Valleywise Community Health Centers Governing Council Meeting

October 6, 2021
6:00 p.m.

Agenda

Council Members	AGENDA - AMENDED
Ryan Winkle, Chairman Michelle Barker, Vice Chairman Nelly Clotter-Woods, Ph.D., Treasurer Terry Benelli, Member Salina Imam, Member Scott Jacobson, Member Joseph Larios, Member Liz McCarty, Member Daniel Messick, Member	**Valleywise Community Health Centers Governing Council** **Mission Statement of the Valleywise Community Health Centers Governing Council** Serve the population of Maricopa County with excellent, comprehensive health and wellness in a culturally respectful environment.

▪ Valleywise Health Medical Center ▪ 2601 East Roosevelt Street ▪ Phoenix, Arizona 85008 ▪

Meeting will be held remotely. Please visit https://valleywisehealth.org/event/valleywise-community-health-centers-governing-council-meeting-10-06-21/ for further information.

Wednesday, October 6, 2021
6:00 p.m.

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

Please silence any cell phones, pagers, computers, or other sound devices to minimize disruption of the meeting.

Call to Order

Roll Call

Call to the Public

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

Agendas are available within 24 hours of each meeting via the Clerk's Office, Valleywise Health Medical Center, 2601 East Roosevelt Street, Phoenix, Arizona 85008, Monday through Friday between the hours of 9:00 a.m. and 4:00 p.m. and on the internet at https://valleywisehealth.org/about/governing-council/. Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice via the Clerk's Office, Valleywise Health Medical Center, 2601 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.

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda: 15 min

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

a. Minutes:

i. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated August 18, 2021

ii. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated September 1, 2021

iii. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated September 14, 2021

b. Contracts:

i. **Acknowledge** a new agreement (MCO-20-021-MSA) between Clover Insurance Company and the Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services

ii. **Acknowledge** a new agreement (MCO-20-020-MSA) between Employers Health Network, LLC and the Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services

iii. **Acknowledge** amendment #1 to the contract (MCO-20-018-1-MSA) between Bright Health and the Maricopa County Special Health Care District dba Valleywise Health, to add small group plans to the contract

iv. **Acknowledge** amendment #1 to the intergovernmental agreement (IGA) (90-21-141-1-01) between the Arizona Department of Economic Security (ADES) and the Maricopa County Special Health Care District dba Valleywise Health, to continue to provide health care management services under the ADES Refugee Resettlement Program

v. **Acknowledge** a new agreement (MCO-20-022-MSA) between Medica Insurance Company and the Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services

vi. **Acknowledge** amendment #49 to the professional services agreement (90-12-084-1-49) between District Medical Group and the Maricopa County Special Health Care District dba Valleywise Health

c. Governance:

i. **Approve** Health Resources and Services Administration grant application for funding in the amount of $500,000, for a two-year period, to establish a dental residency program at Valleywise Health, in partnership with Creighton University

ii. **Acknowledge** grant application to Molina Complete Care Foundation for funding in the amount of $166,800, for one year, to address food insecurities by providing mobile market services at Valleywise Community Health Centers-South Central, South Phoenix/Laveen, North Phoenix, and Valleywise Comprehensive Health Center-Peoria

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

1. Approval of Consent Agenda, cont.:

   c. Governance, cont.:

      iii. **Acknowledge** grant application via Arizona Department of Health Services and Arizona Alliance of Community Health Centers for funding in the amount of $236,158, for one year, to assist with expenses related to COVID-19 vaccination provision

      iv. **Acknowledge** grant application to Arizona Department of Economic Security for funding in the amount of $93,750, for one year for a 0.5 full time equivalent Cultural Health Navigator to provide refugee health literacy education and mental health case management to refugees and other eligible beneficiaries

      v. **Acknowledge** grant application to Blue Cross/Blue Shield Arizona for funding in the amount of $75,000, for one year, to assist with the food pharmacy program

      vi. **Approve** revisions to policy 89100 F; Valleywise Community Health Centers Governing Council Travel and Travel Expense Reimbursement

      vii. **Approve** protocol 20080 F; FQHC Clinic: Coverage for Medical Emergencies During and After Hours

      viii. **Approve** protocol 20082 F; FQHC Clinic: Afterhours, Weekends and Holiday Calls

      ix. **Accept** the audited financial statements, reports, supplementary information, and schedule required by the Uniform Guidance, for fiscal year ended June 30, 2020 and 2019

      x. **Approve** budget modification to American Rescue Plan Act funding received for Valleywise Health's Federally Qualified Health Center Clinics

   d. Medical Staff:

      i. **Acknowledge** the Federally Qualified Health Centers Medical Staff and Allied Health Professional Staff Credentials

      ii. **Acknowledge** proposed revisions to policy 39026 T; Clinical Services/Medical Affairs: Operational Credentialing

_____End of Consent Agenda_____

2. Discuss, Review, and **Approve** the expedited closure of the dental clinic located at Valleywise Community Health Center-Mesa, effective November 30, 2021 15 min
   Christopher Brendemuhl, Director, Federally Qualified Health Center Clinics Dentistry

3. Discussion and **Possible Action** on the appointment of a District Board member as a non-voting member of the Valleywise Community Health Centers Governing Council for the remainder of fiscal year 2022 15 min
   Valleywise Community Health Centers Governing Council

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

4. Recent meeting reports from the Valleywise Community Health Centers Governing Council's committees 5 min

   a. Compliance and Quality Committee
      Michelle Barker, Committee Chair

   b. Executive Committee
      Ryan Winkle, Committee Chair

   c. Finance Committee
      Nelly Clotter-Woods, Ph.D., Committee Chair

   d. Strategic Planning and Outreach Committee
      Joseph Larios, Committee Chair

5. Federally Qualified Health Center Clinics Chief Executive Officer's report 10 min
   Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics

6. Valleywise Health's President and Chief Executive Officer's report 5 min
   Steve Purves, President and Chief Executive Officer, Valleywise Health

7. Chairman and Council Member Closing Comments/Announcements 5 min
   Valleywise Community Health Centers Governing Council

8. Review Staff Assignments 5 min
   Cassandra Santos, Assistant Clerk

   Old Business:

   August 4, 2021
   Revisit appointment of a District board member as non-voting VCHCGC member

Adjourn

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.

Consent Agenda

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.a.i.

Minutes:
August 18, 2021

Minutes

Valleywise Community Health Centers Governing Council
Valleywise Health Medical Center
August 18, 2021
12:00 noon

DRAFT

Members Present:
Ryan Winkle, Chairman - *participated remotely*
Michelle Barker, Vice Chairman - *participated remotely*
Nelly Clotter-Woods, Ph.D., Treasurer - *participated remotely*
Salina Imam, Member - *participated remotely*
Scott Jacobson, Member - *participated remotely*
Joseph Larios, Member - *participated remotely*
Daniel Messick, Member - *participated remotely*
Lisa Porter, Member - *participated remotely*

Members Absent:
Ylenia Aguilar, Member
Terry Benelli, Member
Liz McCarty, Member
Isaac Serna, Member

Others/ Guest Presenters:
Pat Fairchild, Team Lead, Administrative/Governance Reviewer, Health Resources and Services Administration - *participated remotely*
Abner Garcia-Lopez, Federal Representative, Health Resources and Services Administration - *participated remotely*
Alyson Roby, Clinical Reviewer, Health Resources and Services Administration - *participated remotely*
Jack Brandenburg, Fiscal Reviewer, Health Resources and Services Administration - *participated remotely*
Melanie Talbot, Chief Governance Officer - *participated remotely*

Recorded by:
Cassandra Santos, Assistant Clerk - *participated remotely*

Call to Order

Chairman Winkle called the meeting to order at 12:04 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that seven of the twelve voting members of the Valleywise Community Health Centers Governing Council (Council) were present, which represented a quorum. Ms. Imam joined the meeting shortly after roll call.

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

Call to the Public

Chairman Winkle called for public comment.

There were no comments from the public.

General Session, Presentation, Discussion and Action:

1. Discussion on Valleywise Community Health Centers Governing Council authority, roles and responsibilities, program requirements, and other technical assistance topics

Ms. Fairchild introduced the Health Resources and Services Administration's (HRSA) operational site visit (OSV) review team. She explained the role of each reviewer and the reviewers gave a brief description of their background and role with HRSA.

Council members introduced themselves and provided a short summary of their work experience and background.

Mr. Garcia-Lopez explained the purpose of the OSV in depth, as it pertained to the Council. He specifically mentioned the review of HRSA Compliance Manuel Chapter 19: Board Authority and Chapter 20: Board Composition requirements.

Ms. Fairchild pointed out that less than 5% of the health centers nationwide surveyed by HRSA were public health centers such as Valleywise Health. She expressed appreciation to members as it was their representation that made HRSA grant funding possible for the Federally Qualified Health Center (FQHC) clinics.

She highlighted Chapter 19: Board Authority; that required the Council to hold monthly meetings which included a record of the meeting minutes capturing attendance and key actions taken. She added that the meeting minutes she reviewed during the OSV were extraordinarily prepared and very well written.

Ms. Fairchild said that the Council was also responsible for the approval and selection, and/or dismissal, of the Chief Executive Officer (CEO) of the FQHC clinics, as well as routine annual evaluations of their performance.

In addition, the Council was responsible for adopting policies related to the health center's financial management, budget, the Sliding Fee Discount Program and Schedule (SFDP/SFDS), billing and collection, quality of care, service site locations, hours of operations of sites, and scope of services.

The VCHCG must demonstrate long term strategic planning initiative and processes related to service utilization patterns, productivity, patient satisfaction, and patient grievances.

Ms. Fairchild said there was no documentation that the Council reviewed and approved billing and collection policies.

Chairman Winkle said that he recalled reviewing and approving a SFDP.

The group briefly discussed the relationship between the Maricopa County Special Healthcare District (MC SHCD) and the Council and the general role of each entity. They spoke about the Council's Bylaws and Co-Applicant Arrangement between the two entities.

Ms. Fairchild mentioned that the Bylaws were very well written and provided clear understanding.

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

1. Discussion on Valleywise Community Health Centers Governing Council authority, roles and responsibilities, program requirements, and other technical assistance topics, cont.

Mr. Messick expressed his appreciation to staff for their hard work preparing for Council meetings and documentation provided for meeting presentations.

NOTE: Ms. Imam joined the meeting at 12:16 p.m.

Ms. Fairchild described Chapter 20: Board Composition; and commented that it dealt with a variety of membership requirements, including but not limited to, governing board size and member expertise requirements.

She said that Chapter 20 required that the majority of Council members must be patients served by the health center and demonstrate representation of individuals served by the health center. Demographic factors considered included race, ethnicity, and gender, consistent with the demographic elements reported in the health center's Uniform Data System (UDS).

Additional requirements included the establishment of Bylaws to refer to and follow. Also, no more than one half of members may derive more than 10% of their annual income from the health care industry.

Ms. Fairchild proclaimed that the Council met all requirements as stated in Chapter 19 and 20.

She said the HRSA did not require term length limits, however, she believed that officer role term limits were appropriate. She spoke about membership recruitment, training and development, onboarding, and standing committee responsibilities.

Mr. Jacobson agreed that officer term length limits were appropriate because it diversified groups by bringing new perspective in the decision making process. It avoided stagnation and the perpetual concentration of power and allowed the rotation of assignment. All of which improved group dynamics.

Ms. Roby said that from a clinical regulatory standpoint, the Council appeared compliant. She mentioned the process of approving medical staff credentials and asked for feedback from the Council on their understanding of that process.

Chairman winkle said that the process included acknowledgement of licensure, credentialing, and privileges.

Mr. Messick said that the Council often reviewed and discussed medical staff privileges.

Ms. Roby asked whether the Council approved or denied those medical staff privileges.

Vice Chairman Barker explained that neither the Council nor its standing committees actually approved privileges, instead acknowledged review of them.

Ms. Roby commented that HRSA did not require the governing board of the health center to approve credentialing or privileges, therefore the process noted was acceptable.

The group conversed briefly about performance management, UDS quality metrics, strategic planning, and health equity.

Mr. Larios highlighted recent work done by the Strategic Planning and Outreach Committee associated with health equity, social detriments of health, and long term strategic planning.

