	Change	% change
$ 18,255,175	$ 18,892,539	$ (637,364)	-3.4%

MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT
VALLEYWISE HEALTH (COMBINED CARE SYSTEM)
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending February 28, 2024

Due to related parties

Feb-24	Jun-23	Change	% change
$ (2,605,604)	$ 1,434	$ (2,607,038)	-181822.1%

Timing of tax levy revenue accrual and actual collection received.

Other current liabilities

Feb-24	Jun-23	Change	% change
$ 78,670,450	$ 80,724,270	$ (2,053,820)	-2.5%

FY24 other current liabilities includes:
$27.6M in deferred income (Health Foundation)
$13.3M in patient credit balances
$12.4M in deferred income (MC ARPA)
$9.9M in deferred income (FQHC)
$6.2M in settlement reserved for Medicare
$4.7M in other deferred income (TIP, Optum, APSI)
$3.0M in deferred income for grants, research, & study residuals
$1.0M in capitation payments
$379K in unclaimed/stale dated checks
$219K in other deferred income (Target distribution/High impact areas)

Bonds payable

Feb-24	Jun-23	Change	% change
$ 603,300,622	$ 640,746,278	$ (37,445,656)	-5.8%

Reclassed current maturities portion of Bond payable

Other long-term debt

Feb-24	Jun-23	Change	% change
$ 5,005,017	$ 5,005,017	$ -	0.0%

Long-term portion of lease liability

Long-term liabilities

Feb-24	Jun-23	Change	% change
$ 356,444,644	$ 356,444,644	$ -	0.0%

Pension liability per ASRS report - GASB68

Deferred inflows

Feb-24	Jun-23	Change	% change
$ 18,778,412	$ 18,778,412	$ -	0.0%

Net position

Feb-24	Jun-23	Change	% change
$ 143,678,711	$ 182,900,424	$ (39,221,712)	-21.4%

Valleywise Health
Health Plan sale proceeds

Beginning balance - February 01, 2017			**$ -**
ADD:	Payment received from UHC for member transfer	$ 33,361,499.99	
	Investment income	1,601,294.04	
	Fund Interest	1,267,676.04	
	Bank interest income received - YTD	85,560.34	
			36,316,030.41
LESS:	Consulting services expense	(547,601.00)	
	Valleywise Health Foundation Funding	(5,750,000.00)	
	Bank charges - transfer fees	(50.00)	
			(6,297,651.00)
Ending balance as of February 29, 2024			**$ 30,018,379.41**

6. Maricopa County Special Health Care District's Employee Benefits Program for Fiscal Year 2025

March 20, 2024

2024-2025 Valleywise Health Benefits Program

Executive Summary

Executive Summary

Valleywise Health provides a comprehensive Benefits Program for employees and their families.

Valleywise Health Benefit Program costs, are projected to increase by **10.35%** to budget rates.

- The total projected Benefit Program costs (ER/EE) for PY 2024-2025 is **$45.4M**.

- The Benefit Program PEPY costs are approximately **$16,541**.

The projected total costs in this Executive Summary assume:

- No change in current enrollment levels
- No migration between plans
- Approval of recommendations

Changes in the Benefits Program, mainly the medical plan, are recommended as part of a broader longer-term view of benefits for Valleywise and continue supporting overarching objectives to:

- Remain competitive when attracting new employees and retaining current talent.
- Focus on helping employee and family members attain or retain optimal health and well-being so they can provide the best level of care to our patients.
- Align with the overall mission and culture of Valleywise Health.
- Continue to incent employees and their families to utilize the services of Valleywise when available and appropriate.
- Encourage a “consumer” mindset when participants access care.
- Manage the overall costs to the organization.
- Manage employee personal costs for care from both a paycheck and point-of-care perspective.

Executive Summary

Medical and Pharmacy

The overall costs for the medical/pharmacy plan are projected to increase 9.3% over the current plan year period. This increase is contributed to high costs claimants and increased pharmacy spend.

- Total projected costs (ER/EE) of $43.6M (excludes migration fluctuations and includes HSA contributions).
- The plan costs are projected to increase $3,723,245.
- Stop-loss proposal at 4.24%.
- Valleywise enrollment increased over the past year from 2,646 to 2,829.

Recommendation: Split cost increase between Valleywise and employee. Keep employee's contribution percentage the same.

Per Employee Costs

- $15,219 per employee per year (PEPY)
- $1,268 per employee per month (PEPM)

Executive Summary

Medical Plan

To minimize cost increase and to direct employees to the appropriate level of care, the following Medical Plan recommendations are:

- Increase out-of-pocket maximums ($1000/$2000 per plan increase)
- Reduce copay for Teledoc and Urgent Care Services.
- Increase ER copay to $400.
- Increase HDHP deductible due to IRS guidelines ($200/$400 increase).
- Increase Specialist Copay for Preferred Plan to $50 (currently $40).
- Change Specialist copay for POS to 20% after deductible (currently $50).

Recommendation: Make plan changes as outlined above.

Executive Summary

Pharmacy Plan

To eliminate manufacturer coupons being leveraged by employees to reduce their financial responsibility and negatively impact the plan.

- Add Accumulator Adjustment Program for OptumRx – program does not provide employees “credit” towards their deductible for amounts that are paid for when an employee uses a manufacturers coupon.

Recommendation: Make plan changes as outlined above.

Executive Summary

Dental & Vision

Dental Plan – MetLife

Both plans in rate guarantee until 6/30/2025.

Self-funded Dental PPO Plan

- $3.50 PEPM administration fee only and premium equivalent is $68 PEPM.

Fully Insured Dental Copay Plan

- Rate guarantee at roughly $34.67 PEPM.

Vision Plan – United Healthcare

- Rate guarantee until 6/30/2026

Recommendation: No recommended changes.

Executive Summary

Life, AD&D, STD, Leave Management, Critical Illness, Accident Insurance

All product lines moved to Lincoln Financial as of 7/1/2023 through Vizient partnership.

Rate guarantee on all product lines until 6/30/2026.

Life and ADA&D Plans

- No recommended changes.

Voluntary Short-term Disability, Leave Management, Critical Illness and Accident Insurance.

- No recommended changes.

Recommendation: No recommended changes.

Executive Summary

Benefits Billing, Flexible Spending Accounts (FSA) and COBRA Administration

To reduce administrative burden on Valleywise Health and ensure effective compliance, administration and collection of outstanding contributions, when someone is on Leave of Absence for more than 90 days. Employees will be billed directly for their portion of the employee contributions for all benefit plans by Wex.

- Direct Billing Cost - $1,620 annually.

Flexible Spending Account and COBRA Administration - Wex

- No recommended changes

Recommendation: Add Benefits Billing program.

Executive Summary

Employee Assistance Program

Employee Assistance Program - Compsych

- No recommended changes

Recommendation: No recommended changes

Renewal Cost Summary

Renewal Cost Summary Including Voluntary Benefits

Renewal Cost Summary								
		Current - 7/1/2023		Renewal - 7/1/2024				
Coverage	Cost Sharing	Est. Annual Gross Costs	Est. Annual Net Employer Cost	Est. Annual Gross Costs	Est. Annual Net Employer Cost	Gross % Difference	Gross Cost Difference	Net ER % Difference
Medical Premium Equivalents								
Preferred Plan	Shared	$20,832,044	$16,751,385	$22,776,026	$18,314,559	9%	$1,943,982	9%
POS Plan	Shared	$9,255,308	$5,626,690	$10,171,795	$6,183,854	10%	$916,487	10%
HDHP Plan	Shared	$9,244,698	$7,590,756	$10,107,504	$8,299,211	9%	$862,806	9%
HSA Contribution	Employer	$578,000	$578,000	$578,000	$578,000	0%	$0	0%
Total Medical		**$39,910,050**	**$30,546,831**	**$43,633,325**	**$33,375,624**	**9%**	**$3,723,275**	**9%**
Dental								
Dental PPO Plan	Shared	$1,640,247	$581,028	$1,722,059	$622,176	5%	$81,812	7%
Dental Copay Plan	Shared	$19,981	$589	$19,981	$589	0%	$0	0%
Total Dental		**$1,660,228**	**$581,617**	**$1,742,040**	**$622,765**	**5%**	**$81,812**	**7%**
Employer Paid Life & Disability								
Basic Life	Employer	$68,766	$68,766	$68,766	$68,766	0%	$0	0%
Basic AD&D	Employer	$38,509	$38,509	$38,509	$38,509	0%	$0	0%
Total Life & Disability		**$107,275**	**$107,275**	**$107,275**	**$107,275**	**0%**	**$0**	**0%**
Employee Asssitance Program	Employer	$35,985	$35,985	$35,985	$35,985	0%	$0	0%
Total FSA Adminsitration*	Employer	$12,962	$12,962	$12,962	$12,962	0%	$0	0%
Total COBRA Administration*	Employer	$14,164	$14,164	$14,164	$14,164	0%	$0	0%
Total Cost Ancillary		**$63,111**	**$63,111**	**$63,111**	**$63,111**	0%	$0	0%
Sub-Total Estimated Costs		**$41,740,664**	**$31,298,834**	**$45,545,751**	**$34,168,775**	**9%**	**$3,805,087**	**9%**
Total Voluntary Vision	Employee	$506,560	$0	$506,560	$0	0%	$0	0%
Voluntary STD Disability	Employee	$1,408,344	$0	$1,408,344	$0	0%	$0	0%
Voluntary Employee Life	Employee	$43,907	$0	$43,907	$0	0%	$0	0%
Voluntary Spouse Life	Employee	$12,858	$0	$12,858	$0	0%	$0	0%
Voluntary Child Life	Employee	$1,024	$0	$1,024	$0	0%	$0	0%
Total Voluntary Life & Disability		**$1,972,693**	**$0**	**$1,972,693**	**$0**	0%	$0	0%
Grand Totals		**$43,713,357**	**$31,298,834**	**$47,518,444**	**$34,168,775**	**9%**	**$3,805,087**	**9%**

*FSA/COBRA Administration based on proposal guranteed through 7/1/2026 - pending actual from WEX

7. Care Reimagined Projects

March 27, 2024

Care Reimagined Updates

Presented by:
Lia Christiansen, Chief Administrative Officer

Care Reimagined Program Overview

Care Reimagined Program Features

- $935M bond-funded program
- 13 Updated or new locations
- 547 Design & Construction Professionals Engaged
- 7 Decommission sites
- Expanding High Quality Care
- Over 29,351 total views on The Vine

Approximately 14,345,251 Accumulative Man Hours For All Projects

Completion to Date:

Valleywise Health Medical Center Campus	91%
Valleywise Behavioral Health Center Maryvale	100%
Ambulatory	
Peoria	100%
South Phoenix/Laveen	100%
North Phoenix	100%
Mesa	100%
West Maryvale	100%

Source: Vanir CM, updated 03/08/24

Care Reimagined Program Dashboard

Legend:
- Not Applicable
- Not Started
- On Target
- Mitigation Plan
- Major Concern
- Completed

	Schedule	Budget	Land Acquisition	Operational Program	Design	Construction	Off-Site Utilities	Long-Lead Materials	Medical EQUIP	FF&E	Safety	Issues
VHMC MAIN CAMPUS												
Central Utilities Plant / Utility Corridors (2611)			N/A						N/A			
Valleywise Health Medical Center			N/A									
West Parking			N/A						N/A	N/A		
Site Hardscape			N/A				N/A		N/A	N/A		
Admin / Research / Faculty :Support Services Building (SSB)			N/A									
Abatement / Demolition (VHMC)			N/A						N/A	N/A		N/A
Valleywise Behavioral Health Center-Phoenix (Annex)			N/A						N/A			

Valleywise Health Medical Center Campus

Budget alignment and escalation: Valleywise Health approved an alternate funding source for $20M plus the cost of the additional beds. Industry material and labor shortages, and project changes have impacted the cost and schedule for the ACH, as well as future site and demolition work packages.

The project team is reassessing the Go-Live date

Source: Vanir CM, updated 03/31/24

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Vanir Project Director: Mike Miller
Programming: Blue Cottage
CM at Risk: Kitchell Contractors Inc.
Architect: Cuningham Group Architecture Inc.

Project Information:

The Medical Center Campus scope is comprised of many elements for hospital improvement that include replacing the existing Acute Care Hospital, Annex behavioral health air handling unit, and server accommodations. The new Central Utility Plant was built with an immediate connection to the existing site buildings for combined annual energy savings throughout the site construction duration.
Decommissioning of existing buildings, current Valleywise Health Medical Center, CAC (Administration Building), Hogan, and Central Energy Plant, to be phased post-Medical Center go-live. The laundry building decommissioning made way for the Piper Pavilion currently nearing completion (phased occupancy).