Mr. Brandenburg asked for the current financial status of the FQHC clinics.

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

1. Discussion on Valleywise Community Health Centers Governing Council authority, roles and responsibilities, program requirements, and other technical assistance topics, cont.

Chairman Winkle said that he believed the FQHC clinics were financially sound.

As Council Treasurer, Dr. Clotter-Woods, gave a brief summary of the most recent financial performance for the FQHC clinics.

Mr. Messick mentioned that although the FQHC clinics were exposed to the negative impact brought by the COVID-19 pandemic, the financial performance of the clinics seemed to remain relatively strong.

The group discussed how the FQHC clinics compared to other FQHC clinics in general. They spoke about reimbursement rate shifts and COVID-19 relief funding sources.

Mr. Brandenburg questioned whether the Council had knowledge or at least an understanding of the FQHC clinics assets and liabilities, in order to provide proper financial oversight.

Chairman Winkle asked to clarify the question, specifically what was considered an FQHC clinic asset.

Mr. Brandenburg explained that assets were economic resources that were expected to provide future benefit, such as increased cash inflow or reduction in cash outflow. Inventory of supplies, property, and accounts receivables would be considered assets as well. Liabilities were measured as any economic obligation or claim against an asset, such as accounts payable or debt.

Chairman Winkle asked if the Council should request financial accounting statements that reported on the FQHC clinics assets compared to liabilities.

Mr. Brandenburg suggested the Council receive that information.

Adjourn

MOTION: Vice Chairman Barker moved to adjourn the August 18, 2021 Valleywise Community Health Centers Governing Council meeting. Ms. Porter seconded.

VOTE: 8 Ayes: Chairman Winkle, Vice Chairman Barker, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Mr. Messick, Ms. Porter
0 Nays
4 Absent: Ms. Aguilar, Ms. Benelli, Ms. McCarty, Mr. Serna
Motion passed.

Meeting adjourned at 1:22 p.m.

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Cassandra Santos,
Assistant Clerk

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.a.ii.

Minutes:
September 1, 2021

Minutes

Valleywise Community Health Centers Governing Council
Valleywise Health Medical Center
September 1, 2021
6:00 p.m.

DRAFT

Members Present:

Ryan Winkle, Chairman - *participated remotely*
Michelle Barker, Vice Chairman - *participated remotely*
Nelly Clotter-Woods, Ph.D., Treasurer - *participated remotely*
Terry Benelli, Member - *participated remotely*
Salina Imam, Member - *participated remotely*
Scott Jacobson, Member - *participated remotely*
Joseph Larios, Member - *participated remotely*
Liz McCarty, Member - *participated remotely*
Daniel Messick, Member - *participated remotely*
Lisa Porter, Member - *participated remotely*

Members Absent:

Isaac Serna, Member

Others/ Guest Presenters:

Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics - *participated remotely*
Steve Purves, President & Chief Executive Officer, Valleywise Health - *participated remotely*
Michael White, M.D., Chief Clinical Officer - *participated remotely*
Claire Agnew, Chief Financial Officer - *participated remotely*
Nancy Kaminski, Senior Vice President, Revenue Cycle - *participated remotely*
Martin Demos, General Counsel - *participated remotely*
Melanie Talbot, Chief Governance Officer - *participated remotely*

Recorded by:

Cassandra Santos, Assistant Clerk - *participated remotely*

Call to Order

Chairman Winkle called the meeting to order at 6:01 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that nine of the eleven voting members of the Valleywise Community Health Centers Governing Council (VCHCGC) were present, which represented a quorum. Mr. Larios joined the meeting shortly after roll call.

For the benefit of all participants, Ms. Talbot announced the VCHCGC members participating remotely.

Call to the Public

Chairman Winkle called for public comments.

Ms. Harding announced that Maricopa County Special Healthcare District (MC SHCD) dba Valleywise Health, was recognized by Health Resources and Services Administration (HRSA) with community health quality recognition badges for advancement in health information technology and patient centered medical home.

VCHCGC members briefly discussed the accolades.

NOTE: Mr. Larios joined the meeting at 6:04 p.m.

Chairman Winkle announced that Ms. Aguilar resigned from the VCHCGC effective August 22, 2021 and encouraged members to actively recruit candidates for membership.

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda:

   a. Minutes:

      i. Approve Valleywise Community Health Centers Governing Council meeting minutes dated August 4, 2021

   b. Contracts:

      i. Acknowledge a new agreement (MCO-20-018-MSA) between Bright Health and the Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services

      ii. Acknowledge a new agreement (MCO-20-019-MSA) between HealthSmart Preferred Care II and the Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services

   c. Governance:

      i. Accept recommendations from the Compliance and Quality Committee to Approve the revised Compliance and Quality Committee Charter

      ii. Approve registration fee for Ryan Winkle to virtually attend the 2021 Arizona Health Equity Conference, October 14, 2021

      iii. Approve Health Resources and Services Administration grant application for $2,000,000 to evaluate and optimize virtual care at Valleywise Health

      iv. Acknowledge grant application to City of Mesa for COVID-19 funding in the amount of $62,961 to support the eligibility specialist at Valleywise Community Health Center-Mesa, assisting integrated behavioral health patients

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

1. Approval of Consent Agenda, cont.:

   c. Governance, cont.:

      v. Withdraw Health Resources and Services Administration grant application for fiscal year 2021 supplemental funding for hypertension, Grant No. H80CS33644; and Relinquish Notice of Award No. 3 H80CS33644-02-13

      vi. Approve the following Changes in Scope of service to correct Health Resources and Services Administration's form 5A:
      - Add District Medical Group (DMG) for interpretation of screenings including mammography and cytology/histology
      - Add nursing staff to reflect services offered by the health center to provide coverage for emergencies during and after hours
      - Add psychiatry services to the following locations:
        - Valleywise Community Health Center-Avondale
        - Valleywise Community Health Center-Chandler
        - Valleywise Community Health Center-Guadalupe
        - Valleywise Community Health Center-Maryvale
        - Valleywise Community Health Center-McDowell
        - Valleywise Community Health Center-Mesa
        - Valleywise Community Health Center-North Phoenix
        - Valleywise Community Health Center-South Central
        - Valleywise Community Health Center-South Phoenix/Laveen
        - Valleywise Comprehensive Health Center-Peoria

      vii. Approve the revised job description for Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics

   d. Medical Staff:

      i. Approve proposed revisions to the Department of Internal Medicine privileges

MOTION: Mr. Jacobson moved to approve the consent agenda. Mr. Larios seconded.

VOTE: 10 Ayes: Chairman Winkle, Vice Chairman Barker, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty, Mr. Messick, Ms. Porter
0 Nays
1 Absent: Mr. Serna
Motion passed.

2. Presentation on Residency Programs at Valleywise Health's Federally Qualified Health Center Clinics

Dr. White explained that Valleywise Health, in conjunction with District Medical Group (DMG), Creighton University Arizona Health Education Alliance, and Dignity St. Joseph's Hospital and Medical Center, entered a strategic partnership to expand graduate medical education (GME) programs.

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

2. Presentation on Residency Programs at Valleywise Health's Federally Qualified Health Center Clinics, cont.

Given that Maricopa County was one of the fastest growing counties in the United States (US), the need for Primary Care Physicians (PCPs) continued to climb. A strong program would contribute to address and curb the PCP shortage within the community, specifically at Valleywise Health.

Dr. White described details associated with the continuity clinic experience format which was practiced at Valleywise Health Community Health Centers. The format included family medicine, internal medicine, obstetrics and gynecology (OB/GYN), and pediatrics.

He spoke in depth about the family medicine residency program at Valleywise Community Health Center-South Central, formerly housed at Dignity St. Joseph's Hospital and Medical Center. He highlighted the program's history and its basic requirements, pointing out that resident physicians were required to have 1,650 Federally Qualified Health Center (FQHC) clinic patient encounters over the entire course of their residency. The care spectrum, also referred to as the continuum of life stages, included the pediatric OB/GYN, geriatric, emergency medicine, and palliative medicine.

The program was a three-year post-graduate training experience for residents in preparation for provision of care within a chosen medical practice setting.

3. Discuss and Review results from Health Resources and Services Administration's operational site visit

Ms. Harding shared detailed information related to the HRSA operational site visit (OSV) outcome. Reviewers praised the organization for adherence to the HRSA compliance manual requirements, with some areas for opportunity to improve. She explained procedures, timelines, and deadlines associated with the post visit reconciliation process.

She walked through sections of compliance elements sharing notes pertaining to the individual findings and HRSA recommendations. Staff would work to complete areas which required resolution, in a steadfast manner to quickly resolve insufficient findings and respond to HRSA.

Ms. Harding said that she would provide a future update to the VCHCGC once closure was received from HRSA.

4. Discuss, Review, and Approve revisions to the Federally Qualified Health Center Clinics Sliding Fee Discount Program/Policy and Fee Schedule

Ms. Kaminski spoke about the Valleywise Health FQHC Sliding Fee Discount Program (SFDP) Policy and fee schedule and described recent updates to the policy, based on a HRSA OSV finding.

A section was added under the eligibility portion of the SFDP, related to situational waivers for a catastrophic situation or significant changes in income. Verbiage was added regarding refusal to pay under the billing and collections services portion.

In relation to the fee schedule, restorative dental services and dental laboratory services, the sliding fee category one was updated to include removed cost of supplies verbiage. Language was also updated within the restorative grid to omit a phrase pertaining to the inclusion of a nominal charge.

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

4. Discuss, Review, and Approve revisions to the Federally Qualified Health Center Clinics Sliding Fee Discount Program/Policy and Fee Schedule, cont.

Ms. Kaminski said that a survey was conducted on August 23, 2021 at Valleywise Community Health Centers-Chandler and Mesa asking whether patients considered the nominal fee affordable. Patients were also asked whether the fee prevented them from seeking medical care at the clinic. In addition, of those who responded, various demographics such as race, ethnicity, and income were tracked.

Mr. Larios asked for more information about the purpose of the survey.

Ms. Kaminski explained that HRSA reviewers recommended that staff gauge a patient's affordability of the fee schedule with a survey. The survey indicated that the majority of patients thought that it was affordable.

Mr. Larios asked if patients that were surveyed were above 200% of the federal poverty level (FPL).

Ms. Kaminski said that patients who aligned within an array of all five categories were surveyed. She pointed out that the patients who felt the scale was not affordable were considered above 200% of the FPL.

Mr. Larios said that surveys were important, but many definitions of affordability existed, depending on who was specifically questioned, noting that affordability was an objective topic.

Ms. Kaminski said that the reviewers were focused on those who were in category one, under 100% of the FPL.

Chairman Winkle asked when the SFDP and fee schedule would be presented to the VCHCGC for review again.

Ms. Talbot said that the US Department of Health and Human Services (HHS) updated and released the annual FPL Guidelines around February. Based on current FPL guidelines, staff reviews and analyzes the utilization of the program and presents it to the VCHCGC for review and recommendations for change, if any.

MOTION: Mr. Jacobson moved to approve revisions to the Federally Qualified Health Center Clinics Sliding Fee Discount Program/Policy and Fee Schedule. Ms. Porter seconded.

VOTE: 10 Ayes: Chairman Winkle, Vice Chairman Barker, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty, Mr. Messick, Ms. Porter
0 Nays
1 Absent: Mr. Serna
Motion passed.

5. Discuss and Review of Federally Qualified Health Centers Clinics Budget Report from first year of Health Center Program New Access Points Funding (HRSA-19-080)

Ms. Agnew presented a budget report related to the first year of New Access Point (NAP) HRSA grant funding, from September 1, 2019 to August 31, 2020.

She noted that the report was new and would be shared and reviewed by the VCHCGC based on a recommendation from the OSV. The main goal of the 2019 NAP grant funding was for utilization and expansion of behavioral health services.

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

5. Discuss and Review of Federally Qualified Health Centers Clinics Budget Report from first year of Health Center Program New Access Points Funding (HRSA-19-080), cont.

She pointed out that behavioral health services had a substantial increase in referral growth since 2019 amongst other data surrounding the expansion. Budgeted services included the NAP grant and non-federal grants outside of the NAP grant.

Ms. Agnew went into details associated with multiple categories of the report such as revenue which included the NAP grant funding, local funding, and program income.

Various expenses within the report included but not limited to personnel salary, fringe or benefits, travel, supplies, contractual and allocated ancillary expenses. She pointed out that medical supplies were over $1,000,000 in budget attributed to the COVID-19 pandemic. There was a substantial increase in personal protective equipment (PPE) and other medical supply costs.

Other expenses included, but not limited to communication services, rent, infectious waste disposal, and organizational fees.

Total direct and indirect expenses were also part of the report. Indirect expenses were described as services being provided by Valleywise Health which for the benefit of the FQHC clinics, such as informational technology or marketing.

Ms. Agnew said that total expenses for the reported year were $71,937,894.

Mr. Larios asked for an explanation about the variance column of the report.

Ms. Agnew described the variance as the difference between the actuals and the budget associated with revenue and expense.

6. Recent meeting reports from the Valleywise Community Health Centers Governing Council's committees

    a. Compliance and Quality Committee

    b. Executive Committee

    c. Finance Committee

    d. Strategic Planning and Outreach Committee

Vice Chairman Barker reported that the Compliance and Quality Committee met and discussed a variety of items including National Research Corporation (NRC) patient satisfaction data, UDS quality metrics, and detailed quarterly compliance reports. The committee also recommended the VCHCGC to approve a revised committee charter, which was accomplished with approval of the consent agenda.

Chairman Winkle announced that the Executive Committee recently discussed the VCHCGC's excused absence policy and reminded members to submit written requests for excused absences to the appropriate individuals for consideration.

The committee also discussed meeting logistics for the upcoming retreat, as well as the reminder of the council and committee meetings for the remainder of the calendar year. It was decided the meetings would remain virtual, due to the ongoing COVID-19 pandemic.

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

6. Recent meeting reports from the Valleywise Community Health Centers Governing Council's committees, cont.

Dr. Clotter-Woods said the Finance Committee met and reviewed July 2021 clinic statistics, the expenditure report, and the Care Reimagined Capital report. She highlighted the positive variance in FQHC visits, compared to budget, as well as the positive operating margin for the month.

Mr. Larios had nothing to report for the Strategic Planning and Outreach Committee.

7. Report on the National Association of Community Health Centers (NACHC) 2021 Convention and Community Health Institute

Dr. Clotter-Woods gave an overview of the National Association of Community Health Centers (NACHC) 2021 Convention and Community Health Institute that she recently attended. She outlined the various topics of discussion and offered to share the material received.

Mr. Jacobson requested the information.

8. Federally Qualified Health Center Clinics Chief Executive Officer's report

Ms. Harding mentioned the upcoming virtual VCHCGC retreat, which was scheduled for September 29, 2021. She asked that all members confirm their attendance, as an accurate count would assist with the planning.

9. Valleywise Health's President and Chief Executive Officer's report

Mr. Purves acknowledged ongoing activities related to the pandemic, specifically regarding shortages in staffing within direct care teams. He outlined the plans implemented to address, including but not limited to, distributing merit increase and targeted market adjustments for staff, and activation of a labor pool. He explained that the labor pool would disperse non-clinical employees who volunteered to work in patient care units, to assist the bedside providers with administrative and support tasks.

He expressed his appreciation to Ms. Harding, Senior Leadership, and the VCHCGC for their involvement in the recent OSV.

Chairman Winkle asked if Valleywise Health had considered employing individuals with an H1B Visa Status, which was a visa classification that permitted foreign nationals to work in the United States for a temporary period.

Mr. Purves commented that Valleywise Health was currently exploring multiple options to address the staff shortages.

10. Chairman and Council Member Closing Comments/Announcements

Ms. Porter announced that she was resigning from the VCHCGC effective September 2, 2021. She gave a brief statement expressing her appreciation for the opportunity.

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

11. Review Staff Assignments

Ms. Talbot reviewed staff assignments stemming from the meeting.

Adjourn

MOTION: Mr. Jacobson moved to adjourn the September 1, 2021 Valleywise Community Health Centers Governing Council meeting. Ms. McCarty seconded.

VOTE: 10 Ayes: Chairman Winkle, Vice Chairman Barker, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty, Mr. Messick, Ms. Porter
0 Nays
1 Absent: Mr. Serna
Motion passed.

Meeting adjourned at 7:21 p.m.

_____
Cassandra Santos,
Assistant Clerk

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.a.iii.

Minutes:
September 14, 2021

Minutes

Valleywise Community Health Centers Governing Council
Valleywise Health Medical Center
September 14, 2021
6:00 p.m.

DRAFT

Members Present:
Ryan Winkle, Chairman - *participated remotely*
Nelly Clotter-Woods, Ph.D., Treasurer - *participated remotely*
Terry Benelli, Member - *participated remotely*
Salina Imam, Member - *participated remotely*
Scott Jacobson, Member - *participated remotely*
Joseph Larios, Member - *participated remotely*
Liz McCarty, Member - *participated remotely*

Members Absent:
Michelle Barker, Vice Chairman
Daniel Messick, Member
Isaac Serna, Member

Others/ Guest Presenters:
Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics - *participated remotely*
Claire Agnew, Chief Financial Officer - *participated remotely*
Amy Little-Hall, Interim Senior Vice President, Chief Human Resources Officer - *participated remotely*
Ijana Harris, Assistant General Counsel - *participated remotely*
Melanie Talbot, Chief Governance Officer - *participated remotely*

Recorded by:
Cassandra Santos, Assistant Clerk - *participated remotely*

Call to Order

Chairman Winkle called the meeting to order at 6:00 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that seven of the ten voting members of the Valleywise Community Health Centers Governing Council (VCHCGC) were present, which represented a quorum.

For the benefit of all participants, Ms. Talbot announced the VCHCGC members participating remotely.

Call to the Public

Chairman Winkle called for public comments.

There were no comments from the public.

General Session, Presentation, and Discussion:

1. Discuss, Review, and Approve the following Valleywise Health policies and protocols:
   a. Policy 20077 F; FQHC Clinic: After-Hours Care and Calls

Ms. Harding stated that in accordance with recommendations made by the Health Resources and Services Administration (HRSA) operational site visit (OSV) reviewers, revisions were made to Valleywise Health Policy 20077 F; FQHC Clinic: After-Hours Care and Calls.

She explained the changes that were made to the provider follow-up process for after-hours patient care and calls. Minor revisions also included formatting and nomenclature for overall document consistency.

MOTION: Ms. McCarty moved to approve Valleywise Health Policy 20077 F; FQHC Clinic: After-Hours Care and Calls. Mr. Jacobson seconded.

VOTE: 7 Ayes: Chairman Winkle, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty
0 Nays
3 Absent: Vice Chairman Barker, Mr. Messick, Mr. Serna
Motion passed.

2. Discuss, Review, and Acknowledge the following Valleywise Health policies and protocols:
   a. Policy 78250 S; Human Resources (Employment Status/Records): Verification of Required Licenses, Registrations and Certifications

Ms. Little-Hall presented revisions made to Valleywise Health Policy 78250 S; Human Resources (Employment Status/Records): Verification of Required Licenses, Registrations and Certifications, in accordance with findings stemming from the HRSA OSV.

She pointed out that other licensed or certified practitioner (OLCP) and other clinical staff privileges would be reviewed, acknowledged, and approved with the employee and signed by the supervisor at completion of the employee's six month probationary period. This process would be ongoing as part of the employee's annual performance evaluation.

Fitness for duty would be verified via Valleywise Health Employee Health and Wellness department. Clinical staff was required to self-attest to their physical and mental fitness for duty by completing and signing a form subsequently reviewed and signed by the Federally Qualified Health Center (FQHC) medical director, chief clinical officer (CCO) or appointed designee.

Ms. Little-Hall added that Valleywise Health Human Resource staff would conduct routine secondary source verification with an authorizing issuing agency for initial and renewal credential verification.

MOTION: Mr. Jacobson moved to acknowledge Valleywise Health Policy 78250 S; Human Resources (Employment Status/Records): Verification of Required Licenses, Registrations and Certifications. Ms. McCarty seconded.

VOTE: 7 Ayes: Chairman Winkle, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty
0 Nays
3 Absent: Vice Chairman Barker, Mr. Messick, Mr. Serna
Motion passed.

General Session, Presentation, and Discussion, cont.:

3. Discuss, Review, and Approve the following Valleywise Health policies and protocols:
   a. Policy 02014 S; FQHC: Safeguarding the Use of FQHC Resources and Associated Assets and Property

Ms. Agnew explained that in accordance with HRSA OSV reviewer recommendations, Valleywise Health Policy 02014 S; FQHC: Safeguarding the Use of FQHC Resources and Associated Assets and Property, was established.

The policy provided background pertaining to assets utilized by Valleywise Health FQHC clinics, new reporting processes related to the assets, and details surrounding the polices regarding assets. Moving forward, a financial report related to the assets, as outlined in the policy, would be shared with the Finance Committee of the VCHCGC on an annual basis.

MOTION: Ms. McCarty moved to approve Valleywise Health Policy 02014 S; FQHC: Safeguarding the Use of FQHC Resources and Associated Assets and Property. Mr. Jacobson seconded.

VOTE: 7 Ayes: Chairman Winkle, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty
0 Nays
3 Absent: Vice Chairman Barker, Mr. Messick, Mr. Serna
Motion passed.

Adjourn

MOTION: Mr. Jacobson moved to adjourn the September 14, 2021 Valleywise Community Health Centers Governing Council meeting. Mr. Larios seconded.

VOTE: 7 Ayes: Chairman Winkle, Ms. Benelli, Dr. Clotter-Woods, Ms. Imam, Mr. Jacobson, Mr. Larios, Ms. McCarty
0 Nays
3 Absent: Vice Chairman Barker, Mr. Messick, Mr. Serna
Motion passed.

Meeting adjourned at 6:19 p.m.

_____
Cassandra Santos,
Assistant Clerk

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.i.

Contracts:
(MCO-20-021-MSA)

Cynthia Cornejo

To: Melanie Talbot
Subject: RE: Contract Approval Request: Clover Insurance Company Agreement Clover Insurance Company

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From: Compliance 360 <msgsystem@compliance360.com>
Sent: Wednesday, September 1, 2021 6:40 AM
To: Melanie Talbot <Melanie.Talbot@valleywisehealth.org>
Subject: Contract Approval Request: Clover Insurance Company Agreement Clover Insurance Company

Message Information

From	Purves, Steve
To	Talbot, Melanie;
Subject	Contract Approval Request: Clover Insurance Company Agreement Clover Insurance Company
Additional Information	Indicate whether you approve or reject by clicking the Approve or Reject button. Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Contract Information

Division	Contracts Division
Folder	Contracts \ Managed Care/Revenue
Status	Pending Approval
Title	Clover Insurance Company Agreement
Contract Identifier	
Contract Number	MCO-20-021-MSA
Primary Responsible Party	Tucker, Collee K.
Departments	
Product/Service Description	Medicare Advantage
Action/Background	Approve a new agreement (MCO-20-021-MSA) between Clover Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services. This is a new agreement between Clover Insurance Company and Maricopa County Special Health Care District DBA Valleywise Health. Clover Insurance Company is a new Medicare Advantage product being offered for participation. This agreement will allow members to receive comprehensive healthcare services through Valleywise Health facilities and providers.

Evaluation Process	
Notes	
Category	
Effective Date	1/1/2023
Expiration Date	
Annual Value	$0.00
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	Clover Insurance Company

Responses

Member Name	Status	Comments
Tucker, Collee K.	Approved	
Clarke, Renee R.	Approved	
Demos, Martin C.	Approved	
Agnew, Claire F.	Approved	
Purves, Steve A.	Approved	
Talbot, Melanie L.	Current	

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.ii.