VHMC Acute Care & Ancillary Facilities Timeline	
Final Design Completion	Dec 2020
Construction Contract-Substantial Completion	Oct. 30, 2023
Substantial Completion Based on Approved Change Orders	November 29, 2023
Substantial Completion Based on Observed Construction Progress (Estimated)	March 30, 2024
Activation/Licensing	Began Sept. 2023
"Go-Live"	TBD

CONSTRUCTION UPDATE:

- The Pharmacy Board accepted both in and out-patient pharmacy spaces on 2/22/24
- All elevators have been certified
- An initial Air Balance Report has been submitted for all air handling units
- Lab automation line installation final connections is complete
- Med gas testing is complete

EQUIPMENT & ACTIVATION UPDATE:

- Activation planning is ongoing and relocation planning is underway

NEXT 30 DAYS:

- Activation is underway in Pharmacy, Central Sterile, and Surgery
- AHU 3-3 and 3-9 and fire damper revisions are underway
- Medical equipment continues to be installed and activated as it arrives

Estimate at Completion	Paid to Date	Billed to Date	Percent Spent
$616.6M	$545.8M	$559.5M	91%

Days w/o Incident	Manhours	Percent Complete
949*	20,926	99%*
*without loss of time		91%**

* Construction Complete
**Overall Complete

Source: Vanir CM, updated 03/08/24

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Lab, WASP Installation

Lab, Automation Line

Lab, Panther Installation

Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

Valleywise Health Medical Center Campus

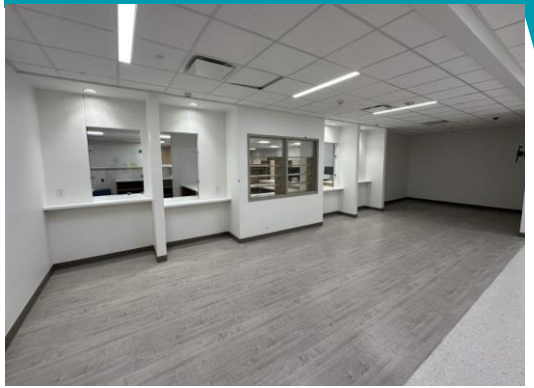
2601 E. Roosevelt St. Phoenix, AZ 85008

Acute Care Hospital

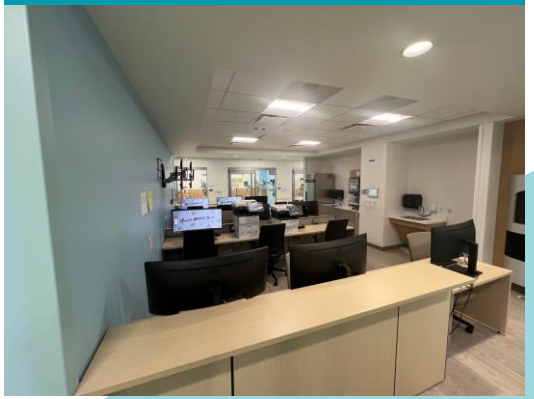
- CT pad work is underway
- Phase 4B concrete and paving work is complete
- Steris light and boom start-up and commissioning is nearly complete
- Punch item corrections continue on all levels

Level 1, ED Trauma Bay

Level 1, OPD Pharmacy Pickup



Level 1, ED Care Team

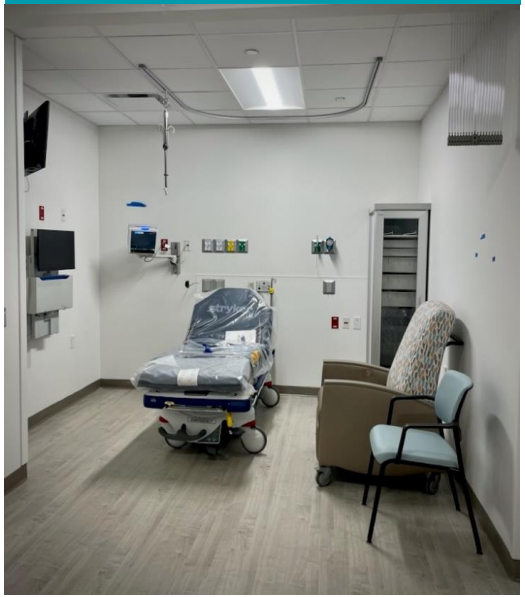


Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Level 2, PACU Bay



Level 7, ICU Room

Level 1, ED Headwall

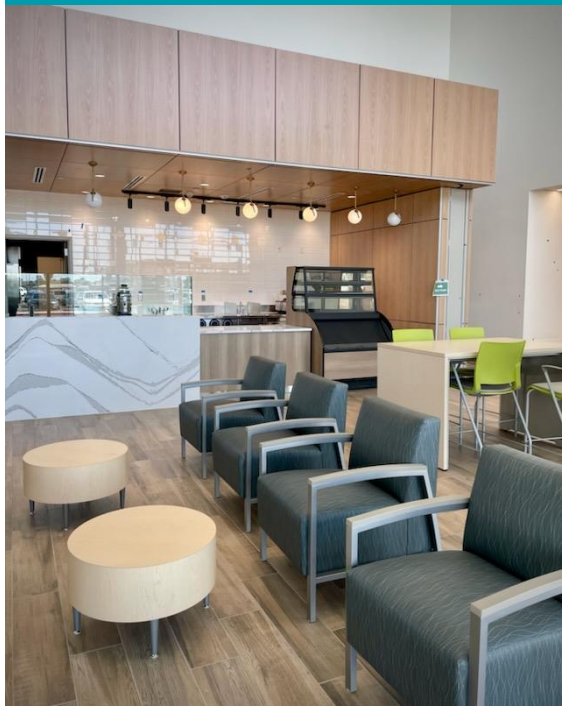
Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

Valleywise Health Medical Center Campus

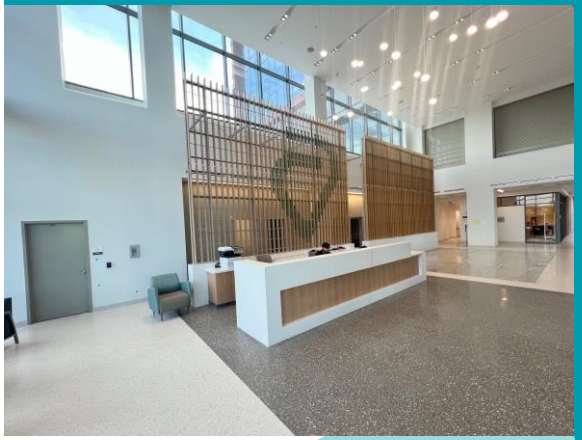
2601 E. Roosevelt St. Phoenix, AZ 85008

Level 1, Dining Area

Level 1, Coffee Shop



Main Lobby



Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

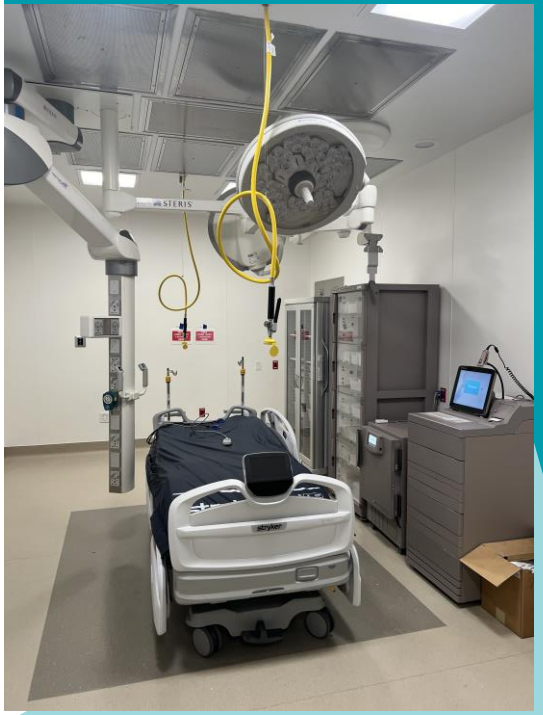
Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Level 4, Patient Room

Level 1, CT Control Room

Level 4, Burn Trauma

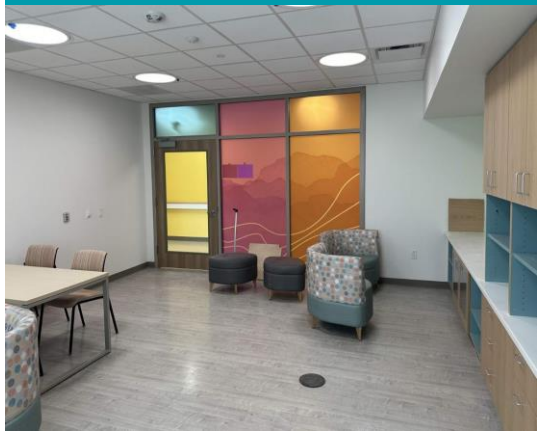


Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Level 6, Teen Room



Level 6, Corridor

Level 5, Group Patient Room

Source: Vanir CM, updated 03/08/24; images courtesy Kitchell Construction

March 27, 2024

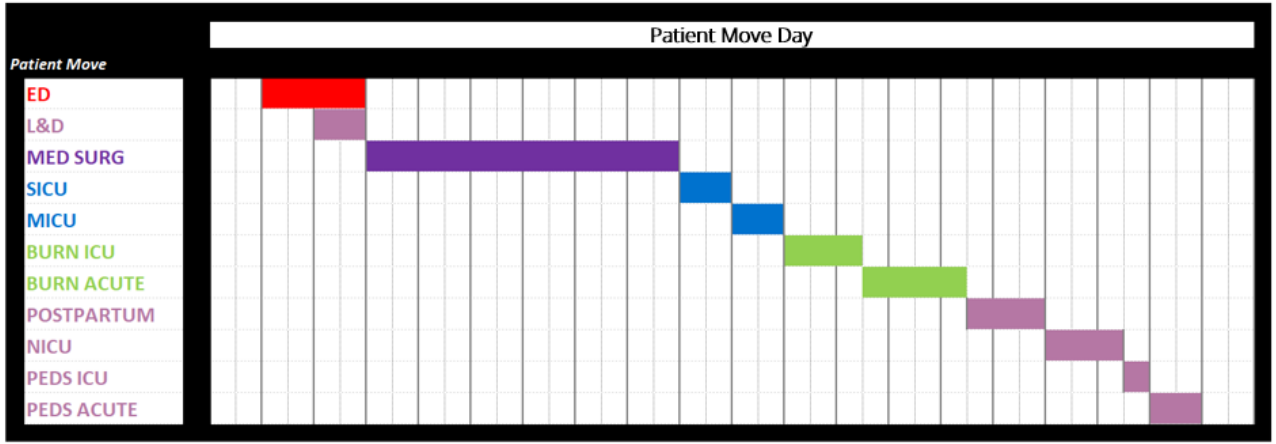
Care Reimagined Updates

Move Management Updates

Valleywise Health Medical Center Campus

2601 E. Roosevelt St. Phoenix, AZ 85008

Patient Move Schedule



Minor adjustments have been made:

- L&D has been shifted to early morning, which will overlap with ED move.
- Burn ICU and Burn Acute will not move concurrently
- Total number of Transfer Teams has increased from 10 to 15

Operational Assumptions:

- Opening day activities will begin at 3:00 am
- Support and Ancillary services will move before the Go-Live date and will be available to support dual operations through the duration of the patient move.
- Emergency Department (ED) services in the Legacy MMC will close at 3:00 am while the ED services in the Acute Care Hospital (ACH) will open at 3:00 am. Any ED patients will be moved over at 3:00 am.
- The following departments will be open in the ACH and available to provide services as needed starting at 3:00 am: Burn ED, Perioperative, IR/Cath Lab, L&D, NICU, and Dialysis.
- The current assumption is that the inpatient move will take 13 hours. However, the patient move team will continue to validate.

Day in the Life & Mock Patient Move Outcomes Summary

Outcomes Summary

DIL and Mock Move #2 - Exercise Photos

Day in the Life Impact

Day in the Life (DIL) #1 & #2

21 Scenarios

200+ Participants Involved

8 Hours

Key Outcomes

- Able to test available systems and building functionality
- Access to more spaces within the facility between DIL #1 and DIL #2
- More spaces outfitted with FF&E and operational technology/hardware
- Multidisciplinary exercises led to real-time issue management and resolution
- Consistent staff participation across both exercises, creating super users

Goals/Areas of Focus for DIL #3

- Resolve as many action items as possible prior to DIL #3
- Larger number of staff trained on facility, processes, equipment/technology, and travel paths prior to participation in DIL
- More building systems/technology fully functional for a more robust exercise

Next Exercise

TBD

Mock Move (MM) Impact

MM1 and MM2

30 | 36
"Mock" Patients Moved

200+
Participants Involved

8
Hours

Key Outcomes

- Additional patient scenarios to simulate more specific patient types
- Ability to simulate move with full beds and equipment from the existing floors
- Addition of staff roles to help navigate travel paths

Goals/Areas of Focus for MM3

- Resolve as many action items as possible prior to MM3
- Increase number of "mock" patients moved to better test move process, logistics, communications, and cadence
- Cultivate as true as possible simulation including all staff who will participate on the actual move day

Next Exercise

TBD

Valleywise Health Medical Center Campus

Feb/Mar 2024:

- Continue deployment of new equipment from the warehouse into final locations
- Complete the migration of the existing histology, cytology and pathology labs to the new lab in ACH
- Start the migration of the existing Chemistry, Hematology and Core Lab operations to the new lab in ACH

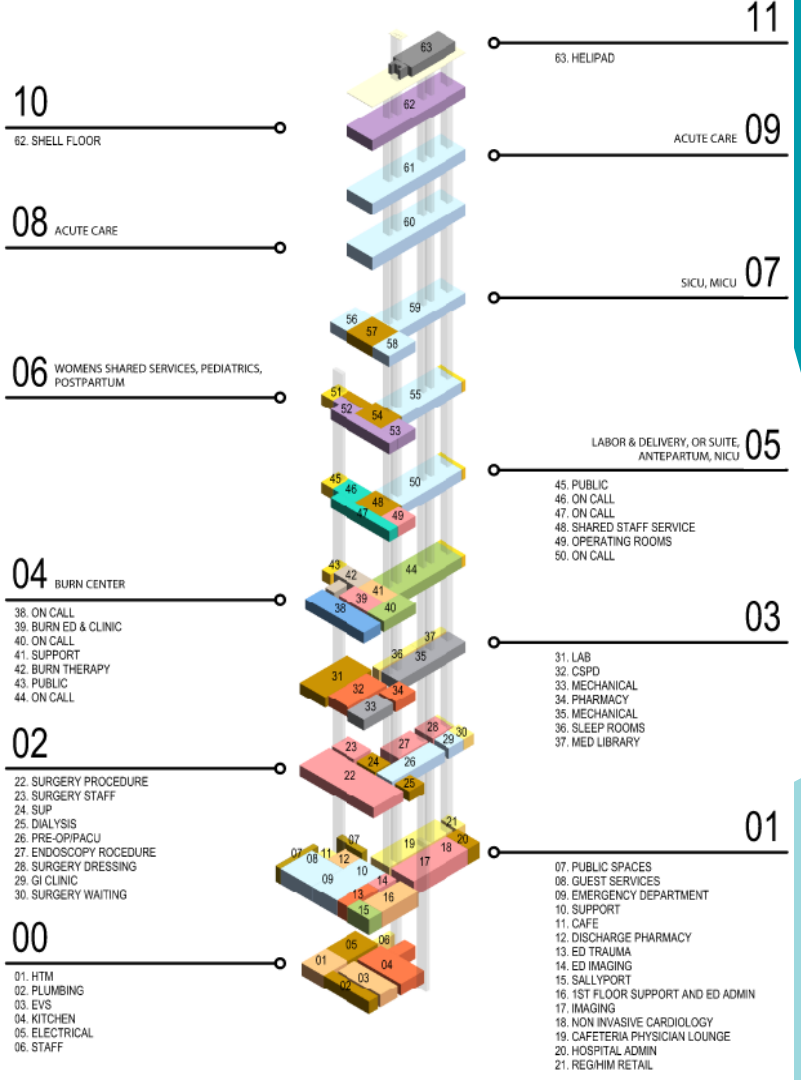
Mar/Apr 2024:

- Continue deployment of new equipment from the warehouse into final locations
- Finish the migration of the existing lab to the new lab in ACH

Source: Vanir CM, updated 03/13/24

Valleywise Health Medical Center Campus

Departmental stacking diagram



Valleywise Health – Virginia G. Piper Charitable Trust Pavilion

2609 E. Roosevelt St. Phoenix, AZ 85008

Vanir Project Manager: Shannon Lobdell
Programming: Blue Cottage
CM at Risk: Kitchell Contractors Inc.
Architect: Cuningham Group Architecture Inc.

Project Information:

The Piper Pavilion scope comprises of a multi-story building that will house Supply Chain, Research & Education, SIM Lab, Faculty Spaces and Administrative Programs to support the new Acute Care Hospital

Piper Pavilion Timeline	
Final Design Completion	January 2021
Construction Completion	Nov 2023
Temporary Certificate of Occupancy (TCO) 1st and 2nd Floors	June 2023
Warehouse "Go Live"	June 2023
Temporary Certificate of Occupancy (TCO) 3rd Floor	July 2023
Temporary Certificate of Occupancy (TCO) 4th and 6th Floors	August 2023
Activation (including 5th Floor)	June –February 2024
Final Certificate of Occupancy (Completion of 5th Floor)	November 2, 2023
5th Floor Move-In	April 18-19, 2024

CONSTRUCTION UPDATE:

- Activation activities continue on level 5

EQUIPMENT & ACTIVATION UPDATE:

Level 5 activation activities continue

NEXT 30 DAYS:

- Activation activities on level 5 will be completed
- Move dates for Physician offices are April 18-19, 2024

Estimate at Completion	Paid to Date	Billed to Date	Percent Spent
$48.3M	$46.6M	$46.8M	97%

Days w/o Incident	Manhours	Percent Complete
747**	1,235**	99%

** No updates since Substantial Completion

Source: Vanir CM, updated 03/08/24

Valleywise Health – Virginia G. Piper Charitable Trust Pavilion

2609 E. Roosevelt St. Phoenix, AZ 85008

Source: Vanir CM, updated 03/08/24

8.a. Reports to the Board - Marketing and Communications Report

Marketing Communications Snapshot

Feb 1, 2024 - Feb 29, 2024

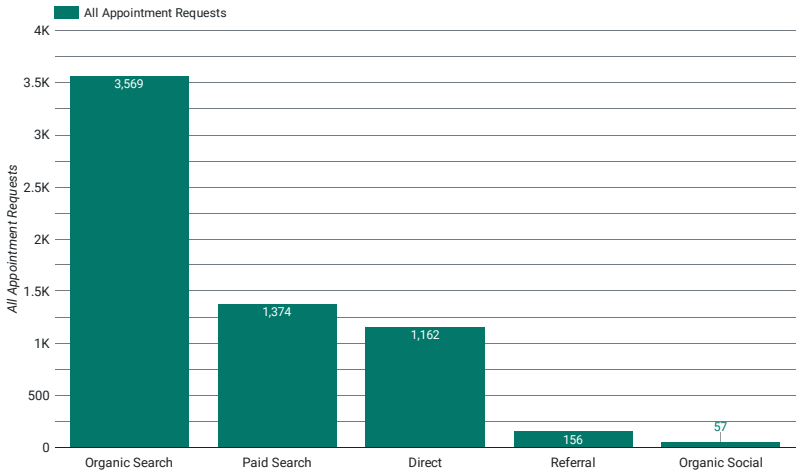
How Many People Are Visiting Valleywise

Book Appointment Form Submissions
1,421
13.0% from same month last year

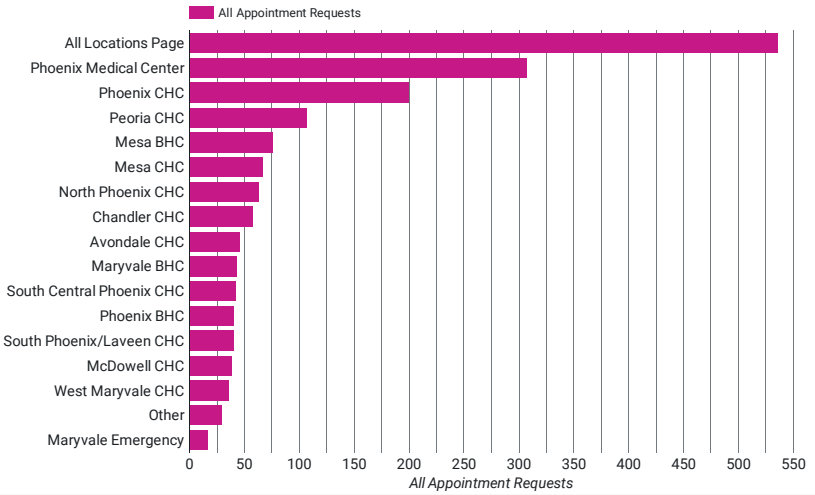
Click to Call
4,955
27.3% from same month last year

Total Appointment Requests
6,376
23.8% from same month last year

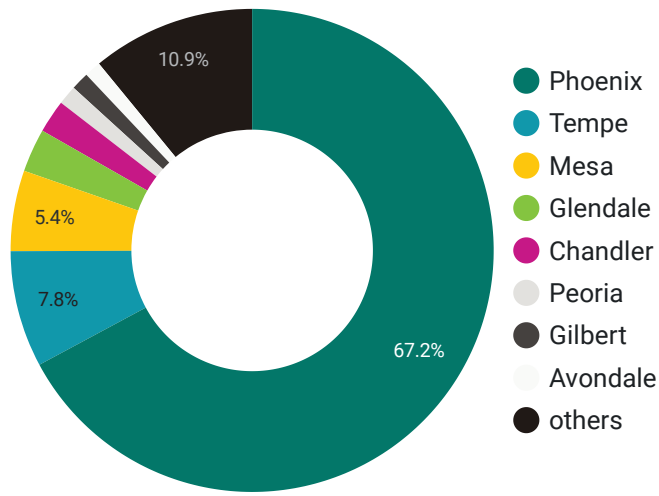
What Marketing Channels Are Driving Visits?



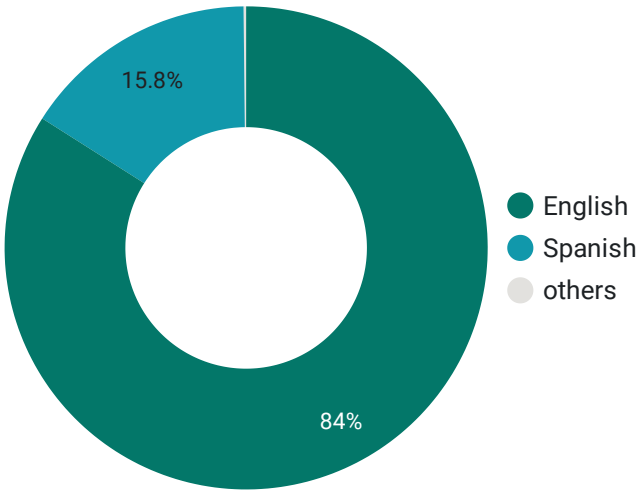
Location Pages Viewed Before Requesting an Appointment



Where Are People in Arizona Making Appointments From?



What Language Do They Speak?

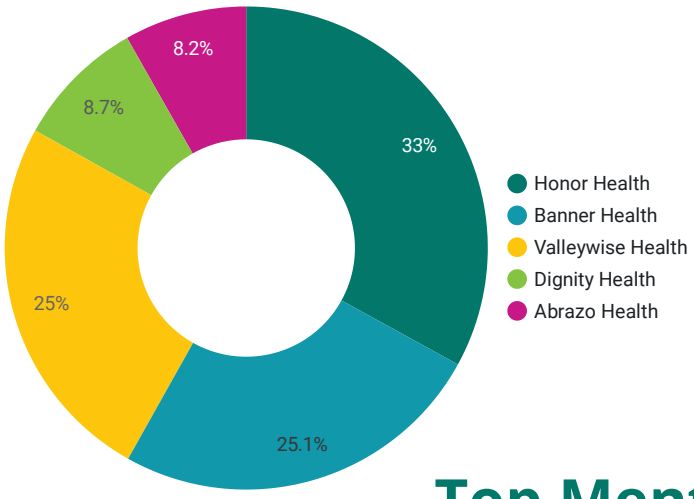


Valleywise Health

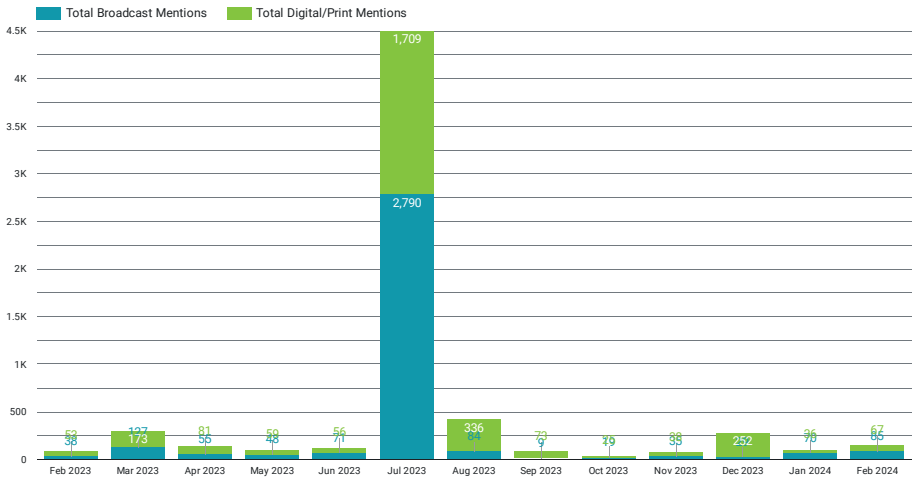
Marketing Communications Snapshot

Feb 1, 2024 - Feb 29, 2024

Share of Voice



Total News Mentions by Month



Top Mentions in the News

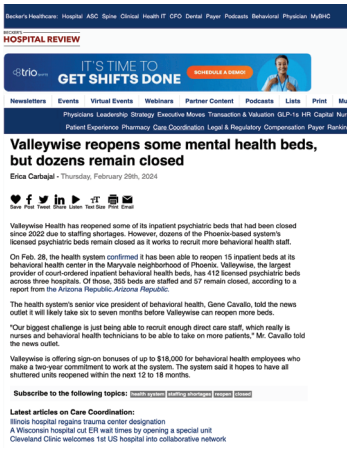
Date	Media Outlet	Local/National	Topic
Feb 13, 2024	AZ Family	Local	Phoenix doctor reacts to Washington Post report about CDC plans to loosen COVID guidelines
Feb 14, 2024	Arizona Central	Local	Enfermedades cardiovasculares son la principal causa de muerte en la comunidad hispana
Feb 29, 2024	Becker's Hospital Revie…	National	Valleywise reopens some mental health beds, but dozens remain closed

Phoenix doctor reacts to Washington Post report about CDC plans to loosen COVID guidelines

azcentral.

Enfermedades cardiovasculares son la principal causa de muerte en la comunidad hispana

Dr. Michael White Opinión



HOSPITAL REVIEW

Valleywise reopens some mental health beds, but dozens remain closed

Erica Carbajal - Thursday, February 29th, 2024

Valleywise Health

How People Are Engaging with Our Newsletters

Community E-News

Open Rate

23.4%

1.00% from previous month

Family Resource Center

Open Rate

35.6%

-1.64% from previous month

McDowell Clinic

Open Rate

19.9%

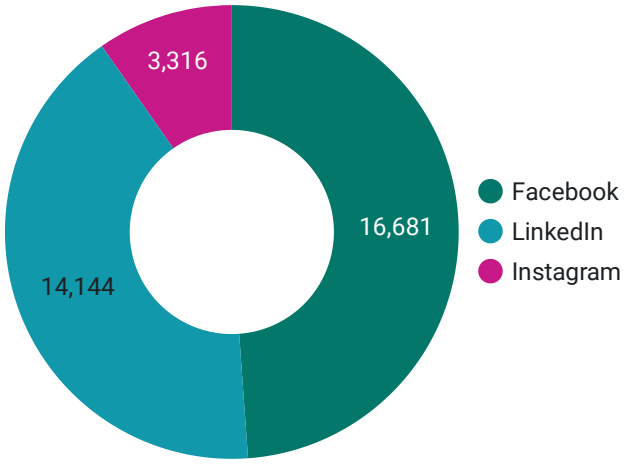
-3.30% from previous month

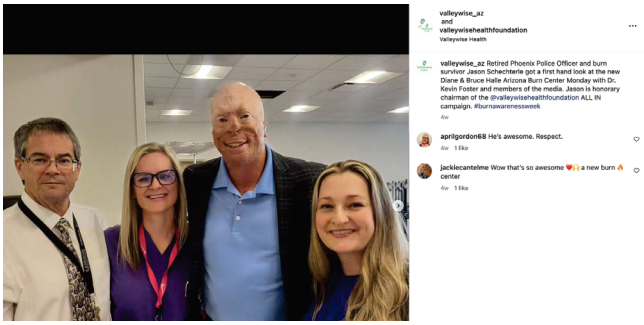
Marketing Communications Snapshot

Feb 1, 2024 - Feb 29, 2024

Social Media

Total Followers





Community Outreach

Partner Engagement

Meetings	Participants
9	238

Candelen
Guadalupe Partnership Council
Maricopa County Public Health – Building Bridges to Health Committee
MesaCAN
Peoria Community Action Network

Events

Approximate Reach
875

5

First Things First Innovation Resource Fair	100 families
Heart of Sunnyslope Health Fair	350 families
Materna Foundation Health Fair	65 families
Rio Salado Community Health Fair	60 families
Unlimited Potential Health and Resource Fair	300 families

Business Development

Events	Meetings
0	4

Arizona Hispanic Chamber of Commerce
Greater Phoenix Equality Chamber
Peoria Chamber of Commerce
WESTMARC

8.b. Reports to the Board - Care Reimagined Capital Purchases Report

Valleywise Health

Care Reimagined – Spend report (February 2024)