Contracts:
(MCO-20-020-MSA)

Cynthia Cornejo

Subject: RE: Contract Approval Request: Employers Health Network, LLC Agreement Employers Health Network, LLC

From: Compliance 360 <msgsystem@compliance360.com>
Sent: Wednesday, September 1, 2021 6:40 AM
To: Melanie Talbot <Melanie.Talbot@valleywisehealth.org>
Subject: Contract Approval Request: Employers Health Network, LLC Agreement Employers Health Network, LLC

Message Information

From	Purves, Steve
To	Talbot, Melanie;
Subject	Contract Approval Request: Employers Health Network, LLC Agreement Employers Health Network, LLC
Additional Information	Indicate whether you approve or reject by clicking the Approve or Reject button. Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Contract Information

Division	Contracts Division
Folder	Contracts \ Managed Care/Revenue
Status	Pending Approval
Title	Employers Health Network, LLC Agreement
Contract Identifier	
Contract Number	MCO-20-020-MSA
Primary Responsible Party	Tucker, Collee K.
Departments	
Product/Service Description	
Action/Background	Approve a new agreement (MCO-20-020-MSA) between Employers Health Network, LLC and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services. This is new agreement is between Employers Health Network, LLC and Maricopa County Special Health Care District DBA Valleywise Health. Employers Health Network, LLC is a new commercial product being offered for participation through our relationship with Arizona Care Network. This agreement will allow members to receive comprehensive healthcare services through Valleywise Health facilities and providers.

Evaluation Process	
Notes	
Category	
Effective Date	9/1/2021
Expiration Date	
Annual Value	$0.00
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	Employers Health Network, LLC

Responses

Member Name	Status	Comments
Clarke, Renee R.	Approved	
Tucker, Collee K.	Approved	
Demos, Martin C.	Approved	
Agnew, Claire F.	Approved	
Purves, Steve A.	Approved	
Talbot, Melanie L.	Current	

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.iii.

Contracts:
(MCO-20-018-1-MSA)

Cynthia Cornejo

Subject: RE: Contract Approval Request: Bright Health Amendment 1 Bright Health

From: Compliance 360 <msgsystem@compliance360.com>
Sent: Wednesday, September 1, 2021 6:40 AM
To: Melanie Talbot <Melanie.Talbot@valleywisehealth.org>
Subject: Contract Approval Request: Bright Health Amendment 1 Bright Health

Message Information

From	Purves, Steve
To	Talbot, Melanie;
Subject	Contract Approval Request: Bright Health Amendment 1 Bright Health
Additional Information	Indicate whether you approve or reject by clicking the Approve or Reject button. Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Contract Information

Division	Contracts Division
Folder	Contracts \ Managed Care/Revenue
Status	Pending Approval
Title	Bright Health Amendment 1
Contract Identifier	
Contract Number	MCO-20-018-1
Primary Responsible Party	Clarke, Renee R.
Departments	
Product/Service Description	
Action/Background	Approve amendment #1 to contract (MCO-20-018-MSA) between Bright Health and Maricopa County Special Health Care District, dba Valleywise Health to add small group plans to the contract for provision of comprehensive healthcare services. The contract executed for a January 1, 2022 effective date originally only included Individual and family Plans. However, Bright Health will also begin offering small group plans effective January 1, 2022. This amendment adds small group benefit plans and rates.
Evaluation Process Notes	

Category	
Effective Date	1/1/2022
Expiration Date	
Annual Value	$0.00
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	Bright Health

Responses

Member Name	Status	Comments
Tucker, Collee K.	Approved	
Clarke, Renee R.	Approved	
Demos, Martin C.	Approved	
Agnew, Claire F.	Approved	
Purves, Steve A.	Approved	
Talbot, Melanie L.	Current	

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.iv.

Contracts:
(90-21-141-1-01)

Melanie Talbot

From: Compliance 360 <msgsystem@compliance360.com>
Sent: Monday, August 30, 2021 8:47 AM
To: Melanie Talbot
Subject: Contract Approval Request: Amendment #1 - IGA Refugee Resettlement Program - Health Promotion (DI21-002306) Arizona Department of Economic Security

Message Information

From Purves, Steve
To Talbot, Melanie;
Subject Contract Approval Request: Amendment #1 - IGA Refugee Resettlement Program - Health Promotion (DI21-002306) Arizona Department of Economic Security
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button.

Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
RFBA - signed and assigned		File	RFBA - DES IGA 90-21-141 Amendment 1 signed.pdf
Amendment 1 - Extension - Pending Board + Legal signatures (2 originals required)		File	ADES - Valleywise Amendment 1 Final 90-21-141.pdf
OIG 2021		File	Arizona Department of Economic Security.pdf

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title Amendment #1 - IGA Refugee Resettlement Program - Health Promotion (DI21-002306)
Contract Identifier Board - Amendment
Contract Number 90-21-141-1-01
Primary Responsible Party Tymczyna, Katherine

Departments	GRANTS ADMINISTRATION
Product/Service Description	Amendment #1 - Extend current Agreement to conduct outreach and provide health care management services to refugees and other eligible beneficiaries resettled in the State of Arizona.
Action/Background	Approve Amendment #1 to the Intergovernmental Agreement (IGA) between the Arizona Department of Economic Security ("ADES") and Maricopa County Special Health Care District dba Valleywise Health to extend the current Agreement for an additional year, effective October 1, 2021 through September 30, 2022, for aggregate term of November 1, 2020 to September 30, 2022, to continue to provide health care management services under the ADES Refugee Resettlement Program. The AZDES Refugee Resettlement Program provides funds for refugee health care management, prioritizing clients enrolled in the COVID-19 CHN Program. These services are provided to promote wellbeing of refugee clients through increasing access to culturally responsive and linguistically appropriate medical services upon arrival. This Amendment #1 is for an anticipated $300,000, matching the previously approved budget, for a new total aggregate value of $600,000. This Agreement is 100% grant funded and includes 25% indirect cost. This Amendment #1 is sponsored by Dr. Michael White, EVP & Chief Clinical 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(2) of the Procurement Code in that any Valleywise Health compliance with the terms and conditions of a grant, gift or bequest is exempt from the solicitation requirements of the Procurement Code.
Notes	Board and Legal signatures required. 2 original signed copies are to be mailed to Ellen Pimental at ADES. Contact: Ellen Pimental epimental@azdes.gov
Category	IGA
Effective Date	10/1/2021
Expiration Date	9/30/2022
Annual Value	$300,000.00
Expense/Revenue	Revenue
Budgeted Travel Type	No
Procurement Number	
Primary Vendor	Arizona Department of Economic Security

Responses

Member Name	Status	Comments
Melton, Christopher C.	Approved	Reviewed and approve
Joiner, Jennifer L.	Approved	
Landas, Lito S.	Approved	
Harding, Barbara J.	Approved	
Meier, Matthew P.	Approved	
Demos, Martin C.	Approved	

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.v.

Contracts:
(MCO-20-022-MSA)

Melanie Talbot

From: Compliance 360 <msgsystem@compliance360.com>
Sent: Tuesday, September 7, 2021 5:17 PM
To: Melanie Talbot
Subject: Contract Approval Request: Medica Insurance Company Medica Insurance Company

Message Information

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

Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Contract Information

Division Contracts Division
Folder Contracts \ Managed Care/Revenue
Status Pending Approval
Title Medica Insurance Company
Contract Identifier
Contract Number MCO-20-022-MSA
Primary Responsible Party Tucker, Collee K.
Departments
Product/Service Description
Action/Background Approve a new agreement (MCO-20-022-MSA) between Medica Insurance Company and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive healthcare services.

This new agreement is between Medica Insurance Company and Maricopa County Special Health Care District DBA Valleywise Health. Medica Insurance Company is a new Commercial product being offered for participation. This agreement will allow members to receive comprehensive healthcare services through Valleywise Health facilities and providers.
Evaluation Process
Notes
Category

Effective Date	1/1/2022
Expiration Date	
Annual Value	$0.00
Expense/Revenue	
Budgeted Travel Type	
Procurement Number	
Primary Vendor	Medica Insurance Company

Responses

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

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.b.vi.

Contracts:
(90-12-084-1-49)

Melanie Talbot

From: Compliance 360 <msgsystem@compliance360.com>
Sent: Wednesday, September 8, 2021 3:06 PM
To: Melanie Talbot
Subject: Contract Approval Request: Amendment #49 to the Professional Medical Services District Medical Group (DMG)

Message Information

From Purves, Steve
To Talbot, Melanie;
Subject Contract Approval Request: Amendment #49 to the Professional Medical Services District Medical Group (DMG)
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button.

Add comments as necessary.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL
V2.Board Narrative VH-DMG Agreement-Amendment 49-Sept. 2021.docx		File	V2.Board Narrative VH-DMG Agreement-Amendment 49-Sept. 2021.docx

Contract Information

Division Contracts Division
Folder Amendments
Status Pending Approval
Title Amendment #49 to the Professional Medical Services
Contract Identifier Board - Amendment
Contract Number 90-12-084-1-49
Primary Responsible Party Melton, Christopher C.
Departments
Product/Service Description Amendment #49 to the Professional Medical Services
Action/Background A request for approval of Amendment #49 to the contract between District Medical Group (DMG) and Valleywise Health has been included in the September 22, 2021 Formal Meeting Consent Agenda. This amendment will

be effective July 1, 2021, unless otherwise noted. The following requests are segregated by those that have or do not have a financial impact.

Amendment #49 Requests with a Financial Impact

• Revise Peoria Anesthesia FTE rates from MGMA blended rates to clinical only rates, Effective July 1, 2021
Valleywise Health is requesting to revise Peoria Anesthesia FTE rates from the MGMA blended rates to the MGMA clinical only rates as the providers will only be providing time at the Peoria site.

The total cost in staffing fees for Fiscal Year 2022 with the revised rates is $83,313.

• Add an annual stipend for the FQHC Medical Director, July 1, 2021
Valleywise Health is requesting to add a $25,000 annual stipend for the FQHC Medical Director total annual reimbursement.

The total cost in staffing fees for Fiscal Year 2022 for the FQHC Medical Director annual stipend is $25,000.

Amendment #49 Requests without a Financial Impact

The following item has no impact to the cost of the DMG contract with Valleywise Health and consists of corrections or modifications to the language of the contract:

N/A

The total Fiscal Year 2022 financial impact of Amendment #49 to the Valleywise Health-DMG Contract is: $108,313.

This Amendment# 49 is sponsored by Claire Agnew, EVP & Chief Financial Officer.

Evaluation Process Notes	
Category	Other
Effective Date	7/1/2021
Expiration Date	
Annual Value	$108,313.00
Expense/Revenue	Expense
Budgeted Travel Type	Yes
Procurement Number	
Primary Vendor	District Medical Group (DMG)

Responses

Member Name	Status	Comments
Melton, Christopher C.	Approved	
Harris, Ijana M.	Approved	
White, Michael	Approved	
Agnew, Claire F.	Approved	

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.i.

Governance:
HRSA Grant Application -
Dental Residency Program

Grant Synopsis

Category	Response
Name of funding opportunity	Teaching Health Center Planning and Development Program
Name of person submitting opportunity	Christopher Brendemuhl, DMD, Director of Dentistry
Sustainability required? If yes, provide details.	Yes (●) No ( ) Details: We must have a clearly defined, factual, and validated sustainability plan that includes ongoing funding stream(s) to sustain long-term resident training once the program is established through the following options: A. State or other public and/or private support B. Combination of multiple funding streams (e.g., a mix of Department of Veterans Affairs, Indian Health Service, or other public funding). Dr. White is assisting with the sustainability information
Indirect rate or return on investment outcome (completed by Grants)	Yes (●) No ( ) Details: We can request our full 25% Indirect Cost Rate
Name of funder	HRSA
Application deadline	
Proposed amount requesting	$500,000
Purpose and aims of funding	Establish a Dental Residency program in partnership with Creighton University. Valleywise would be the sponsoring organization.
Areas of focus	Dental / Residency Program
Budget (How will the funds be used)	Are items in the approved capital budget? Yes ( ) No (●) Are personnel expenses included in the budget? Yes (●) No ( ) New hires? Yes (●) No ( ) Offsetting revenue for current employees? Yes (●) No ( ) Provide a description of the main expenses covered under this grant. Program Director, curriculum development, CODA (Commission on Dental Accreditation) application and licensing fees.
Link to grant opportunity or include the Request for Grant Application	
Length of program (i.e. 1 year, 2 years)	2 years
Other notes to be considered by the Grants Advisory Committee:	
Key stakeholders reviewed:	☑ Ambulatory ☐ Behavioral Health ☐ Biomed ☑ Clinic Manager ☐ Facilities ☐ Family Learning Center ☐ IT ☐ Marketing ☐ Nursing ☐ Research ☐ VHF ☑ Other Dental Department, CCO

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.ii.