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
FunCWional Area - Outpatient Health Facilities							
ABBOTT RAPID DIAGNOSTICS		19-930					$ 1,870
ADVANCED STERILIZATION		19-930					$ 140,587
Advanced Testing		19-930					$ 10,605
Airpark Signs		19-930					$ 184,498
ALLEGIANCE CORP		19-930					$ 40,417
ALTURA		19-930					$ 204,410
AMICO		19-930					$ 5,648
ARC Products LLC		19-930					$ 3,699
Arizona Department of Health		19-930					$ 300
ARIZONA PUBLIC SERVICE		19-930					$ (32,545)
Armstrong Medical		19-930					$ 8,955
ARTHREX		19-930					$ 64,558
B BRAUN		19-930					$ 180,457
BAYER HEALTHCARE		19-930					$ 86,500
Baxter Health		19-930					$ 4,995
BONNY PIONTKOWSKI		19-930					$ 7,720
BPG Technologies		19-921					$ 174,467
BPG Technologies		19-930					$ 16,080
CAPSULE TECH		19-930					$ 164,493
CARDINAL HEALTH		19-930					$ 2,070
CAREFUSION		19-930					$ 269,605
CDW Government		19-930					$ 296,946
CENTURYLINK		19-930					$ 12,532
CHEMDAQ		19-930					$ 21,874
City of Peoria							$ 80,987
CME		19-930					$ 1,731,072
COOPER ATKINS		19-930					$ 33,020
COOPER SURGICAL		19-930					$ 11,787
COVIDIEN		19-930					$ 83,550
CROSSPOINT COMMUNICATIONS		19-930					$ 18,657
Cushman and Wakefield of Arizona	$ 16,500		$ 16,500				$ 4,000
C-SCAN TECHNOLOGIES		19-930					$ 230
DAAVLIN DISTRUBITING		19-930					$ 7,000
DAN GWILLIAM CONSULTING							$ 300
DANIELS MOVING		19-930					$ 23,133
Davis Enterprises		19-930					$ 14,807
DATA INNOVATIONS LLC							$ 14,285
DATEX OHMEDA							$ 387,508
DEPUY SYNTHES		19-930					$ 48,170
DIBBLE ENGINEERING							$ 12,570
ELITECHGROUP INC		19-930					$ 16,895

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
EXTENDATA		19-930					$ 60,844
FILLMASTER		19-930					$ 1,494
FOLLETT		19-930					$ 1,690
E3 DIAGNOSTICS		19-930					$ 7,319
GE		19-930					$ 4,264,076
GE PRECISION HEALTHCARE LLC		19-930					$ 42,646
GLOBAL SURGICAL		16-930					$ 14,442
Goodmans		19-930					$ 898,159
GRAINGER							$ 19,076
GRAYBAR ELECTRIC							$ 630
HELMER							$ 137,145
Henry Schein		19-930					$ 404,003
HILL ROM		19-930					$ 49,105
Hobbs and Black Associates Inc	$ 1,080,140		$ 1,080,140				$ 3,224,039
Hobbs and Black Associates Inc		19-930					$ 35,773
Hologic		19-907	$ 659,797				$ 673,682
HP INC		19-930					$ 134,737
Hye Tech Network							$ 1,015,724
INTELLIGENT HEARING		19-930					$ 4,185
INTERMETRO INDUSTRIES							$ 147,669
J AND J HEALTHCARE SYSTEMS		19-930					$ 32,013
KRONOS		19-930					$ 23,505
Lanmor		19-930					$ 664
LEICA MICROSYSTEMS		19-930					$ 28,107
LPIT SOLUTIONS							$ 10,500
Mar Cor Purification		19-930					$ 205,641
Maricopa County Environmental Services	$ 2,200	19-930	$ 2,200				$ 2,515
Maricopa County Planning and Development	$ 3,000	19-930	$ 3,000				$ 571,470
MDM COMMERCIAL		19-930					$ 43,692
MEDIVATORS							$ 8,982
MEDTRONIC		19-930					$ 12,909
MIZUHO ORTHOPEDICS		19-930					$ 2,347
MONOPRICE INC		19-930					$ 757
NATUS MEDICAL		19-930					$ 35,088
NCI INC							$ 9,262
Ninyo and Moore Geotechnical and Environment	$ 38,350		$ 38,350				$ 131,484
NUAIER		19-930					$ 13,123
OIEC MEDICAL SYSTEMS		19-930					$ 250,893
Okland Construction Company	$ 465,089	19-930	$ 465,089				$ 43,421,603
Olympus		19-930					$ 592,862
OWENS AND MINOR		19-930					$ 1,683
O&M HALYARD INC		19-930					$ 11,441
PARKS MEDICAL		19-930					$ 710

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
PARTS SOURCE		19-930					$ 1,761
PATRIOT PURVEYORS							$ 29,499
PENTAX MEDICAL		19-930					$ 122,737
PHILIPS HEALTHCARE		19-930					$ 29,975
Radiation Physics and Engineering							$ 6,250
RICOH		19-930					$ 17,536
SIGNOSTICS INC		19-930					$ 22,020
SCRIPTPRO							$ 199,244
SOFT COMPUTER		19-930					$ 65,675
SMITH & NEPHEW		19-930					$ 49,859
SMITHS MEDICAL		19-930					$ 12,972
SPEEDIE AND ASSOCIATES							$ 2,637
SPHERE COMMERCE							$ 1,577
Steris		19-930					$ 387,839
Stryker Communications	$ 515,073	19-921	$ 515,073				$ 683,239
Stryker Communications		19-930					$ 8,397
STRYKER SALES CORPORATION		19-930					$ 300,593
TBCX							$ 156,758
THUNDERBIRD GRANT		19-930					$ (187,982)
THE BAKER CO.		19-930					$ 14,485
THE CBORD GROUP		19-930					$ 21,623
THE CLOROX SALES		19-930					$ 44,800
THE GRAPHICS MEDICAL		19-930					$ 6,550
Thomas Printworks		19-930					$ 5,204
TRANSONIC SYSTEMS							$ 24,389
UTECH PRODUCTS							$ 47,600
VERATHON		19-930					$ 14,620
Vizient Inc	$ 132,024		$ 132,024				$ 379,135
West Valley Fidelity National Title - Land Purchase (Grand Ave/Cotton)	$ 5,595,598		$ 5,595,598				$ 5,595,598
West Valley Fidelity National Title (escrow)	$ 75,000		$ 75,000				$ 75,000
AS SOFTWARE INC							$ 9,500
GF HEALTH PRODUCTS INC							$ 5,519
INVIVO CORPORATION							$ 53,865
TOTAL West Valley Specialty Center (WVSC)	$ 7,922,974		$ 8,582,771	$ -	$ -	$ -	$ 69,114,874.76
Alliance Land Surveying LLC		19-942					$ 1,825
Great American Title (escrow/property tax) - Chandler		19-942	$ 15,000				$ 1,195,064
SPEEDIE AND ASSOC		19-942					$ 3,600
Ninyo and Moore Geotechnical and Environment		19-942					$ 70,599
TOTAL Chandler FHC (CHAN)	$ -		$ 15,000	$ -	$ -	$ -	$ 1,271,088.42
Fidelity National Title (escrow) - Miller&Main	$ 25,000	19-944	$ 25,000				$ 1,989,756
AMAZON		19-944					$ 129
Allstare Rent A Fence		19-944					$ 2,847
ALLEGIANCE CORPORATION		19-944					$ 8,996

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
ALTURA COMMUNICATIONS		19-944					$ 16,489
ABBOTT RAPID DIAGNOSTICS INFORMATICS INC		19-944					$ 67
BPG TECHNOLOGIES LLC		19-944					$ 1,075
BONNY PIONTKOWSKI		19-944					$ 1,120
CDW G		19-944					$ 36,138
ALTURA COMMUNICATIONS		19-944					$ 18,826
CENTURYLINK		19-944					$ 19,853
CITY OF MESA		19-944					$ 92,022
GE PRECISION HEALTHCARE		19-944					$ 34,138
GE HEALTHCARE IITS USA CORP		19-944					$ 134,394
CME		19-944					$ 139,688
COOPER ATKINS CORPORATION		19-944					$ 6,560
CAPSULE TECH INC		19-944					$ 55,920
SPEEDIE AND ASSOC		19-944					$ 3,600
DAVES CONSTRUCTION		19-944					$ 72,981
DIBBLE ENGINEERING		19-944					$ 8,256
DWL ARCHITECTS + PLANNERS INC		19-944					$ 1,027,447
DANIELS MOVING & STORAGE		19-944					$ 15,825
HELMER INC		19-944					$ 18,323
HP INC		19-944					$ 23,058
HOLOGIC INC		19-944					$ 349,945
HYE TECH NETWORK AND SECURITY SOLUTIONS		19-944					$ 143,092
FILLMASTER		19-944					$ 1,494
INTERMETRO INDUSTRIES		19-944					$ 13,859
JENSEN HUGHES		19-944					$ 7,031
Maricopa County - Envionmental Services Dept		19-944					$ 1,485
Maricopa County Planning		19-944					$ 64,615
MDM COMMERCIAL		19-944					$ 6,997
MONOPRICE		19-944					$ 335
OKLAND CONSTRUCTION		19-944		$ 10.00			$ 9,989,592
THE CBORD GROUP INC		19-944					$ 2,826
TEMP ARMOUR		19-944					$ 9,947
THE GRAPHS MEDICAL PHYSICS		19-944					$ 2,450
SCIPTPRO USA		19-944					$ 104,544
SMITHCRAFT SIGNS		19-944					$ 106,105
SPEEDIE AND ASSOC		19-944					$ 20,116
STRYKER SALES		19-944					$ 6,665
SPRAY SYSTEMS		19-944					$ 29,640
TRANSACT COMMERCIAL		19-944					$ 332,754
Ninyo and Moore Geotechnical and Environment	$ 15,400	19-944	$ 15,400				$ 34,055
CROSSPOINT COMMUNICATIONS							$ 8,161
FIDELITY NATIONAL TITLE AGENCY INC							$ 557
VANIR CONSTRUCTION MANAGEMENT INC							$ 1,209,344

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
TOTAL Mesa FHC (MESA)	$ 40,400		$ 40,400	$ 10.00	$ -	$ -	$ 16,173,120.85
Clear Title Agency (escrow) - Central Phoenix Clinic							$ 2,704,752
Clear Title Agency (escrow) - Phoenix Metro	$ 50,000		$ 50,000				$ 50,000
Cushman and Wakefield of Arizona Inc		19-945					$ 4,750
DAVES CONSTRUCTION		19-945					$ 171,254
DWL ARCHITECTS + PLANNERS INC		19-945					$ 681,890
JENSEN HUGHES		19-945					$ 398
MARICOPA COUNTY PLANNING		19-945					$ 62,251
Ninyo and Moore Geotechnical and Environment		19-945					$ 53,438
OKLAND CONSTRUCTION		19-945					$ 346,215
SPEEDIE AND ASSOC		19-945					$ 3,600
Spray Systems		19-945					$ 119,430
ALLIANCE LAND SURVEYING LLC							$ 2,400
STRYKER SALES CORPORATION							$ 247
VANIR CONSTRUCTION MANAGEMENT INC							$ 840,810
TOTAL Central Phoenix FHC (PHXM)	$ 50,000		$ 50,000	$ -	$ -	$ -	$ 5,041,435.57
DIBBLE ENGINEERING		19-929					$ 6,904
ABBOTT RAPID DIAG		19-929					$ 190
ALLEGIANCE CORP		19-929					$ 1,591
ALTURA COMMUNICATI0N		19-929					$ 52,314
BONNY PIONTKOWSKI		19-929					$ 1,645
BPG TECHNOLOGIES		19-929					$ 28,099
CAPSULE TECH		19-929					$ 57,185
CITY OF PHOENIX		19-929					$ 1,262
COOPER ATKINS		19-929					$ 9,754
CROSSPOINT COMMUNICATION		19-929					$ 8,138
DANIELS MOVING		19-929					$ 11,266
DWL ARCHITECTS + PLANNERS INC		19-929					$ 942,593
CDW G		19-929					$ 21,797
CME		19-929					$ 162,064
FED EX FREIGHT		19-929					$ 376
Fidelity National Title (escrow) - North Metro	$ 20,000	19-929	$ 20,000				$ 2,307,776
FILLMASTER		19-929					$ 1,494
GE HEALTHCARE		19-929					$ 331,885
GRAINGER		19-929					$ 3,225
HP INC		19-929					$ 17,086
HYE TECH NETWORK		19-929					$ 152,885
INTERMETRO INDUSTRIES		19-929					$ 11,756
Jensen Hughes		19-929					$ 8,788
LOVITT & TOUCHE		19-929					$ 8,196
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-929					$ 51,093
MDM COMMERCIAL		19-929					$ 4,339
OFFSITE OFFICE EQUIPMENT STORAGE		19-929					$ 250

VALLEYWISE HEALTH

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
OLYMPUS		19-929					$ 1,232
SCRIPTPRO		19-929					$ 104,544
SMITHCRAFT SIGNS		19-929					$ 99,956
SPEEDIE AND ASSOC		19-929					$ 11,910
SALT RIVER PROJECT		19-929					$ 4,265
SPHERE COMMERCE		19-929					$ 797
Stryker Communications		19-929					$ 12,626
Sundt Construction Inv		19-929					$ 9,303,374
THE GRAPHS MEDICAL PHYSICS, INC.		19-929					$ 700
TEMP ARMOUR		19-929					$ 9,897
TRANSACT COMMERCIAL		19-929					$ 279,878
THE CBORD GROUP		19-929					$ 2,794
AMAZON							$ 136
EXTENDATA SOLUTIONS							$ 11,706
MONOPRICE INC							$ 513
PAL-WW NORTHERN STORAGE JV LLC							$ 106,121
RICOH AMERICAS CORPORATION							$ 140
THOMAS PRINTWORKS							$ 71
VANIR CONSTRUCTION MANAGEMENT INC							$ 1,561,667
TOTAL North Phoenix FHC (19AV)	$ 20,000		$ 20,000	$ -	$ -	$ -	$ 15,716,277.76
Cox Communications		19-928					$ 4,489
Cox Communications							$ (1,699)
ABBOTT RAPID DIAG		19-928					$ 238
ALTURA		19-928					$ 50,192
ALLEGIANCE CORP		19-928					$ 10,318
AZ Dept of Env Quality		19-928					$ 100
BONNY PIONTKOWSKI		19-928					$ 1,645
BPG Technologies		19-928					$ 28,048
CAPSULE TECH		19-928					$ 56,193
CDW GOVERNMENT INC		19-928					$ 21,760
Centurylink		19-928					$ 24,539
CITY OF PHOENIX		19-928					$ 218,063
CME		19-928					$ 184,168
COOPER ATKINS		19-928					$ 6,576
CROSSPOINT COMMUNICATION		19-928					$ 8,008
Daniels Moving		19-928					$ 11,441
DIBBLE ENGINEERING		19-928					$ 7,168
DWL ARCHITECTS + PLANNERS INC		19-928					$ 1,152,163
EXTENDATA		19-928					$ 11,102
Fidelity National Title (escrow) - South Mountain		19-928					$ 721,482
FILLMASTER SYSTEMS		19-928					$ 1,494
GE HEALTHCARE		19-928					$ 502,285
GRAINGER		19-928					$ 978

VALLEYWISE HEALTH

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
HELMER		19-928					$ 20,426
HP INC		19-928					$ 12,772
Hye Tech Network		19-928					$ (59,083)
INTERMETRO INDUSTRIES		19-928					$ 19,591
JENSEN HUGHES		19-928					$ 11,464
LOVITT & TOUCHE		19-928					$ 3,144
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-928					$ 51,046
MDM COMMERCIAL		19-928					$ 5,429
MONOPRICE		19-928					$ 526
NATUS		19-928					$ 2,130
OFFSITE OFFICE		19-928					$ 395
OLYMPUS AMERICA		19-928					$ 1,229
Ricoh		19-928					$ 132
SCRIPTPRO USA INC		19-928					$ 104,544
SMITHCRAFT SIGNS		19-928					$ 100,570
Speedie and Associates		19-928					$ 15,670
SPHERE COMMERCE		19-928					$ 795
SRP		19-928					$ 13,775
Sundt Construction Inc		19-928					$ 9,083,290
Stryker Communications		19-928					$ 12,626
TEMP ARMOUR		19-928					$ 6,448
THE CBORD GROUP		19-928					$ 2,794
THE GRAPHICS MEDICAL		19-928					$ 700
TRANSACT		19-928					$ 280,739
THOMAS PRINTWORKS		19-928					$ 326
VANIR CONSTRUCTION MANAGEMENT INC							$ 1,295,734
TOTAL South Phoenix FHC (SPHX)	$ -		$ -	$ -	$ -	$ -	$ 14,007,963.47
CDW GOVERNMENT INC		19-946					$ 56,372
ADVANCE INNOVATIVE SOLUTIONS		19-946					$ 4,623
ALLEGIANCE CORP		19-946					$ 920
ALTURA COMMUNICATIONS		19-946					$ 33,123
ABBOTT RAPID DIAGNOSTICS INFORMATICS INC		19-946					$ 96
BPG TECHNOLOGIES		19-946					$ 757
BONNY POINTKOWSKI		19-946					$ 1,645
CARDINAL HEALTH		19-946					$ 8,996
CAPSULE TECH		19-946					$ 56,272
CITY OF PHOENIX		19-946					$ 40,670
CME		19-946					$ 156,950
COOPER ATKINS		19-946					$ 8,233
DIBBLE ENGINEERING		19-946					$ 6,534
DWL ARCHITECTS + PLANNERS INC		19-946					$ 811,095
DANIELS MOVING		19-946					$ 20,892
Fidelity National Title (escrow) - 79thAve&Thomas	$ 50,000	19-946	$ 50,000				$ 1,878,902

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
FILLMASTER SYSTEMS		19-946					$ 1,494
GE PRECISION		19-946					$ 168,532
HYE TECH		19-946					$ 138,754
HP INC		19-946					$ 29,510
INTERMETRO INDUSTRIES		19-946					$ 15,951
JENSEN HUGHES		19-946					$ 9,999
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-946		$ (1,913.00)			$ 60,744
MARICOPA COUNTY ENVIRONMENTAL SERVICES		19-946					$ 1,490
MARICOPA COUNTY RECORDER		19-946					$ 30
MDM COMMERICIAL		19-946					$ 5,546
MONOPRICE		19-946					$ 522
MOBILE COMMUNICATIONS AMERICA INC		19-946					$ 8,161
NATUS MEDICAL		19-946					$ 1,141
Ninyo and Moore Geotechnical and Environment	$ 6,600	19-946	$ 6,600				$ 11,400
Okland Construction Company		19-946					$ 9,433,806
OLYMPUS		19-946					$ 1,211
SALT RIVER PROJECT		19-946					$ 25,648
SMITHCRAFT SIGNS		19-946					$ 106,985
SPEEDIE AND ASSOC		19-946					$ 24,143
SCRIPT PRO		19-946					$ 104,544
THE CBORD GROUP		19-946					$ 2,883
TEMP ARMOUR		19-946					$ 9,947
TRANSACT COMMERCIAL		19-946					$ 291,462
THE GRAPHICS MEDICAL		19-946					$ 950
SPHERECOMMERCE LLC		19-946					$ 895
AMAZON							$ 135
KITCHELL CONTRACTORS INC OF ARIZONA							$ 3,280
STRYKER SALES CORPORATION							$ 247
VANIR CONSTRUCTION MANAGEMENT INC							$ 1,034,425
TOTAL West Maryvale FHC (WM79)	$ 56,600		$ 56,600	$ (1,913.00)	$ -	$ -	$ 14,579,914.85
	$ 138,657,244		**$ 8,764,771**	**$ (1,903.00)**	**$ -**	**$ -**	**$ 135,904,675.67**

Note: Prior months amount paid are hidden

Functional Area - Behavioral Health Services							
Adams and WENDT							$ 118,891
ADVANCED INN VATIVE SOLUTIONS							$ 11,735
Advanced Egress Solutions		19-912					$ 3,090
Airclean Systems		19-912					$ 4,457
Allscripts Healthcare		18-913					$ 5,760
Allscripts Healthcare		19-909					$ 225,345

VALLEYWISE HEALTH

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
Altura Communications		19-909					$ 477,526
Altura Communications		19-939					$ 91,807
Altura Communications		18-913					$ 1,340
Amazon		19-909					$ 1,080
AMT Datasouth		19-912					$ 4,124
ARC Products LLC		19-912					$ 58,715
ARIZONA DEPT OF HEALTH		19-939					$ 150
Arizona Lock and Safe							$ 1,025
Armstrong Medical		19-912					$ 36,470
Arrington Watkins Architects	$ 52,167		$ 52,167				$ 301,274
Arrow International		19-912					$ 610
Baxter Healthcare Corp		19-912					$ 5,368
Bayer Healthcare		18-920					$ 74,376
BEL-Aire Mechanical							$ 40,215
Burlington Medical		19-912					$ 3,028
CAPSA SOLUTIONS		19-909					$ 5,936
CAPSA SOLUTIONS		19-912					$ (25)
Capsule Tech		19-912					$ 143,422
CAPSULE TECH INC		18-913		$ 10,481.06			$ -
Cardinal Health		19-912					$ 85,931
CDW Government		19-909					$ 275,954
CDW Government		19-938					$ 48,448
CDW Government		19-939					$ 161,925
CME		19-912					$ 185,907
Comprehensive Risk Services							$ 547,333
Coviden		19-912					$ 11,817
Crosspoint Communications							$ 25,724
Datcard Systems		19-909					$ 18,821
EXTENDATA SOLUTIONS		19-909					$ 500
KRONOS INC		19-909					$ 196
RETAIL MANAGEMENT SOLLUTIONS		19-909					$ (5,961)
THE CBORD GROUP INC		19-909					$ (1,234)
CME		18-918					$ 68
MEDTRONIC USA INC		18-918					$ 59
THE CBORD GROUP INC		18-918					$ 14
GE MEDICAL SYSTEMS ULTRASOUND PRIMARY		18-918					$ 527,736
GE MEDICAL SYSTEMS ULTRASOUND PRIMARY		18-922					$ 219,671
Delynn Consultant		19-940					$ 114,187
DLR Group Inc							$ 4,222,015
EMD Millpore		19-912					$ 7,175
ENDOSCOPE SERVICES		19-912					$ 32,270
Epstexas Storage		19-912					$ 633
EQ2 LLC		19-912					$ 67,500

VALLEYWISE HEALTH

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
Ethos Evacuation		19-912					$ 10,130
ETL REPONSE		19-912					$ 29,482
EXTENDATA SOLUTIONS							$ 66,659
Felix Storch Inc							$ 5,796
FERGUSON ENTERPRISES		19-912					$ 3,571
First American Title - Maryvale Hospital	$ 7,438,977		$ 7,438,977				$ 7,582,335
Follett		19-912					$ 40,303
GE Healthcare		18-915	$ 2,029,921				$ 773,012
GE Healthcare		19-901	$ 14,880				$ 14,880
GE Healthcare		18-917					$ 766,491
GE Healthcare		18-918	$ 4,172,080				$ (787,011)
GE Healthcare		19-938					$ 13,999
GE Medical Systems		19-912					$ 13,999
GE Medical Ultrasound		18-917					$ 138,680
General Devices		19-912					$ 47,400
Gentherm		19-912					$ 16,692
Gilbane Building CO.		18-913					$ 55,180,150
FED EX FREIGHT		18-913					$ 3,481
Global Equipment		19-912					$ 2,003
Goodmans		19-916					$ 96,476
Goodmans		19-917					$ 104,809
Goodmans		19-923					$ 551,725
Goodmans		19-926					$ 154,049
Goodmans		19-939					$ 1,570
Goodmans		18-913					$ 3,900
JENSEN HUGHES INC		18-913					$ 11,538
VALLEY SYSTEMS		18-913					$ 9,952
Grainger		19-912					$ 63,690
Graybar Electric							$ 5,586
GUEST COMMUNICATIONS		19-912					$ 17,130
Haemonetics		19-912					$ 83,854
HD Supply Facilities Maintenance Ltd		19-912					$ 39,937
Helmer Inc		19-912					$ 144,487
Hill Rom							$ 20,409
HP INC		19-909					$ 363,091
HP INC		19-939					$ 168,146
HUMANE RESTRAINT		19-909					$ 40,160
HUMANE RESTRAINT		19-912					$ (4,480)
Hye Tech Network		19-909					$ 368,641
IMEG Corp							$ 91,590
Interior Solutions		19-923					$ 242,017
Interior Solutions		19-926					$ 100,132
Intermetro Industries		19-912					$ 42,332

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
Intersan Manufacturing		19-912					$ 3,603
Jensen Hughes							$ 2,750
Kronos Inc							$ 72,000
Lanmor Services Inc							$ 1,952
LOGIQUIP		19-912					$ 1,059
MARICOPA COUNTY PLANNING AND DEVELOPMENT							$ 299,669
MARICOPA COUNTY PLANNING AND DEVELOPMENT		18-913					$ (19,806)
MARKETLAB		19-912					$ 10,824
MCG HEALTH LLC							$ 37,017
MDM Commericial		19-909					$ 40,622
Medline		19-912					$ 3,628
Medtronic		19-912					$ 7,931
Mindray		19-912					$ 98,014
Monoprice		19-909					$ 968
Monoprice		19-939					$ 842
MOPEC		19-912					$ 20,479
NORIX GROUP INC		19-926					$ 11,918
NANOSONICS INC		19-912					$ 22,944
Ninyo and Moore Geotechnical and Environment		19-923					$ 11,700
NORIX GROUP INC							$ 400,689
Olympus America							$ 32,231
Olympus America		19-912					$ 135
OEC Medical Systems		19-904					$ 80,529
OMC INVESTERS LLC							$ 11,518
OMC INVESTERS LLC		19-912					$ 117
Owens and Minor		19-912					$ 56,788
PAC VAN							$ (790)
PAC VAN							$ 1,295
Parks Medical		19-912					$ 2,167
Philips Healthcare	$ 38,597	18-921	$ 38,597				$ 38,523
Physio Control		19-912					$ 19,458
Progressive Roofing		19-931					$ 84,628
PRONK TECHNOLOGIES INC							$ 3,040
PRONK TECHNOLOGIES INC		19-912					$ 16
QRS Calibrations		19-912					$ 7,151
Radiation Physics and Engineering		18-917					$ 1,250
Radiation Physics and Engineering		18-920					$ 1,600
RAY-BAR		18-913					$ 4,905
RETAIL MANAGEMENT SOLUTIONS							$ 5,961
RICOH AMERICAS CORPORATION							$ 29,892
Ruiz Custom Upholstery		19-912					$ 53,718
SCOTTSDALE RESTAURANT SUPPLY							$ 5,391
Signodtics		19-912					$ 22,460

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
Smiths Medical		19-912					$ 9,253
SOFT COMPUTER CONSULTANT INC							$ 89,550
Smithcraft Signs		18-913					$ 10,266
Speedie and Associates	$ 900		$ 900				$ 17,823
SALT RIVER PROJECT		18-913					$ (23,852)
Standard Textile		19-912					$ 4,464
Stryker Communications	$ 170,089	19-910	$ 170,089				$ (14,174)
Stryker Communications		19-910					$ 5,103
Stryker Communications		19-920					$ 9,072
Steris Corp							$ 13,950
Stryker							$ 175,192
TBJ Inc		19-912					$ 5,654
TD INDUSTRIES		19-924					$ 460,415
The Cbord Group		19-909					$ 26,421
THYSSENKRUPP ELEVATOR CORP		19-912					$ 587,346
Translogic		19-912					$ 3,931
Tucson Business Interiors		19-912					$ 3,000
Tucson Business Interiors		19-923					$ 34,193
Tucson Business Interiors		19-926					$ 335,704
UMF Medical		19-912					$ 11,788
Verathon		19-912					$ 14,020
VERIZON		19-909					$ 16,853
WAXIE		19-912					$ 3,002
World Wide Technology							$ 701,128
Zoll Medical		19-912					$ 46,732
AFFILIATED ENGINEERS INC							$ 203,070
CUSHMAN AND WAKEFIELD OF ARIZONA INC							$ 12,500
MARICOPA COUNTY TREASURER							$ 10,000
PHOENIX FENCE							$ 2,283
RELAYHEALTH INC							$ 11,250
THOMAS PRINTWORKS							$ 4,863
TOTAL Maryvale Campus (MV)	$ 7,700,731		$ 13,917,612	$ 10,481.06	$ -	$ -	$ 79,088,184.52
Adams and Wendt		19-936					$ 114,235
APS		19-936					$ (14,700)
AIRPARK SIGNS							$ 1,305
Arizona Department of Health		19-936					$ 1,050
AFFILIATED ENGINEERS		19-936					$ 394,767
BUREAU VERITAS		19-936					$ 28,125
Engineering Economics		19-936		$ 151,297.00	$ 61,453.00		$ 63,807
GOODMANS		19-936					$ 109,429
Grainger		19-936					$ 5,504
JENSEN HUGHES		19-936					$ 15,462
KITCHELL		19-936					$ 8,386,706