Governance:
Molina Complete Care Foundation Grant Application -
Mobile Market Services

Valleywise Health

Grant Synopsis

Category	Response
Name of funding opportunity	Molina Complete Care Nourishing Arizona's families
Name of person submitting opportunity	Rebecca Birr/Melissa DiCesare
Sustainability required? If yes, provide details.	Yes ○ No ◉ Details:
Indirect rate or return on investment outcome (completed by Grants)	Yes ○ No ○ Details:
Name of funder	Molina Complete Care Foundation (Molina Complete Care in AZ will submit application to their foundation)
Application deadline	
Proposed amount requesting	$166,800
Purpose and aims of funding	VH, VHF, Molina Complete Care, and Activate Food Arizona/Farm Express will create a partnership to help address food insecurity for patients and the community at large. This pilot project has Activate Food Arizona/Farm Express operating a minibus mobile market service at four clinics: Peoria, South Phoenix/Laveen, South Central and North Phoenix. VH staff can issue $10 vouchers to use at the mobile market for patients that have health conditions that can benefit from consistent and reliable access to healthy fruits and vegetables. The market visits will also provide boxes of fresh produce to the Family Learning Centers for distribution throughout the week. Voucher usage will be tracked by Family Learning Center staff.
Areas of focus	Family Learning Center / Food Insecurity
Budget (How will the funds be used)	Are items in the approved capital budget? Yes ○ No ◉ Are personnel expenses included in the budget? Yes ◉ No ○ New hires? Yes ○ No ◉ Offsetting revenue for current employees? Yes ◉ No ○ Provide a description of the main expenses covered under this grant. Partnership/Co-Sponsorship Mini Mobile Market with Farm Express - $75,000 Vouches/Food Boxes - $36,800 Program Management by Family Learning Center Staff and Supplies - $55,000
Link to grant opportunity or include the Request for Grant Application	See attached partnership proposal. Molina Complete Care provided questions they will have to answer as part of their application.
Length of program (i.e. 1 year, 2 years)	1 year
Other notes to be considered by the Grants Advisory Committee:	Molina Complete Care is also working on a value-based purchasing agreement with this pilot mobile market idea to impact their health plan members. This grant is meant for non-Molina patients/ community.
Key stakeholders reviewed:	☑ Ambulatory ☐ Behavioral Health ☐ Biomed ☐ Clinic Manager ☐ Facilities ☑ Family Learning Center ☐ IT ☑ Marketing ☐ Nursing ☐ Research ☑ VHF ☐ Other

Valleywise Community Health Centers Governing Council Meeting

September 1, 2021

Item 1.c.iii.

Governance:
ADHS and AACHC Grant Application - COVID-19 Vaccination Provisions

Valleywise Health

Grant Synopsis

Category	Response
Name of funding opportunity	COVID Vaccine Grant
Name of person submitting opportunity	Barbara Harding
Sustainability required? If yes, provide details.	Yes ○ No ◉ Details: One time funding.
Indirect rate or return on investment outcome (completed by Grants)	Yes ○ No ◉ Details:
Name of funder	This is a pass-through grant via ADHS and Arizona Alliance of Community Health Centers
Application deadline	
Proposed amount requesting	$236,158
Purpose and aims of funding	Funding will be used to assist with offsetting Valleywise's expenses related to providing COVID vaccinations.
Areas of focus	COVID vaccination
Budget (How will the funds be used)	Are items in the approved capital budget? Yes ○ No ◉ Are personnel expenses included in the budget? Yes ◉ No ○ New hires? Yes ○ No ◉ Offsetting revenue for current employees? Yes ◉ No ○ Provide a description of the main expenses covered under this grant. The project will provide funding for a COVID vaccination/testing area outside of the CHC and funds to offset relevant current staff salary and ERE expenses.
Link to grant opportunity or include the Request for Grant Application	n/a
Length of program (i.e. 1 year, 2 years)	1 year
Other notes to be considered by the Grants Advisory Committee:	Project cost estimate for the testing/vaccination area was completed by Facilities for the amount of $79,924.89 which is included in this budget.
Key stakeholders reviewed:	☑ Ambulatory ☐ Behavioral Health ☐ Biomed ☐ Clinic Manager ☑ Facilities ☐ Family Learning Center ☑ IT ☐ Marketing ☐ Nursing ☐ Research ☐ VHF ☐ Other

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.iv.

Governance:
ADES Grant Application –
Cultural Health Navigator
for Refugee Health

Valleywise Health

Grant Synopsis

Category	Response
Name of funding opportunity	Refugee Program - Health Promotion
Name of person submitting opportunity	Jeanne Nizigiyimana
Sustainability required? If yes, provide details.	Yes ○ No ◉ Details:
Indirect rate or return on investment outcome (completed by Grants)	Yes ◉ No ○ Details: We are requesting our full 25% indirect rate.
Name of funder	Department of Economic Security
Application deadline	
Proposed amount requesting	$93,750
Purpose and aims of funding	Funds will be used for a 0.5 FTE Cultural Health Navigator to provide refugee health literacy education and mental health case management to refugees and other eligible beneficiaries
Areas of focus	Refugees
Budget (How will the funds be used)	Are items in the approved capital budget? Yes ○ No ◉ Are personnel expenses included in the budget? Yes ◉ No ○ New hires? Yes ○ No ◉ Offsetting revenue for current employees? Yes ○ No ◉ Provide a description of the main expenses covered under this grant. We are requesting funding for an existing 0.5 FTE CHN to become a 1.0 FTE during the duration of this grant.
Link to grant opportunity or include the Request for Grant Application	
Length of program (i.e. 1 year, 2 years)	1 year with possibility of renewal for up to 5 years.
Other notes to be considered by the Grants Advisory Committee:	
Key stakeholders reviewed:	☑ Ambulatory ☑ Behavioral Health ☐ Biomed ☐ Clinic Manager ☐ Facilities ☐ Family Learning Center ☐ IT ☐ Marketing ☐ Nursing ☐ Research ☐ VHF ☑ Other RWHC

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.v.

Governance:
BC/BS AZ Grant Application -
Food Pharmacy Assistance Programs
and FLC Support

Valleywise Health

Grant Synopsis

Category	Response
Name of funding opportunity	BCBS Mobilize AZ - Diabetes Grant Program
Name of person submitting opportunity	Melissa DiCesare, Rebecca Birr
Sustainability required? If yes, provide details.	Yes ○ No ◉ Details:
Indirect rate or return on investment outcome (completed by Grants)	Yes ○ No ○ Details:
Name of funder	BCBS AZ
Application deadline	
Proposed amount requesting	$75,000.00
Purpose and aims of funding	Funding will assist with continuing work on the Food Pharmacy (FP) program. The FP addresses food insecurity and partners with the FLC to help with support/referrals of other social determinants of health questions that might arise.
Areas of focus	Food Pharmacy/Family Learning Center / Food Insecurity/ Internal Medicine
Budget (How will the funds be used)	Are items in the approved capital budget? Yes ○ No ◉ Are personnel expenses included in the budget? Yes ◉ No ○ New hires? Yes ○ No ◉ Offsetting revenue for current employees? Yes ◉ No ○ Provide a description of the main expenses covered under this grant. Funding will be used to offset FLC Coordinator salary and ERE, and food supply costs after the Arizona Women's Board grant ends.
Link to grant opportunity or include the Request for Grant Application	
Length of program (i.e. 1 year, 2 years)	12-month term, beginning November 1, 2021
Other notes to be considered by the Grants Advisory Committee:	
Key stakeholders reviewed:	☑ Ambulatory ☐ Behavioral Health ☐ Biomed ☐ Clinic Manager ☐ Facilities ☑ Family Learning Center ☐ IT ☐ Marketing ☐ Nursing ☐ Research ☑ VHF ☐ Other

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.vi.

Governance:
Policy 89100 F – Redline

Valleywise Health Administrative Policy & Statement

DRAFT

Effective Date: **11/17**

Reviewed Dates: **00/00**

Revision Dates: **12/19, 10/21**

Policy #: 89100 F

Policy Title: Valleywise Community Health Centers Governing Council Travel and Travel Expense Reimbursement

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

Policy:

Members of the Valleywise Community Health Centers Governing Council (Governing Council) shall serve without compensation; however, each Governing Council member is allowed reimbursement of Governing Council approved travel expenses.

Procedure:

~~1.~~ 1. Travel expenses will be charged against the Governing Council's ~~Office~~ cost center. Each fiscal year, the Governing Council approves a budget for travel and seminar expenses. ~~If expenses exceed the annual amount budgeted for travel; the Council must approve the excess expenses.~~

2. Travel expenses for educational conferences or seminars need Governing Council approval prior to travel. Travel expenses include commercial transportation, mileage, lodging, conference registration fees, and meals and incidentals.

3. The ~~Council Office~~Assistant Clerk or Chief Governance Officer should be notified immediately if a Governing Council member needs to cancel his/her travel plans~~of any cancellations~~.

4. All air transportation, lodging accommodation, and conference registration must be made through the ~~Council Office~~Assistant Clerk. The ~~Council Office~~Assistant Clerk will reserve and pre-pay air transportation, lodging accommodations, and any conference or seminar fees after the Governing Council approves the ~~travel~~ expense. A copy of this policy and any cancellation notice requirements will be provided to the Governing Council member in advance to any expenditures being made. The Governing Council member will also receive a ~~copy of the~~ travel itinerary.

5. Air travel is limited to locations outside of Arizona. Airline tickets will be booked as early as possible to obtain lower pricing and using the lowest available coach class airfare while attempting to meet reasonable needs such as avoidance of multiple connecting flights and lengthy layovers. No more than two (2) Governing Council members will be booked on the same flight.

6. Rental car reservation may be made by the ~~Council Office~~Assistant Clerk in advance when out of state, however, rental cars are not paid for in advance and are considered a reimbursable expense. The use of a rented car must only be used when other means of transportation are unavailable and not as a matter of personal convenience. Car rentals will be intermediate-size cars or smaller. Rental cars should be refueled prior to return to avoid refueling surcharges. Gas purchased when using a rental car is reimbursable with receipts. The Maricopa County Special Health Care District's (District) Risk Management Insurance and Self-Insurance Plan provides coverage to employees while traveling on company business. Therefore, optional rental car insurance should be declined when offered through the rental car office.

7. Travel by personal vehicle is permitted for out of state travel in lieu of air travel. Mileage will be reimbursed at the current Internal Revenue Service (IRS) standard mileage rate up to the amount of the lowest priced roundtrip commercial air option available at the time of travel. When more than one Governing Council member is traveling by the same personal vehicle to a Governing Council approved conference or seminar, only one mileage reimbursement may be allowed.

8. If a Governing Council member is involved in a motor vehicle accident while using their personal vehicle on District business, damage to a Governing Council member's vehicle is not covered by the District's auto insurance. The District does not pay any ~~out of pocket~~out-of-pocket expenses for physical damage or any portion of a Governing Council member's deductible.

9. Repairs made to personal vehicles will not be reimbursed by the District.

10. When a conference is held at a hotel, such hotel shall be used for lodging when possible. Travel discounts for conference attendees may have been negotiated by the sponsoring organization. The ~~Council Office~~Assistant Clerk will take advantage of these when possible.

11. Meals and incidental expenses shall not exceed the amounts published by the U.S. General Services Administration (GSA) and will follow the GSA guidelines for travel days; which will be reimbursed at 75% of the determined rate. Meals and incidentals reimbursements will not be made when an overnight stay is not needed or when the location is less than 50 miles from the departure point (Governing Council member's residence).

12. Baggage fees, airport parking and taxicab fare are considered a reimbursable expense.

13. Reimbursement requests shall be made within 30 days of travel.

14. Any expenses incurred over the Governing Council approved amount are the personal responsibility of the respective Governing Council member.

15. The District will not reimburse expenses incurred by a spouse and/or guest in connection with travel of Governing Council member.