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-936					$ 230
Speedie and Assoc		19-936					$ 2,040
Valley Systems		19-936					$ 14,320
INNERFACE ARCHITECTURAL SIGNAGE							$ 862
MARICOPA COUNTY TREASURER							$ 8,212
THE CBORD GROUP INC							$ 13,022
VANIR CONSTRUCTION MANAGEMENT INC							$ 631,930
TOTAL Annex HVAC Replacement (RSVT)	$ -		$ -	$ 151,297.00	$ 61,453.00	$ -	$ 9,776,304.24
	$ 7,700,731		**$ 13,917,612**	**$ 161,778.06**	**$ 61,453.00**	**$ -**	**$ 88,864,489**

Note: Prior months amount paid are hidden

Functional Area - Acute Care Facilities'							
eSTF - Enterprise Strengthening the Foundation (see attached for detail)	$ 14,000,000	17-900	$ 14,000,000				$ 6,237,142
Client & Mobility (Phase 1)	$ 4,340,400	16-934	$ 1,356,068				$ 1,434,893
Client & Mobility (Phase 2)		17-906	$ 1,377,677				$ 1,512,376
IPT (PBX Replacement)	$ 3,188,083	16-909	$ 3,000,000				$ 2,789,264
Legacy Storage (DP-007)	$ 2,500,000	16-910	$ 2,500,000				$ 2,506,978
Single Sign on	$ 500,000	17-913	$ 90,000				$ 81,150
OPTIV SECURITY INC		16-900					$ (25)
Perimeter, Internal security	$ 700,000	16-900	$ 67,176				$ 67,213
Perimeter, Internal security		18-907	$ 151,109				$ 151,310
Perimeter, Internal security		18-910	$ 44,235				$ 44,235
Perimeter, Internal security		18-912	$ 51,561				$ 51,561
Epic 2014 Monitors (Phase 1)	$ 1,050,000	16-933	$ 421,500				$ 341,470
Epic 2014 Monitors (Phase 2)		17-905	$ 457,910				$ 474,480
LCM	$ 200,000	16-937	$ 125,000				$ 199,936
SEIMS	$ 250,000	17-912	$ 235,134				$ 235,134
SEIMS		18-911	$ 14,468				$ 14,468
ESB Framework Enablement	$ 1,280,900	18-914	$ 1,280,900				$ 1,111,233
Clinical Image Repository	$ 1,262,914	18-915	$ 1,262,914				$ 1,271,214
Imprivata Identity	$ 576,880	18-916	$ 576,880				$ 576,880
Chartmaxx Infrastructure Upgrade	$ 757,484	19-906	$ 757,484				$ 859,682
Imprivata ConfirmID	$ 139,872	19-911	$ 139,872				$ 137,295
ESB (Tibco) - Infrastructure	$ 176,464	19-918	$ 176,464				$ 34,861
PWIM Global Monitor Software - additional funding required to support imple	$ 33,200	16-924	$ 35,400				$ 35,400
AMICO ACCESSORIES		16-908					$ (704)
Patient monitors - High Acuity	$ 6,979,132	16-908	$ 6,979,132				$ 6,240,243
NHR NEWCO HOLDINGS LLC		16-908					$ (339)
NHR NEWCO HOLDINGS LLC		16-910					$ (86)
Stretcher replacement	$ 403,200	16-912	$ 398,013				$ 395,538

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
IVUS - intravascular ultrasound for placement of stents	$ 160,000	16-922	$ 132,500				$ 128,371
VOLCANO CORPORATION		16-922					$ (323)
EDWARDS LIFESCIENCES LLC		16-928					$ (116)
Vigileo Monitors (8)	$ 112,000	16-928	$ 111,930				$ 96,132
VANIR CONSTRUCTION		16-928					$ 463,755
Balloon Pumps	$ 110,000	16-920	$ 142,151				$ 149,197
MAQUET MEDICAL SYSTEMS USA		16-920					$ (2,897)
Zeiss - Cirrus HD opthal camera	$ 60,655	16-919	$ 60,655				$ 60,654
Vivid Q BT12 Ultrasound	$ 55,750	16-931	$ 55,750				$ 55,019
MINDRAY DS USA INC		16-931					$ (19)
Zoll Thermoguard XP (formerly Alsius)	$ 33,230	16-906	$ 33,230				$ 33,230
3:1 Mesher	$ 13,300	16-927	$ 13,300				$ 12,870
1:1 Mesher	$ 26,600	16-927	$ 26,600				$ 26,190
2:1 Mesher	$ 26,600	16-927	$ 26,911				$ 26,190
Urodynamics machine (for surgery Clinic)	$ 22,835	16-929	$ 17,935				$ 17,935
UltraMist System	$ 20,120	16-925	$ 24,670				$ 20,195
MIZUHO ORTHOPEDIC SYSTEMS INC		NO PO					$ (52)
Doppler	$ 3,950	16-935	$ 3,950				$ 3,950
Ultrasound (for breast Clinic)	$ 27,821	16-931	$ 27,821				$ 22,685
Biom 5	$ 10,513	16-930	$ 10,513				$ 8,103
Wilson Frame	$ 5,253	18-902	$ 5,322				$ 4,852
Medical Beds for Psych Units	$ 209,968	16-932	$ 207,429				$ 211,197
SIZEWISE RENTALS		16-932					$ (4,056)
King Tong Pelvic fx reducer	$ 8,600	16-926	$ 8,600				$ 9,500
Stryker Core Power Equipment --Contract	$ 369,113	16-904	$ 369,113				$ 369,113
Patient Monitoring (Low Acuity) - Formerly named Alarm Management	$ 350,010	16-907	$ 350,010				$ 347,029
AIMS Upgrade	$ 176,382	16-901	$ 52,482				$ 51,232
AIMS Upgrade		16-902	$ 12,000				$ 12,000
AIMS Upgrade		16-903	$ 101,500				$ 112,850
Temperature Monitoring - Non FQHC Depts	$ 150,000	17-908	$ 119,219				$ 133,615
2 Pillcams for Endo	$ 13,950	17-911	$ 13,826				$ 13,826
Replace 11 ultrasounds	$ 1,307,000	16-931	$ 1,307,000				$ 1,884,099
POC Ultrasounds (10)	$ 450,000	16-931	$ 455,128				$ 634,702
Ice Machine Replacement		16-911	$ 23,801				$ 23,881
FOLLETT CORPORATION		16-911					$ (880)
Steam Condensate Return Piping Replacement		16-914	$ 62,569				$ 62,529
Laundry/Finance/Payroll/Facilities Roof Repairs		17-917	$ 82,955				$ 82,955
MMC 7th Floor Roof		16-905	$ 276,425				$ 274,582
Facility upkeep	$ 3,655	17-910	$ 3,655				$ 4,205
Facility upkeep	$ 52,790	18-905	$ 52,790				$ 69,218
Colposcopes	$ 23,421	18-909	$ 23,421				$ 24,607
OWENS AND MINOR		18-909					$ 279
Chandler ADA Doors	$ 5,667	18-042	$ 5,667				$ 5,867

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
Glendale Digital X-Ray unit and Sensors (Panoramic Digital AND Nomad digital	$ 68,202	16-917	$ 68,202				$ 63,217
Chandler Dental Digital Radiology - Panoramic x-ray	$ 63,564	16-915	$ 63,564				$ 63,564
CHC - Digital Panoramic x-ray	$ 60,419	16-916	$ 60,419				$ 60,419
CHC Dental Replace CHairs Lights, Compressor and Deliverey Units	$ 127,642	18-905	$ 127,642				$ 127,642
CHC Cost for new equipment and cost of moving existing to Avondale X-Ray	$ 70,276	16-921	$ 70,276				$ 83,327
Avondale- Replace all flooring.	$ 70,435	17-904	$ 70,435				$ 72,635
Temperature Monitoring - FQHC Depts	$ 52,936	17-909	$ 52,936				$ 82,219
McDowell Dental	$ 15,990	16-918	$ 15,990				$ 15,990
CHC Internal Medicine Clinic Renovation - Increase the number of exam room	$ 217,539	18-900	$ 217,539				$ 221,124
CHC Dental Autoclave Replacement including printer & Cassette rack	$ 19,122	18-908	$ 19,122				$ 19,122
Chandler Dental Autoclave Replacement including printer & Cassette rack	$ 6,374	18-908	$ 6,374				$ 6,374
Avondale Dental Autoclave Replacement including printer & Cassette rack	$ 6,374	18-908	$ 6,374				$ 6,374
FHC Helmer Medical Refrigerators	$ 11,110	17-714	$ 11,110				$ 11,110
FHC Helmer Medical Refrigerators	$ 156,625	17-901	$ 156,625				$ 164,096
Cabinet and Countertop Replacement South Central FHC	$ 8,419	18-904	$ 8,419				$ 8,419
CHC Dental Refresh	$ 89,374	18-905	$ 89,374				$ 96,361
POC Molecular (26 units)	$ 1,069,947	19-914	$ 1,069,947				$ 1,049,613
CEPHEID		19-914					$ 1,098
Bili Meter - Draegar (10 units)	$ 71,875	19-927	$ 71,875				$ 71,875
Colposcope - Guadalupe	$ 9,686	19-925	$ 9,686				$ 9,927
EKG machines (3 units)	$ 37,278	19-922	$ 37,278				$ 37,278
Bond related expenses (legal fees, etc.)	$ 325,646	N/A	$ 325,646				$ 325,646
Audiology - Astera Audiometer	$ 11,326	16-913	$ 11,326				$ 11,326
ALTURA COMMUNICATIONS		16-909					$ 138,061
AMICO ACCESSORIES		17-903					$ (55)
ASCOM WIRELESS SOLUTIONS		17-903					$ (35)
EXTENDATA SOLUTIONS		17-903					$ (92)
3rd Floor Behavioral Health/Medical Unit Remodel	$ 2,532,000	17-903	$ 2,532,000				$ 2,570,464
CREATIVE COMMUNICATIONS		17-903					$ (23)
OWENS AND MINOR		17-903					$ (230)
PATIENT TELEPHONE SUPPLY LLC		17-903					$ (22)
22 Behavioral Health Beds for 3rd Floor MMC	$ 181,773	17-907	$ 181,773				$ 188,527
SIZEWISE RENTALS		17-907					$ (3,377)
Replace MMC Radiology GE Fluoroscopy Imaging Equipment	$ 274,145	17-914	$ 274,145				$ 262,145
Endura CCTV System Replacement	$ 167,422	18-901	$ 167,422				$ 168,739
IT - (17-900) eSTF Project	$ 92,032	17-900	$ 92,032				$ 95,059
Diablo Infrastructure Costs	$ 306,662	18-903	$ 306,662				$ 431,149
KRONOS INC		18-903					$ (37)
HP INC		16-923					$ (38)
Epic Willow - Ambulatory & Inventory	$ 964,038	18-906	$ 964,038				$ 428,269
Navigant - Proposition 480 planning	$ 994,000	16-923	$ 994,000				$ 910,000
Kaufmann Hall - Prop 480 planning	$ 370,019	16-923	$ 370,019				$ 370,019
IPv4XChange (ARIN Based Transfer Escrow Payment)	$ 7,040	16-923	$ 7,040				$ 7,040

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MARSH & MCLENNAN AGENCY LLC		16-923					$ 15,000
MARSH & MCLENNAN AGENCY LLC		17-916					$ (15,000)
Vanir Construction Management (Planning Phase)	$ 749,971	17-915	$ 749,971				$ 749,971
Vanir Construction Management ($48M) ($48,300,501 - Entire Project)	$ 6,227,840	17-916	$ 6,227,840				$ 4,580,656
Vanir Construction Management (Planning Phase)		16-923		$ 424,345.78		$ 483,046.80	$ 1,286,190
IPMO Modular Building	$ 305,106	17-902	$ 305,106				$ 329,631
Dickenson Wright PLLC	$ 181,495	16-923	$ 181,495				$ 181,495
GE HEALTHCARE		19-918					$ (32,336)
Sims Murrary LD	$ 24,128	16-923	$ 24,128				$ 24,128
Devenney Group LTD	$ 242,450	16-923	$ 242,450				$ 242,450
MTI Connect Inc	$ 181	16-923	$ 181				$ 181
SHI INTERNATIONAL		19-911					$ 2,577
Payroll/Supplies/Misc Expenses	$ 792,042	16-923	$ 792,042				$ 792,042
EPIC replatform and upgrade to 2016 (see attached for detail)	$ 9,000,000	17-900	$ 9,000,000				$ 7,675,491
Guidesoft		17-900					$ (27,373)
Reimbursement for Capital Expenditures	$ 36,000,000	N/A	$ 36,000,000				$ 36,000,000
OCULUS SURGICAL INC							$ (52)
Vcore Technology							$ (68,550)
Other exp/recon items							$ 677
TOTAL TRANCH 1	$ 117,224,854		$ 102,000,075	$ 424,345.78	$ -	$ 483,046.80	$ 92,162,569.38
Bond issuance costs	$ 228,750		$ 228,750				$ 817,684
BPG Technologies LLC							$ 288,397
Dickinson Wright PLLC							$ 323,597
Hye Tech Neywork and Security Solutions							$ 3,795,099
Goodmans							$ 4,790
GOODMANS		16-923					$ (2,921)
JRC DESIGN		19-955					$ 282,995
Lovitt & Touche INC		16-923					$ 75,000
Lovitt & Touche INC		19-934			$ 8,189.17		$ 4,168,537
PAC VAN INC		19-934					$ 80,395
MARSH & MCLENNAN AGENCY LLC		19-934					$ 653,165
LOVITT & TOUCHE INC		19-951					$ 505
PAC-VAN		19-955					$ 71,160
Payroll/Supplies/Misc Expenses	$ 792,900		$ 792,900				$ 8,068,292
Sims Murrary LD							$ 30,441
Sims Murrary LD		19-955					$ 9,433
Vanir Construction Management ($48M) ($48,300,501 - Entire Project)	$ 4,054,473		$ 4,054,473				$ 21,497,247
World Wide Technology Co Inc							$ 448,569
Zurich North America		16-923					$ 60,512
AFFILIATED ENGINEERS INC							$ 38,348
BALLARD SPAHR							$ 288,544
BLUETREE NETWORK INC							$ 178,563
CARAHSOFT TECHNOLOGY CORPORATION							$ 143,344

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
CDW GOVERNMENT INC							$ 555,016
CENTURYLINK							$ 170,013
CORPORATE TECHNOLOGY SOLUTIONS LLC							$ 178,552
DEVENNEY GROUP LTD							$ 530,623
DWL ARCHITECTS + PLANNERS INC							$ 272,318
EPIC SYSTEMS CORPORATION							$ 554,536
FITCH RATINGS							$ 120,000
GRAYBAR ELECTRIC							$ 17,357
GREENBERG TRAURIG, LLP							$ 240,000
GUIDESOFT INC							$ 503,715
HP INC							$ 19,960
INTEGRATED CONTROL SYSTEMS INC							$ 2,160
LANMOR SERVICES INC							$ 209,036
MISCELLANEOUS							$ 228,750
MOODY'S							$ 120,000
MOSS ADAMS LLP							$ 42,500
ORRICK							$ 35,000
PRESIDIO NETWORKED SOLUTIONS INC							$ 310,797
RICOH AMERICAS CORPORATION							$ 180
RMJ ELECTRICAL CONTRACTORS INC							$ 43,305
SAVVIS COMMUNICATIONS LLC							$ 116,363
SHI INTERNATIONAL CORP							$ 122,929
SPRAY SYSTEMS ENVIRONMENTAL INC							$ 13,780
STIFEL							$ 268,910
THOMAS PRINTWORKS							$ 1,291
US BANK							$ 900
US BANK - CORPORATE TRUST SERVICES							$ 600
Valleywise							$ 1,509
VANIR CONSTRUCTION MANAGMENT INC							$ (4,511,972)
WALMART.COM							$ 549
WOODRUFF CONSTRUCTION							$ 17,015
TOTAL Enterprise	$ 5,159,627		$ 5,159,627	$ -	$ 8,189.17	$ -	$ 41,507,386.02
Adams and Wendt		19-935					$ 32,697
APS		19-935					$ (2,108,461)
Affiliated Engineers Inc		19-935					$ 1,587,215
Affiliated Engineers Inc		19-935					$ 2,068,896
Arnold Machinery		19-935					$ 34,209
ARIZONA DEPARTMENT OF HEALTH		19-935					$ 150
ALTURA COMMUNICATIONS SOLUTIONS LLC		19-935					$ 5,749
BPG TECHNOLOGIES LLC		19-935					$ 2,774
CABLE SOLUTIONS LLC		19-935					$ 80,880
CDW GOVERNMENT INC		19-935					$ 337
CENTERLINE MECHANICAL		19-935					$ 24,522

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid	Amount Paid	Amount Paid	Amount Paid
				DEC'23	JAN'24	FEB'24	Cumulative Total
CITY OF PHOENIX		19-935					$ 2,296
ELONTEC LLC		19-935					$ 3,414
ENGINEERING ECONOMICS		19-935					$ 135,362
GOODMANS		19-935					$ 12,143
HYE TECH		19-935			$ 17,862.01		$ 2,078,861
JENSEN HUGHES		19-935					$ 12,263
KITCHELL		19-935					$ 54,628,414
KM FACILITY SERVICES		19-935					$ 71,885
LANMOR		19-935					$ 23,708
Maricopa County		19-935					$ 1,500
MDM COMMERCIAL		19-935					$ 1,760
Soft Computer Consultants		19-935					$ 5,250
SMITHCRAFT SIGNS		19-935					$ 5,782
Speedie snd Assoc		19-935					$ 29,245
SOUTHWEST GAS		19-935					$ 121,938
SYNTELLIS PERFORMANCE SOLUTIONS LLC		19-935					$ 28,000
Thomas Printworks		19-935					$ 41
VALLEY SYSTEMS		19-935					$ 960
WESTERN STATES FIRE		19-935					$ 705
ARIZONA PUBLIC SERVICE COMPANY							$ 1,773,158
HYE TECH NETWORK AND SECURITY SOLUTIONS							$ 7,125
MARICOPA COUNTY PLANNING AND DEVELOPMENT							$ 239,965
MARICOPA COUNTY TREASURER							$ 135,146
VANIR CONSTRUCTION MANAGEMENT INC							$ 719,110
TOTAL Central Utility Plant (RSVT)	$ -		$ -	$ -	$ 17,862.01	$ -	$ 61,766,996.64
ADAMS AND WENDT		19-949					$ 65,342
ADAMS AND WENDT		19-948					$ 32,968
ADAMS AND WENDT		19-947					$ 71,561
ADAMS AND WENDT		19-951					$ 90,538
ADAMS AND WENDT							$ 6,600
ADVANCED INSTRUMENTS LLC		19-947					$ 30,605
ACIST MEDICAL SYSTEMS INC		19-947					$ 150,700
ACCUVEIN INC		19-947					$ 28,925
HYE TECH NETWORK		19-947					$ 2,953,494
HYE TECH NETWORK		19-951					$ 14,702
ADAMS AND WENDT		19-953					$ 5,460
ADAMS AND WENDT		19-948					$ 2,596
AFFILIATED ENGINEERS		19-948					$ 396,165
AFFILIATED ENGINEERS		19-954					$ 1,050
AFFILIATED ENGINEERS							$ 1,092
ANCO SANITATION		19-948					$ 1,450
ATLANTIC RELOCATIONS		19-948					$ 49,125
ALLEGIANCE CORPORATION		19-947					$ 14,858

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
ABBOTT LABORATORIES INC		19-947					$ 178,515
ALTURA COMMUNICATIONS		19-947					$ 34,924
AMAZON		19-947					$ 965
ARMSTRONG MEDICAL INDUSTRIES INC		19-951					$ 2,151
ARMSTRONG MEDICAL INDUSTRIES INC		19-947					$ 10,755
AMICO ACCESSORIES		19-951					$ 43,425
BAKER SERVICES		19-951					$ 2,950
BAKER SERVICES		19-947					$ 4,600
BECTON DICKINSON		19-947				$ 48,500.00	$ 48,500
BUNNELL INC		19-947					$ 82,940
BPG TECH		19-948					$ 182,186
BPG TECH		19-947					$ 7,339
BPG TECH		19-951					$ 23,013
B BRAUN MEDICAL INC		19-947					$ 58,963
BAYER HEALTHCARE LLC		19-947		$ 55,065.00			$ 55,065
CABLE SOLUTIONS		19-947			$ 383,746.27	$ 114,286.69	$ 7,882,455
CABLE SOLUTIONS		19-951		$ 53,412.47	$ 686.34		$ 1,089,912
CARL ZEISS MEDITEC INC		19-947					$ 1,086,286
C-SCAN TECHNOLOGIES		19-947					$ 12,513
CAPSULE TECH		19-951					$ 8,708
CAPSULE TECH		19-947					$ 154,564
CDW G		19-947		$ 3,338.02	$ 12,835.28	$ (115.60)	$ 1,368,258
CDW G		19-951					$ 1,024
CENTURY LINK		19-951					$ 6,706
CENTRAK INC		19-947			$ 147,621.20	$ 68,361.65	$ 1,042,349
CITY OF PHOENIX		19-947					$ 84,493
CITY OF PHOENIX		19-948					$ 9,525
CME		19-948					$ 21,924
CME		19-951					$ 7,046
CME		19-947		$ 2,468.14	$ 16,766.80	$ 131,627.68	$ 959,506
CUNINGHAM ARCHITECT		19-947		$ 541,059.13	$ 39,883.35	$ 40,800.00	$ 32,458,108
CUNINGHAM ARCHITECT		19-951					$ 40,640
CUNINGHAM ARCHITECT		19-937					$ 73,619
CLIMATEC LLC		19-947					$ 8,322
CONNECWIVITY WIRELESS INC		19-947		$ 30,202.29			$ 1,364,094
CONNECWIVITY WIRELESS INC		19-951		$ 593.84			$ 188,390
CONNECTIVITY WIRELESS SOLUTIONS		19-951			$ 20,421.72		$ 111,636
CONNECTIVITY WIRELESS SOLUTIONS		19-947			$ 46,524.72		$ 99,256
COOPER ATKINS CORPORATION		19-947					$ 32,350
CARAHSOFT TECHNOLOGY		.					$ 2,520
CS MEDICAL LLC		19-947					$ 27,880
DBTEX OHMEDB		19-951					$ 708,780
DANIELS MOVING		19-948					$ 18,756

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DYNAMIC INSTALLATION		19-948					$ 23,932
DYNAMIC INSTALLATION		19-951					$ 501
DISTRICT MEDICAL GROUP		19-948					$ 89,356
ECD SYSTEMS		19-947		$ 154,624.00	$ 38,802.11	$ 177,590.00	$ 2,011,631
ECD SYSTEMS		19-951					$ 40,938
ENDOSCOPE SERVICES		19-951		$ 4,866.38			$ 16,503
ENGINEERING ECONOMICS		19-951					$ 62,767
ENGINEERING ECONOMICS		19-947					$ 508,258
ENDOSOFT LLC		19-947					$ 73,920
EVOQUA WATER TECHNOLOGIES		19-947		$ 97,291.23			$ 97,291
EXCESSIVE CARTS		19-948					$ 23,182
EPIC SYSTEMS CORPORATION		19-947					$ 5,000
FISHER HEALTHCARE		19-947					$ 245,295
FC HOSPITALITY		19-948					$ 216,732
FEDWIRE CREDIT (APS)						$ (1,773,157.95)	$ -
Follett		16-923					$ 63,102
Follett		19-947		$ (32.86)			$ 53,753
FILLMASTER SYSTEMS LLC		19-947					$ 1,495
GOODMANS							$ 101,011
GOODMANS		19-951					$ 30,993
GOODMANS		19-947		$ 3,146.50		$ 2,595,842.32	$ 4,636,590
GENERAL DEVICES LLC		19-947			$ 20,595.00		$ 20,595
GRAINGER		19-947			$ 39,390.08		$ 135,530
GRAINGER		19-951				$ 3,650.52	$ 32,661
GE MEDICAL SYSTEMS		19-947		$ (81,131.60)		$ 932,197.23	$ 932,197
GE HEALTHCARE IITS USA CORP		18-915				$ (75.74)	$ -
GE HEALTHCARE IITS USA CORP		19-947		$ 172,900.55	$ 2,924,749.41	$ 640,242.25	$ 5,296,169
GE PRECISION HEALTHCARE LLC		19-947		$ 61,549.91		$ 335,646.08	$ 1,582,117
GETINGE USA SALES LLC		19-947					$ 721,318
Helmer Inc		19-947		$ 33,737.57	$ 237,896.07	$ 39,087.35	$ 356,693
HILL ROM		19-951					$ 16,453
HILL ROM		19-947		$ 59,816.88			$ 185,040
HP INC		19-947			$ 128,603.64	$ 1,033,579.76	$ 1,237,479
HOLOGIC INC		19-947					$ 4,000
HOME DEPOT - Buyers Log		19-948					$ 587
HYE TECH NETWORK AND SECURITY SOLUTIONS		19-951			$ 2,295.80		$ 64,438
HYE TECH NETWORK AND SECURITY SOLUTIONS		19-947					$ 746,692
Innerface Architectural Signage		19-948					$ 13,927
Innerface Architectural Signage		19-951					$ 833
INTERMETRO INDUSTRIES CORPORATION		19-947		$ 27,461.99	$ 42,945.20	$ 386,462.27	$ 708,897
INTERMETRO INDUSTRIES CORPORATION							$ 1,351
INDOFF INCORPORATED		19-947			$ 29,784.00		$ 29,784
INNERSPACE		19-947			$ 104,101.18	$ 37,295.66	$ 141,397

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JENSEN HUGHES		19-947					$ 82,763
JENSEN HUGHES		19-951					$ 41,127
KRONOS INC		19-947					$ 6,444
KITCHELL		19-947		$ 1,484,899.42	$ 3,344,687.47	$ 1,394,136.44	$ 302,261,428
KITCHELL		19-937					$ 667,452
KITCHELL		19-948					$ 11,950,855
KITCHELL		19-951		$ 89,839.27	$ 93,306.00		$ 33,998,619
KITCHELL		19-954					$ 8,373
LANMOR		19-947			$ 100,000.00		$ 933,283
LANMOR		19-948					$ 4,547
LANMOR		19-951					$ 124,428
LEVEL 3 AUDIO VISUAL		19-947					$ 636,289
LEVEL 3 AUDIO VISUAL		19-951					$ 265,798
LEICA MICROSYSTEMS INC		19-947			$ 367,342.45		$ 367,342
MCMASTER CARR		19-947			$ 809.86		$ 810
MASIMO AMERICAS INC		19-947		$ 22,485.93			$ 22,486
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-951					$ 289,918
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-947					$ 2,044,437
MARICOPA COUNTY PLANNING AND DEVELOPMENT							$ 6,211
MARICOPA COUNTY ENVIRONMENTAL SERVICES		19-947					$ 3,550
MARICOPA COUNTY PLANNING AND DEVELOPMENT		19-948					$ 3,308
MARKETLAB INC		19-947				$ 15,551.91	$ 15,552
MEDLINE INDUSTRIES INC		19-947					$ 4,538
MINDRAY DS USA INC		19-947		$ 6,835.38			$ 270,878
MIZUHO ORTHOPEDICS SYSTEMS INC		19-947					$ 183,505
MDM COMMERCIAL		19-951					$ 14,695
MDM COMMERCIAL		19-947		$ 235,074.70	$ 66,920.00		$ 335,977
MDM COMMERCIAL		19-950					$ 748
MOBILE COMMUNICATIONS AMERICA INC		19-947					$ 5,738
MONOPRICE INC		19-947					$ 15,477
MIHS PAYROLL				$ 202,887.76			$ -
NINYO AND MOORE		19-947					$ 11,200
NINYO AND MOORE		19-947					$ 6,824
NINYO AND MOORE		19-951					$ 16,293
NCI INC		19-947					$ 19,725
NATUS MEDICAL INC		19-947					$ 60,912
OHIO MEDICAL LLC		19-947					$ 238,474
OHIO MEDICAL LLC		19-951					$ 1,029
OLYMPUS AMERICA INC		19-947		$ 31,244.44		$ 348,861.91	$ 380,106
OFFSITE EQUIPMENT STORAGE		19-948					$ 650
OEC MEDICAL SYSTEMS INC		19-947			$ 207,774.00	$ 222,074.10	$ 429,848
PAC-VAN		19-947					$ 7,220
POHLE NV CENTER INC		19-948					$ 11,904