16. Non-reimbursable expenses include:
    - Tips (that is included in meals and incidentals rates)
    - In room movies, spa or resort services or fees, laundry or dry-cleaning costs
    - Alcoholic beverages (both in-flight and during travel)
    - In flight movies
    - Traffic or parking fines
    - Trip and auto insurance
    - Rental car insurance
    - Theft, loss or damage to personal property
    - Childcare expenses
    - Air, hotel, and auto upgrade fees

17. Governing Council members may be asked to submit or present to the Council, a report on the results of their travel within fifteen working days of their return. The report may include but not limited to:
    - A listing of any workshops, seminars, presentations, speeches or other sessions attended with descriptions of information gathered
    - A listing of presentations made with a description of information Presented
    - A listing of individuals or groups with whom the Governing Council members met while traveling including subjects addressed at the meeting and any outcome of the meeting.

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

POLICY RESPONSIBLE PARTY: Valleywise Community Health Centers Governing Council

DEVELOPMENT TEAM(S): Clerk's Office

Policy #: 89100 F

Policy Title: Valleywise Community Health Centers Governing Council Travel and Travel Reimbursement Policy

e-Signers: Melanie Talbot, Chief Governance Officer and Board Clerk

Place an X on the right side of applicable description:

New -

Retire - **Reviewed -**

Revised with Minor Changes - X

Revised with Major Changes -

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

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

Committee:	**00/00**
Committee:	**00/00**
Committee:	**00/00**
Reviewed for HR:	**00/00**
Reviewed for EPIC:	**00/00**
Other:	**00/00**
Other:	**00/00**
Other:	**00/00**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.vi.

Governance:
Policy 89100 F – Clean

Valleywise Health Administrative Policy & Statement

DRAFT

Effective Date: **11/17**

Reviewed Dates: **00/00**

Revision Dates: **12/19, 10/21**

Policy #: 89100 F

Policy Title: Valleywise Community Health Centers Governing Council Travel and Travel Expense Reimbursement

Scope:
[ ] District Governance (G)
[ ] System-Wide (S)
[ ] Division (D)
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    - A listing of individuals or groups with whom the Governing Council members met while traveling including subjects addressed at the meeting and any outcome of the meeting.

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

POLICY RESPONSIBLE PARTY: Valleywise Community Health Centers Governing Council

DEVELOPMENT TEAM(S): Clerk's Office

Policy #: 89100 F

Policy Title: Valleywise Community Health Centers Governing Council Travel and Travel Reimbursement Policy

e-Signers: Melanie Talbot, Chief Governance Officer and Board Clerk

Place an X on the right side of applicable description:

New -

Retire - **Reviewed -**

Revised with Minor Changes - X

Revised with Major Changes -

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

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

Committee:	**00/00**
Committee:	**00/00**
Committee:	**00/00**
Reviewed for HR:	**00/00**
Reviewed for EPIC:	**00/00**
Other:	**00/00**
Other:	**00/00**
Other:	**00/00**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.vii.

Governance:
Protocol 20080 F - Redline

Office of the Sr Vice President & CEO FQHC Clinics

2525 East Roosevelt Street • Phoenix • AZ• 85008

DATE: October 6, 2021

TO: Valleywise Community Health Centers Governing Council

FROM: Barbara Harding, BAN, RN, MPA, PAHM, CCM
Sr VP Amb Srvcs & CEO FQHC Clinics

SUBJECT: Policy # 20080 F FQHC Clinic: Coverage for Medical Emergencies During and After Hours

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Health centers must assure continuity of required primary health services of the center, including provisions for promptly responding to patient medical emergencies during and after regularly scheduled hours.

The Valleywise Community Health Centers Governing Council is responsible for ensuring that policies exist for the conduct of the Health Center Program project.

We are requesting the Governing Council to approve changes to policy #20080 F FQHC: Coverage for Medical Emergencies During and After Hours, which specifies that the protocol is for the Federally Qualified Health Center (FQHC) Clinics, including the Valleywise Community Health Centers (CHCs) and certain clinics within Valleywise CHCs – Phoenix and Peoria.

Other revisions include formatting and nomenclature for consistency.

Valleywise Health Protocol

DRAFT

Effective Date: **06/18**

Review Date: **00/00**

Revision Date: **02/21, 10/21**

Protocol #: 20080 F

Protocol Title: ~~Ambulatory~~FQHC Clinic: Coverage for Medical Emergencies During and After Hours

Protocol Scope: **[ ] Departmental (T)**
[ ] Multi-Department (MT)
[X] FQHC~~s~~ [F]

Purpose:

To establish a protocol for Valleywise Health employees, contracted staff, and medical staff to follow when a medical emergency occurs during and/or after hours at ~~a Valleywise Health~~ Federally Qualified Health Center (FQHC) Clinics, which include Valleywise Community Health Centers and certain clinics within Valleywise Comprehensive Health Centers-Phoenix and Peoria.

Definitions:

AED – Automated External Defibrillator
BLS – Basic Life Support
ECG - Electrocardiogram
EHR – Electronic Health Record
EMS – Emergency Medical Services
FQHC – Federally Qualified Health Center
MA – Medical Assistant
PCP – Primary Care Provider
RN – Registered Nurse

Code White: A response to a situation where a patient, visitor or staff requires medical assistance.

Medical Emergency: Defined as a medical situation posing an immediate risk to a patient's life or long-term health.

Equipment: Vital signs machine and if indicated oxygen tank/tubing, AED, blood glucose monitor, wheelchair or gurney, as needed.

Scope: FQHCs will have processes to assess and manage medical emergencies.

Responsibilities & Roles:
The FQHC Clinic Manager, or designee, with guidance and in collaboration with the Ambulatory Director of Operations and Ambulatory Director of Nursing, or designee, is responsible for implementing and maintaining coverage for medical emergencies during and after operational hours.

Procedures:
During Operational Hours:
A. In the event a patient/visitor is showing signs of medical distress during operational hours**:**

1. Any Valleywise Health employee who notices a patient/visitor in distress will page "Code White" using the overhead paging system.
2. A provider or RN will assess the person to determine if there is a medical emergency and will initiate BLS if needed.
3. If necessary, medication will be ordered by a provider and documented in the EHR system.
4. If necessary, medication will be administered by a provider, RN, and under restricted circumstances an MA.
    a) If there is no RN available, and it is within the scope of an MA to administer the medication, the MA may administer only under the direct supervision of the ordering provider.
    b) If there is no RN available and the prescribed medication is one that cannot be administered by the MA, a provider will administer.
5. The provider or RN can instruct any staff member to call 911.
6. The provider, RN, or MA will give the following information to the designee prior to the staff member calling 911:
    a) Location of emergency.
    b) Reason for the call, including but not limited to patient diagnosis, symptoms, and pertinent medical history.
    c) Patient name, gender, age, and date of birth if available.
7. The provider, RN, or MA will stay with the patient from the time the staff was alerted of the medical emergency, to the time EMS arrives.
8. Security or designee is notified to wait by the entry doors for EMS.
    Prior to EMS arriving, an MA, RN, or designee will print out a copy of the following:
        i. EPIC (i.e., EHR) "SnapShot" which includes:

            1. Patient demographic information
            2. Patient vitals
            3. Patient problem list

4. Patient medication list
5. Patient allergies

ii. ECG results, if performed
iii. Lab result(s), if performed

Security or designee opens the entry doors for EMS and directs/guides them to the patient's location.

9. The provider or RN will provide reports and documentation to EMS staff and will answer any questions regarding the patient's status.

After Operational Hours:

B. In the event a patient/visitor arrives after hours, a sign is posted on each FQHC~~'s~~ clinic's front door listing the phone numbers the patient may contact for a medical emergency or any other type of assistance.

C. In the event a patient/visitor calls the main Valleywise Health phone line requesting assistance, there is an option to have the operator page the on-call provider.

References:

Health Resources and Services Administration (HRSA) Compliance Manual Chapter 7: Coverage for Medical Emergencies During and After Hours. Last reviewed January 2018.

Valleywise Health Policy # 31253 S Medical Staff/Clinical Services/Medical Affairs: Management of Code Blue

Valleywise Health Protocol # 47141 Code White

Valleywise Health Protocol # 20082 F FQHC Clinic: Afterhours, Weekends and Holiday Calls

Valleywise Health Policy # 20077 F FQHC Clinic: Afterhours Care and Calls

Valleywise Health Protocol - Approval Sheet
(**Before submitting, fill out COMPLETELY**.)

PROTOCOL RESPONSIBLE PARTY: Jori Davis, Director of Operations Ambulatory Services, FQHC Clinics; Nelson Silva-Craig, Ambulatory Director of Nursing

DEVELOPMENT TEAM(S):

Protocol #: 20080

Protocol Title: FQHC Clinic: Coverage for Medical Emergencies During and After Hours

e-Signers: Barbara Harding, BAN, RN, MPA, PAHM, CCM, Senior Vice President, CEO FQHC Clinics

~~**Barbara Harding, SVP Ambulatory Services and CEO FQHC Clinics**~~

Place an X on the right side of applicable description:

New -

Retire - **Reviewed** -

Revised with Minor Changes -

Revised with Major Changes - X

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

-Corrected information regarding emergency protocols during and after operational hours.
List associated form(s): (If applicable)

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

Committee: System-wide P&P ~~**01/21**~~ **9/21**

Committee: Valleywise Community Health Governing Council ~~**02/21**~~**09/21**

Reviewed for EPIC:	**00/00**
Other:	**00/00**
Other:	**00/00**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.vii.

Governance:
Protocol 20080 F - Clean

Valleywise Health Protocol

DRAFT

Effective Date: **06/18**

Review Date: **00/00**

Revision Date: **02/21, 10/21**

Protocol #: 20080 F

Protocol Title: FQHC Clinic: Coverage for Medical Emergencies During and After Hours

Protocol Scope: **[ ] Departmental (T)**
[ ] Multi-Department (MT)
[X] FQHC [F]

Purpose:

To establish a protocol for Valleywise Health employees, contracted staff, and medical staff to follow when a medical emergency occurs during and/or after hours at Federally Qualified Health Center (FQHC) Clinics, which include Valleywise Community Health Centers and certain clinics within Valleywise Comprehensive Health Centers-Phoenix and Peoria.

Definitions:

AED – Automated External Defibrillator
BLS – Basic Life Support
ECG - Electrocardiogram
EHR – Electronic Health Record
EMS – Emergency Medical Services
FQHC – Federally Qualified Health Center
MA – Medical Assistant
PCP – Primary Care Provider
RN – Registered Nurse

Code White: A response to a situation where a patient, visitor or staff requires medical assistance.

Medical Emergency: Defined as a medical situation posing an immediate risk to a patient's life or long-term health.

Equipment: Vital signs machine and if indicated oxygen tank/tubing, AED, blood glucose monitor, wheelchair or gurney, as needed.

Scope: FQHCs will have processes to assess and manage medical emergencies.

Responsibilities & Roles:
The FQHC Clinic Manager, or designee, with guidance and in collaboration with the Ambulatory Director of Operations and Ambulatory Director of Nursing, or designee, is responsible for implementing and maintaining coverage for medical emergencies during and after operational hours.

Procedures:
During Operational Hours:
A. In the event a patient/visitor is showing signs of medical distress during operational hours**:**

1. Any Valleywise Health employee who notices a patient/visitor in distress will page "Code White" using the overhead paging system.
2. A provider or RN will assess the person to determine if there is a medical emergency and will initiate BLS if needed.
3. If necessary, medication will be ordered by a provider and documented in the EHR system.
4. If necessary, medication will be administered by a provider, RN, and under restricted circumstances an MA.
    a) If there is no RN available, and it is within the scope of an MA to administer the medication, the MA may administer only under the direct supervision of the ordering provider.
    b) If there is no RN available and the prescribed medication is one that cannot be administered by the MA, a provider will administer.
5. The provider or RN can instruct any staff member to call 911.
6. The provider, RN, or MA will give the following information to the designee prior to the staff member calling 911:
    a) Location of emergency.
    b) Reason for the call, including but not limited to patient diagnosis, symptoms, and pertinent medical history.
    c) Patient name, gender, age, and date of birth if available.
7. The provider, RN, or MA will stay with the patient from the time the staff was alerted of the medical emergency, to the time EMS arrives.
8. Security or designee is notified to wait by the entry doors for EMS.
    Prior to EMS arriving, an MA, RN, or designee will print out a copy of the following:
        i. EPIC (i.e., EHR) "SnapShot" which includes:

            1. Patient demographic information
            2. Patient vitals
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4. Patient medication list
5. Patient allergies

ii. ECG results, if performed
iii. Lab result(s), if performed

Security or designee opens the entry doors for EMS and directs/guides them to the patient's location.