VALLEYWISE HEALTH

Care Reimagined - Expenditure Report

DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
PERRY BAROMEDICAL CORPORATION		19-947				$ 27,502.10	$ 297,771
PRINTWORKS		19-947					$ 41
PHILIPS HEALTHCARE		19-947					$ 3,575,331
PATIENT TELEPHONE SUPPLY		19-947					$ 3,825
PERIGEN		19-947			$ 43,499.20		$ 43,499
RETROTEL INC		19-947				$ 4,247.00	$ 4,247
RECLASS UTILITIES ALLOCATION TO CONSTRUCTION PROJECTS		19-951					$ (34,000)
RECLASS UTILITIES ALLOCATION TO CONSTRUCTION PROJECTS		19-947					$ 34,000
RMJ Electrical Contractors							$ 551
SIEMENS HEALTHCARE DIAGNOSTICS		19-947				$ 775,950.00	$ 3,956,350
SKYTRON		19-947					$ 239,934
SKYTRON		19-951					$ 13,430
SKYTRON							$ (207,963)
SMITHCRAFT SIGNS		19-947					$ 34,085
SMITHCRAFT SIGNS		19-951					$ 54,388
SMITHCRAFT SIGNS		20-404			$ 52,405.00		$ 468,253
SPEEDIE AND ASSOC		19-947		$ 5,645.00	$ 24,965.00	$ 6,665.00	$ 332,948
SPEEDIE AND ASSOC		19-951		$ 190.00			$ 55,190
STERIS CORPORATION		19-947		$ -	$ 52,027.00	$ 101,080.94	$ 5,382,932
STERIS CORPORATION		19-951					$ 110,622
SCRIPTPRO USA INC		19-947					$ 146,801
STRYKER SALES CORPORATION		19-951			$ 2,757.36		$ 52,056
STRYKER SALES CORPORATION		19-947		$ 4,237,583.92	$ 489,269.08	$ 800,054.08	$ 5,821,475
STRYKER COMMUNICATIONS		19-947					$ 1,339,235
SWISSLOG		19-947					$ 2,500
SIRVA MOVE MANAGEMENT		19-947					$ 368,989
TEMP ARMOUR		19-951					$ 6,649
Valley Systems		19-948					$ 756
Valley Systems		19-951					$ 1,018
Speedie and Assoc		19-947					$ 80,881
Speedie and Assoc		19-951					$ 28,802
Speedie and Assoc		19-948					$ 1,120
SRP		19-947					$ 500
WAXIE SANITARY SUPPLY		19-947					$ 840
UTILITY ALLOCATION		19-947		$ 54,000.00			$ 1,346,500
UTILITY ALLOCATION							$ 18,500
VYAIRE MEDICAL 211 INC		19-947		$ 62,815.30			$ 62,815
TED PELLA INC		19-947				$ 38,629.06	$ 38,629
THOMAS PRINTWORKS							$ 4,069
THOMAS PRINTWORKS		19-947				$ 37.45	$ 568
THUNDER BISCUIT LLC		19-947				$ 18,650.00	$ 18,650
Trademark Visual		19-948					$ 2,576
THE BAKER COMPANY		19-947					$ 148,103

VALLEYWISE HEALTH

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DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
TRANSACTT COMMERCIAL INTERIORS		19-951			$ 1,030.66		$ 16,188
TRANSACT COMMERCIAL FURNISHINGS INC		19-947			$ 2,760.33		$ 2,760
TRANSACT COMMERCIAL FURNISHINGS INC		19-951			$ 2,760.33		$ 2,760
ORANGE FACTOR IMAGING PHYSICISTS LLC							$ 6,400
ZURICH NORTH AMERICA					$ 12,184.93		$ -
ZOLL MEDICAL CORPORATION		19-947				$ 4,248.55	$ 4,249
ZORO TOOLS		19-948					$ 14,481
ALTURA COMMUNICATIONS SOLUTIONS LLC							$ 11,827
DH PACE COMPANY INC							$ 1,468
ENTERPRISE SECURITY INC							$ 13,715
HD SUPPLY FACILITIES MAINTENANCE LTD							$ 3,780
INTERMETRO INDUSTRIES CORPORATION							$ 833
LOVITT & TOUCHE INC							$ 505
MARICOPA COUNTY TREASURER							$ 7,310
SKYLINE BUILDERS AND RESTORATION INC							$ 122,769
STRYKER SALES CORPORATION							$ 384,697
TEMPE DIABLO LLC							$ 33,132
TUCSON BUSINESS INTERIORS INC							$ 447,192
VANIR CONSTRUCTION MANAGEMENT INC							$ 13,782,360
WORLD WIDE TECHNOLOGY HOLDINGS CO LLC							$ 35,500
TOTAL Roosevelt Campus Site Development Plan (RSVT)	$ 482,057		$ 482,057	$ 7,653,870.56	$ 9,102,146.84	$ 8,569,508.71	$ 468,553,700.30
CDW GOVERNMENT INC		IPMO				$ 185,796.83	
ASSI (ACCURATE SURG/SCI INSTR CORP)		IPMO				$ 2,060.30	
INTUITIVE SURGICAL INC		IPMO				$ 116,860.00	
J & J HEALTHCARE SYSTEMS INC		IPMO				$ 1,575.86	
MEDLINE INDUSTRIES INC		IPMO				$ 392.67	
OLYMPUS AMERICA INC		IPMO				$ 3,195.00	
STRYKER ORTHOPAEDICS		IPMO				$ 406.98	
SYNTHES USA ORTHO		IPMO				$ 28,967.08	
CME		IPMO				$ 39,781.96	
AESCULAP INC		IPMO				$ 39,292.84	
CAREFUSION 2200 INC		IPMO				$ 61,338.98	
Total IPMO						$ 479,668.50	
	$ 122,866,539		**$ 107,641,759**	**$ 8,078,216.34**	**$ 9,128,198.02**	**$ 9,052,555.51**	**$ 663,990,652**
Bond Proceeds received to DBte:							
$935,805,959							
TOTAL MONTHLY SPENT AMOUNT	**$ 631,287,454**		**$ 130,324,142**	**$ 8,238,091.40**	**$ 9,189,651.02**	**$ 9,052,555.51**	**$ 888,759,817**
VARIANCE: Bond Proceeds amount vs CER amount issued			**$ 500,963,312**				(41.09)

VALLEYWISE HEALTH

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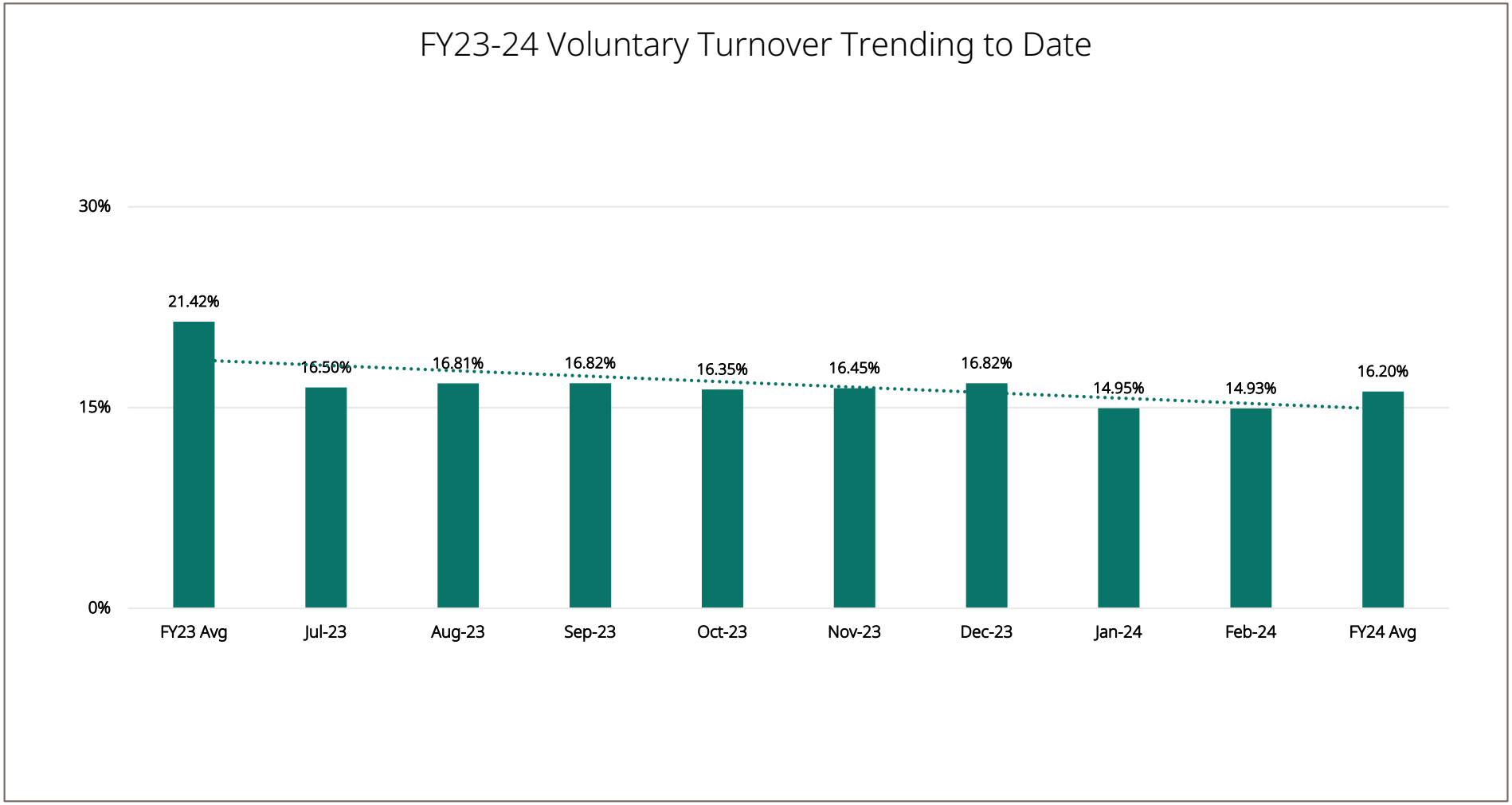
DeSCRIPTion	Budgeted Amount	CER Number	CER Amount	Amount Paid DEC'23	Amount Paid JAN'24	Amount Paid FEB'24	Amount Paid Cumulative Total
REMAINING Cash for disbursement				**$65,288,389**	**$56,098,738**	**$47,046,182.93**	**$47,046,141.84**
IPMO Funds							**$ 479,668.50**

8.c. Reports to the Board - Valleywise Health Employee Turnover Report

Human Resources
Board Turnover Data

February 2024



Valleywise Health February Turnover

Valleywise Health

ALL Valleywise Health Summary

February - 2024	Avg Emps	Hires	Vol Terms	Invol Terms	Uncon Terms	Vol %	Invol %	Uncon %
Administrative	550	9	8	5	3	1.45%	0.91%	0.55%
Clinical Certified	239	5	3	1	0	1.26%	0.42%	0.00%
Clinical Non-Certified	728	36	11	8	7	1.51%	1.10%	0.96%
Dentist	10	0	0	0	0	0.00%	0.00%	0.00%
Director	50	1	0	0	0	0.00%	0.00%	0.00%
Executive	22	0	0	0	0	0.00%	0.00%	0.00%
Manager	99	1	0	0	0	0.00%	0.00%	0.00%
Nurse	742	24	13	2	2	1.75%	0.27%	0.27%
Nurse Coordinator	104	0	0	0	1	0.00%	0.00%	0.96%
Nurse Director	11	0	0	0	0	0.00%	0.00%	0.00%
Nurse Manager	21	0	0	0	0	0.00%	0.00%	0.00%
Nurse Practitioner	6	0	0	0	0	0.00%	0.00%	0.00%
Nurse Supervisor	135	0	0	0	0	0.00%	0.00%	0.00%
Professional IT	123	1	0	0	1	0.00%	0.00%	0.81%
Professional Licensed	208	3	0	0	0	0.00%	0.00%	0.00%
Professional Non-Licensed	194	4	1	0	0	0.52%	0.00%	0.00%
Supervisor	72	0	0	0	0	0.00%	0.00%	0.00%
Support IT	38	1	2	0	0	5.26%	0.00%	0.00%
Support Service	147	3	2	0	0	1.36%	0.00%	0.00%
Technologists	157	2	3	0	0	1.91%	0.00%	0.00%
Total	3,656	90	43	16	14	1.18%	0.44%	0.38%

Total (Last 12 Months)	Avg Emps	Hires	Vol Terms	Invol Terms	Uncon Terms	Vol %	Invol %	Uncon %
Administrative	542	146	72	22	31	13.28%	4.06%	5.72%
Clinical Certified	237	104	54	17	13	22.78%	7.17%	5.49%
Clinical Non-Certified	715	354	156	75	58	21.82%	10.49%	8.11%
Dentist	10	1	1	0	0	10.00%	0.00%	0.00%
Director	52	9	1	2	3	1.92%	3.85%	5.77%
Executive	24	0	1	0	1	4.17%	0.00%	4.17%
Manager	101	12	4	3	4	3.96%	2.97%	3.96%
Nurse	671	339	136	13	24	20.27%	1.94%	3.58%
Nurse Coordinator	109	14	11	1	4	10.09%	0.92%	3.67%
Nurse Director	11	1	0	0	1	0.00%	0.00%	9.09%
Nurse Manager	21	4	1	0	1	4.76%	0.00%	4.76%
Nurse Practitioner	6	0	0	0	0	0.00%	0.00%	0.00%
Nurse Supervisor	144	8	3	3	6	2.08%	2.08%	4.17%
Professional IT	122	15	6	0	6	4.92%	0.00%	4.92%
Professional Licensed	208	32	10	2	6	4.81%	0.96%	2.88%
Professional Non-Licensed	191	49	18	4	4	9.42%	2.09%	2.09%
Resident	1	0	0	0	2	0.00%	0.00%	200.00%
Supervisor	82	9	5	2	1	6.10%	2.44%	1.22%
Support IT	33	22	10	1	2	30.30%	3.03%	6.06%
Support Service	144	45	18	8	8	12.50%	5.56%	5.56%
Technologists	159	45	28	5	4	17.61%	3.14%	2.52%
Total	3,583	1,209	535	158	179	14.93%	4.41%	5.00%

*Per Diem staff are excluded from these %