9. The provider or RN will provide reports and documentation to EMS staff and will answer any questions regarding the patient's status.

After Operational Hours:

B. In the event a patient/visitor arrives after hours, a sign is posted on each FQHC clinic's front door listing the phone numbers the patient may contact for a medical emergency or any other type of assistance.

C. In the event a patient/visitor calls the main Valleywise Health phone line requesting assistance, there is an option to have the operator page the on-call provider.

References:

Health Resources and Services Administration (HRSA) Compliance Manual Chapter 7: Coverage for Medical Emergencies During and After Hours. Last reviewed January 2018.

Valleywise Health Policy # 31253 S Medical Staff/Clinical Services/Medical Affairs: Management of Code Blue

Valleywise Health Protocol # 47141 Code White

Valleywise Health Protocol # 20082 F FQHC Clinic: Afterhours, Weekends and Holiday Calls

Valleywise Health Policy # 20077 F FQHC Clinic: Afterhours Care and Calls

Valleywise Health Protocol - Approval Sheet
(**Before submitting, fill out COMPLETELY**.)

PROTOCOL RESPONSIBLE PARTY: Jori Davis, Director of Operations Ambulatory Services, FQHC Clinics; Nelson Silva-Craig, Ambulatory Director of Nursing

DEVELOPMENT TEAM(S):

Protocol #: 20080

Protocol Title: FQHC Clinic: Coverage for Medical Emergencies During and After Hours

e-Signers: Barbara Harding, BAN, RN, MPA, PAHM, CCM, Senior Vice President, CEO FQHC Clinics Place an X on the right side of applicable description:

New -

Retire - **Reviewed** -

Revised with Minor Changes -

Revised with Major Changes - X

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

-Corrected information regarding emergency protocols during and after operational hours.
List associated form(s): (If applicable)

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

Committee: System-wide P&P	**9/21**
Committee: Valleywise Community Health Governing Council	**09/21**
Reviewed for EPIC:	**00/00**
Other:	**00/00**
Other:	**00/00**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.viii.

Governance:
Protocol 20082 F - Redline

Office of the Sr Vice President & CEO FQHC Clinics

2525 East Roosevelt Street • Phoenix • AZ• 85008

DATE: October 6, 2021

TO: Valleywise Community Health Centers Governing Council

FROM: Barbara Harding, BAN, RN, MPA, PAHM, CCM
Sr VP Amb Srvcs & CEO FQHC Clinics

SUBJECT: Policy # 20082 F FQHC Clinic: Afterhours, Weekends and Holiday Calls

---

Health centers must assure continuity of required primary health services of the center, including after-hours coverage operating procedures.

The Valleywise Community Health Centers Governing Council is responsible for ensuring that policies exist for the conduct of the Health Center Program project.

We are requesting the Governing Council to approve changes to policy #20082 F FQHC: Afterhours, Weekends and Holiday Calls, which specifies that the protocol is for the Federally Qualified Health Center (FQHC) Clinics, including the Valleywise Community Health Centers (CHCs) and certain clinics within Valleywise CHCs – Phoenix and Peoria. Clinics and corresponding Caller IDs have been updated for accuracy.

Other revisions include formatting and nomenclature for consistency.

DRAFT

Valleywise Health Protocol

Effective Date: **04/16**

Review Date: **06/18**

Revision Date: **07/20, 10/21**

Protocol #: 20082 [F]

Protocol Title: ~~Ambulatory:~~ FQHC Clinic: Afterhours, Weekends and Holiday Calls

Protocol Scope: **[ ] Departmental (T)**
[ ] Multi-Department (MT)
[X] FQHC (F)

Purpose:

This document provides information and instruction on what to do when the Valleywise Health Switchboard receives afterhours calls for the ~~Valleywise Health~~ Federally Qualified Health Centers (FQHC) ~~sites~~clinics, which include~~s~~ the Valleywise Community Health Centers and certain clinics within ~~the~~ Valleywise Comprehensive Health Centers-Phoenix and Peoria.

Procedure:

In the event a patient/visitor arrives after the Community Health Centers and Comprehensive Health Centers have~~has~~ closed, a sign is posted on each ~~FQHC's~~ clinic's front door listing the phone numbers the patient may contact for a medical emergency or any other type of assistance.

In the event a patient/visitor calls the main Valleywise Health Switchboard~~phone line~~ requesting assistance, there is an option to have the provider on call, for that respective clinic, to be contacted for assistance.

The ~~Switchboard~~ switchboard ~~Operators~~ operators receive afterhours calls from these clinics and need to determine whether a provider needs to be paged, which provider needs to be paged, or if the caller needs to call back during normal business hours.

The ~~On Call~~on-call ~~Provider~~provider, as well as the backup, for the Community Health Centers and the Comprehensive Health Centers will call in to the Valleywise Health Switchboard to advise if they would like to be paged on their pager, if they would like to be called on a cellular phone, or a mixture of different scenarios on how to reach the provider. If the provider provides a cell number or home number, the ~~Switchboard~~ switchboard ~~Operator~~ operator taking the call will send an email to their IT Switchboard Distribution List to advise how the provider would like to be called and include their number in the email in case they have multiple phone numbers in their profile. If the provider would like to be paged with their assigned pager, the switchboard operator will verify the pager number on file and send an email to their IT Switchboard Distribution List to advise the provider would like to be paged.

A Provider is Required to be Paged

Critical Labs

If a lab calls with critical lab results, a provider will need to be paged. It can be any lab, including the lab at Valleywise Health. The Switchboard Operator will obtain the following information from the lab:

1. Name of the patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Primary care provider (This helps the switchboard operators determine if they should be paging the Family Practice provider versus the Internal Medicine provider, etc.)
4. Reason for the call
5. Name of the physician who ordered the labs
6. Date and time of the lab
7. Type of the lab (Might help determine whether this is an OB or not)
8. Name and phone number of person calling

After the switchboard operator obtains all the information, they will do one of two things to get a hold of the provider based on their preferred method of contact. They will either call the provider directly and provide the information over the phone and connect the lab to the provider, or they will page the provider to contact the Valleywise Health Switchboard at 602-344-5011. When the provider calls back, the switchboard operator will provide all this information to them, including the name of the lab calling, person to speak to, and the phone number.

If the switchboard operator has been unable to get a hold of the primary on-~~-~~call provider the first time, they will try to contact them again in about 5 minutes. If

they are still unable to get a hold of the primary on-~~-~~call provider, the switchboard operator will page or call the ~~back up~~backup provider. The switchboard operators keep track of the time each provider has been paged or called, and the time they call back or answer their phone. If the Valleywise Health Switchboard is still unable to get a hold of a provider, then they will escalate the matter to the appropriate area for resolution. For example, if a~~n~~ Community Health Center on call provider does not call back, then the switchboard operator will escalate to FQHC Administration.

Prescription Calls

If a patient calls to the Valleywise Health Switchboard for a new or refill prescription, the provider will need to be paged. The switchboard operator will obtain the following information from the patient:

1. Name of patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Primary care provider (This helps the switchboard operators determine if they should be paging the Family Practice provider versus the Internal Medicine provider, etc.)
4. Patient's phone number
5. Reason for call

After the switchboard operator obtains all of this information, they will get a hold of the on-~~-~~call provider to explain they have a patient on the line that needs a new prescription or refill, and provide all of the additional information they have obtained. If the provider states they are unable to either call in a new prescription or refill before speaking to the patient and asks the switchboard operator to explain this to them, the operator will advise the provider they are not medically trained to provide this information to the patient and will need to bring them on the line to explain this to the patient if they were called. If the provider was paged, then the provider should call the Valleywise Health Switchboard and have the Valleywise Health Switchboard conference in the provider and patient to explain why this cannot be called in.

*****NOTE: There will be times a provider will be able to call in a refill because they are the patient's Primary Care Provider.*****

Medical Advice Calls

If a patient calls to the Valleywise Health Switchboard for medical advice, and they have previously been seen by a~~n~~ ~~MIHS~~ Valleywise Health provider, the provider will

need to be paged. The switchboard operator will obtain the following information from the patient:

1. Name of patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Primary care provider (This helps the Switchboard Operators determine if they should be paging the Family Practice provider versus the Internal Medicine provider, etc.)
4. Patient's phone number
5. Reason for call

After the switchboard operator obtains all of this information, they will get a hold of the on-call provider to explain they have a patient on the line that is asking for some medical advice. The switchboard operator will provide all of the obtained information to the provider, which will include the reason why the patient called in. If the provider was paged, then the provider should call the Valleywise Health Switchboard, and the Valleywise Health Switchboard will conference in the patient and provider. If the provider was called, then warm transfer the provider to the patient and introduce the call.

After Surgery Calls

If a patient calls to the Valleywise Health Switchboard because they have had surgery recently, the switchboard operator will page the provider based on how recent the surgery was. If the surgery was less than 48 hours ago, the switchboard operator will page the surgery consult pager to have the provider call the Valleywise Health Switchboard back at 602-344-5011. The operator will provide the following information to the provider:

1. Name of patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Name of provider that performed surgery
4. Patient's phone number
5. Reason for call

If the surgery was more than 48 hours ago, the switchboard operator will advise the patient if they are still experiencing any post-surgery issues/symptoms to go to the Emergency Room. If the patient is still adamant about speaking to a physician, the switchboard operator will page the surgery consult pager to have the provider call the Valleywise Health Switchboard back. The switchboard operator will provide all information collected from the patient to the provider and conference them in together.

A Provider Should Not be Paged

Make an Appointment

If a patient calls to make an appointment, the switchboard operator will verify which clinic the patient would like an appointment at, advise what time the clinic is open, and ask them to call back during normal business hours. The operators know which clinic the patient is calling by the caller ID that comes up on their phones. The below is what the caller ID shows and what clinic it belongs to:

Caller ID	Clinic
CHC Nites	CHC-Phoenix and Peoria
MD Night Service	McDowell
GU Night Service	Guadalupe
CH Night Service	Chandler
ME Night Service	Mesa
~~SS Night Service~~	~~Sunnyslope~~
SC Night Service	South Central
~~EM Night Service~~	~~El Mirage~~
~~Sv Night Service~~	~~7th Ave~~
~~GD Night Service~~	~~Glendale~~
AD Night Service	Avondale
MV Night Service	Maryvale

Cancel an Appointment

If a patient calls to cancel an appointment, the switchboard operator will verify which clinic the patient is calling, advise what time the clinic is open, and ask them to call back during normal business hours to cancel their appointment.

*****NOTE: The Switchboard Operators are not able to take messages for patients wanting to cancel appointments.*****

Check Appointment Date and Time

If a patient calls to find out what date and time their appointment is, the switchboard operator is able to go into Epic to advise of the date and time of the appointment, as well as which area.

*****NOTE: The Switchboard Operator will verify the patient's name and date of birth before providing any information.*****

*****NOTE: The Switchboard Operators fill out a form whenever they receive a call that needs a provider to be paged. These forms are filed in the Switchboard Supervisor's desk every day and is locked. Please see form on next page.*****

Purpose

Please use this form to document how many calls you receive to page a provider, such as critical labs, medical advice, prescription refills, etc. Please turn in these papers to switchboard supervisor or place on their desk, face down, in order for them to file for future reference. period.

Date:_____ Name:_____

Clinic	
Name of Patient	
Date of Birth	
Primary Care Provider	
Patient's Phone Number	
Reason For Call	
FOR CRITICAL LABS: **1) Name of the Physician Who Ordered the Labs** **2) Date and Time of Lab** **3) Name of Lab (Might help determine whether this is OB or not)**	**1)** **2)** **3)** **4)**

4) Name and Phone Number of Person Calling	
Time Primary On Call Provider Contacted (1st Call)	
Time Primary On Call Provider Called Back	
Time Primary On Call Provider Contacted (2nd Call)	
Time Primary On Call Provider Called Back	
Time Back Up On Call Provider Called	
Additional Comments	

References:

Valleywise Health Protocol # 20080 F FQHC Clinic: Coverage for Medical Emergencies During and After Hours

Valleywise Health Policy # 20077 F FQHC Clinic: Afterhours Care and Calls

Valleywise Health Protocol - Approval Sheet
(Before submitting, fill out COMPLETELY.)

PROTOCOL RESPONSIBLE PARTY: Jori Davis, Director Ambulatory Operations, FQHC Clinics

DEVELOPMENT TEAM(S):

Protocol #: 20082

Protocol Title: ~~Ambulatory~~FQHC Clinic: Afterhours, Weekends, and Holiday Calls to the Switchboard

e-Signers: Barbara Harding, BAN, RN, MPA, PAHM, CCM, Senior Vice President, CEO FQHC Clinics~~Barbara Harding, Sr VP Amb Srvcs & CEO, FQHC Clinics~~

Place an X on the right side of applicable description:

New -

Retire - **Reviewed** -

Revised with Minor Changes - X

Revised with Major Changes -

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

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

Committee: Systemwide P&P	**~~00/00~~09/21**
Committee:	**00/00**
Committee:	**00/00**
Reviewed for EPIC:	**00/00**
Other: Valleywise Community Health Centers Governing Council	**~~00/00~~10/21**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.viii.

Governance:
Protocol 20082 F - Clean

Valleywise Health Protocol

DRAFT

Effective Date: **04/16**

Review Date: **06/18**

Revision Date: **07/20, 10/21**

Protocol #: 20082 [F]

Protocol Title: FQHC Clinic: Afterhours, Weekends and Holiday Calls

Protocol Scope: **[ ] Departmental (T)**
[ ] Multi-Department (MT)
[X] FQHC (F)

Purpose:

This document provides information and instruction on what to do when the Valleywise Health Switchboard receives afterhours calls for the Federally Qualified Health Centers (FQHC)clinics, which include the Valleywise Community Health Centers and certain clinics within Valleywise Comprehensive Health Centers-Phoenix and Peoria.

Procedure:

In the event a patient/visitor arrives after the Community Health Centers and Comprehensive Health Centers have
closed, a sign is posted on each clinic's front door listing the phone numbers the patient may contact for a medical emergency or any other type of assistance.

In the event a patient/visitor calls the main Valleywise Health Switchboard requesting assistance, there is an option to have the provider on call, for that respective clinic, to be contacted for assistance.

The switchboard operators receive afterhours calls from these clinics and need to determine whether a provider needs to be paged, which provider needs to be paged, or if the caller needs to call back during normal business hours.

The on-call provider, as well as the backup, for the Community Health Centers and the Comprehensive Health Centers will call in to the Valleywise Health Switchboard to advise if they would like to be paged on their pager, if they would like to be called on a cellular phone, or a mixture of different scenarios on how to reach the

provider. If the provider provides a cell number or home number, the switchboard operator taking the call will send an email to their IT Switchboard Distribution List to advise how the provider would like to be called and include their number in the email in case they have multiple phone numbers in their profile. If the provider would like to be paged with their assigned pager, the switchboard operator will verify the pager number on file and send an email to their IT Switchboard Distribution List to advise the provider would like to be paged.

A Provider is Required to be Paged

Critical Labs

If a lab calls with critical lab results, a provider will need to be paged. It can be any lab, including the lab at Valleywise Health. The Switchboard Operator will obtain the following information from the lab:

1. Name of the patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Primary care provider (This helps the switchboard operators determine if they should be paging the Family Practice provider versus the Internal Medicine provider, etc.)
4. Reason for the call
5. Name of the physician who ordered the labs
6. Date and time of the lab
7. Type of the lab (Might help determine whether this is an OB or not)
8. Name and phone number of person calling

After the switchboard operator obtains all the information, they will do one of two things to get a hold of the provider based on their preferred method of contact. They will either call the provider directly and provide the information over the phone and connect the lab to the provider, or they will page the provider to contact the Valleywise Health Switchboard at 602-344-5011. When the provider calls back, the switchboard operator will provide all this information to them, including the name of the lab calling, person to speak to, and the phone number.

If the switchboard operator has been unable to get a hold of the primary on-call provider the first time, they will try to contact them again in about 5 minutes. If they are still unable to get a hold of the primary on-call provider, the switchboard operator will page or call the backup provider. The switchboard operators keep track of the time each provider has been paged or called, and the time they call back or answer their phone. If the Valleywise Health Switchboard is still unable to get a hold of a provider, then they will escalate the matter to the appropriate area

for resolution. For example, if a Community Health Center on call provider does not call back, then the switchboard operator will escalate to FQHC Administration.

Prescription Calls

If a patient calls to the Valleywise Health Switchboard for a new or refill prescription, the provider will need to be paged. The switchboard operator will obtain the following information from the patient:

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1. Name of patient
2. Date of birth for the patient (Can help determine whether this is a PEDS patient or not.)
3. Name of provider that performed surgery
4. Patient's phone number
5. Reason for call

If the surgery was more than 48 hours ago, the switchboard operator will advise the patient if they are still experiencing any post-surgery issues/symptoms to go to the Emergency Room. If the patient is still adamant about speaking to a physician, the switchboard operator will page the surgery consult pager to have the provider call the Valleywise Health Switchboard back. The switchboard operator will provide all information collected from the patient to the provider and conference them in together.

A Provider Should Not be Paged

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• MD Night Service	McDowell
• GU Night Service	Guadalupe
• CH Night Service	Chandler
• ME Night Service	Mesa
• SC Night Service	South Central
•	
•	
•	
• AD Night Service	Avondale
• MV Night Service	Maryvale

Cancel an Appointment

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Date:_____ **Name:**_____

Clinic	
Name of Patient	
Date of Birth	
Primary Care Provider	
Patient's Phone Number	
Reason For Call	
FOR CRITICAL LABS: **1) Name of the Physician Who Ordered the Labs** **2) Date and Time of Lab** **3) Name of Lab (Might help determine whether this is OB or not)** **4) Name and Phone Number of Person Calling**	**1)** **2)** **3)** **4)**
Time Primary On Call Provider Contacted (1st Call)	
Time Primary On Call Provider Called Back	

Time Primary On Call Provider Contacted (2nd Call)	
Time Primary On Call Provider Called Back	
Time Back Up On Call Provider Called	
Additional Comments	

References:

Valleywise Health Protocol # 20080 F FQHC Clinic: Coverage for Medical Emergencies During and After Hours

Valleywise Health Policy # 20077 F FQHC Clinic: Afterhours Care and Calls

Valleywise Health Protocol - Approval Sheet
(**Before submitting, fill out COMPLETELY**.)

PROTOCOL RESPONSIBLE PARTY: Jori Davis, Director Ambulatory Operations, FQHC Clinics

DEVELOPMENT TEAM(S):

Protocol #: 20082

Protocol Title: FQHC Clinic: Afterhours, Weekends, and Holiday Calls to the Switchboard

e-Signers: Barbara Harding, BAN, RN, MPA, PAHM, CCM, Senior Vice President, CEO FQHC Clinics

Place an X on the right side of applicable description:

New -

Retire - **Reviewed** -

Revised with Minor Changes - X

Revised with Major Changes -

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

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

Committee: Systemwide P&P	**9/21**
Committee:	**00/00**
Committee:	**00/00**
Reviewed for EPIC:	**00/00**
Other: Valleywise Community Health Centers Governing Council	**10/21**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.ix.

Governance:
Audited Financial Statements, Reports, Supplementary Information, and Schedule

Maricopa County
Special Health Care District

Hospital Administration & Finance
2601 E. Roosevelt
Phoenix, AZ 85008
Phone: (602) 344-8428

DATE: October 1, 2021

TO: Valleywise Community Health Centers Governing Council

FROM: Claire Agnew, EVP, Chief Financial Officer

SUBJECT: Audited Financial Statements, Reports, Supplementary Information and Schedule Required by the Uniform Guidance, FYE June 30, 2020 and 2019

Accountability and transparency of federal award spending is necessary for effective stewardship of these federal funds, and the audit and reporting under the Office of Management and Budget's (OMB) *Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards* (commonly called "Uniform Guidance") is to fulfill this requirement.

The draft *Audited Financial Statements, Reports, Supplementary Information and Schedule Required by the Uniform Guidance for the years ended June 30, 2020 and 2019* is attached for acceptance by the Valleywise Community Health Centers Governing Council (Governing Council). This has also been submitted for acceptance by the Finance Committee of the Governing Council (Finance Committee). It had been accepted by the Maricopa County Special Healthcare District Board on September 22nd, 2021.

The annual audit for fiscal year ending June 30, 2020, was accepted by the Governing Council and Finance Committee in January 2021. Unlike in previous years, the audit accepted did not include the results of the Uniform Guidance audit for the same time period.

The submission of the Uniform Guidance report to the OMB Financial Audit Clearinghouse is normally due the earlier of 30 calendar days after receipt of the auditor's reports or 9 months after the end of the audit period, so usually submitted to the Board for approval simultaneous to the financial audit results. OMB Memorandum M-21-20 extended this deadline to six months beyond the normal due date, making the new Valleywise Health Uniform Guidance submission deadline September 30, 2021. This additional time was needed due to an update in the Uniform Guidance implemented in August 2020 and new COVID-19 related federal awards.

The added section regarding the Uniform Guidance audit begins on **page 60**. The Schedule of Findings and Questionable Costs on **page 64** indicates that there were no material weaknesses nor significant deficiencies identified in the audit.

Draft

AUDITED FINANCIAL STATEMENTS, REPORTS, SUPPLEMENTARY INFORMATION AND SCHEDULE REQUIRED BY THE UNIFORM GUIDANCE

Maricopa County Special Health Care District
d/b/a Valleywise Health
Year Ended June 30, 2020 and 2019
With Report of Independent Auditors

Maricopa County Special Health Care District
d/b/a Valleywise Health

Audited Financial Statements, Reports, Supplementary Information and Schedule Required by the Uniform Guidance

Year Ended June 30, 2020 and 2019

Contents

Report of Independent Auditors

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

Report on the Financial Statements

We have audited the accompanying financial statements of the Maricopa County Special Health Care District d/b/a Valleywise Health (the District), as of and for the year ended June 30, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2020 and 2019, the changes in its financial position and its cash flows for the year then ended in conformity with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that the management's discussion and analysis on pages 3–11, the Schedule of District's Proportionate Share of the Net Pension Liability, Schedule of District's Proportionate Share of the Net OPEB Liability (Asset), the Schedule of Contributions Pension Plan and the Schedule of Contributions OPEB Plan be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements. The schedule of expenditures of federal awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purposes of additional analysis and are not a required part of the basic financial statements.

The schedule of expenditures of federal awards is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the schedule of expenditures of federal awards is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our report dated December 9, 2020 on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

December 9, 2020

Maricopa County Special Health Care District
d/b/a Valleywise Health

Management's Discussion and Analysis

Years Ended June 30, 2020 and 2019

The following discussion and analysis of the operational and financial performance of Maricopa County Special Health Care District d/b/a Valleywise Health (the District or VW) provides an overview of the financial position and activities for the years ended June 30, 2020 and 2019. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements, as well as the notes to the financial statements, which follow this section.

Organizational Overview

Founded in 1877, the District has served as Maricopa County's public teaching hospital and safety net system, filling critical gaps in care for underserved populations. In partnership with District Medical Group, the District provides care through the Arizona Burn Center, Level 1 trauma center, inpatient and behavioral health hospitals, specialty services, comprehensive health center, community health centers, and clinical education programs.

The District is an academic training center, a regional provider of primary and specialized medical services, and a leading provider of mental health services. It provides clinical rotations each year for allopathic and osteopathic medical students, nursing students, and allied health professionals. The District is one of four partners in the Creighton University – Arizona Health Education Alliance.

The District is comprised of Valleywise Health Medical Center, Valleywise Behavioral Health Center-Maryvale, Valleywise Behavioral Health Center-Mesa, Valleywise Comprehensive Health Center-Phoenix and 12 Valleywise Community Health Centers.

COVID-19

In 2020, the world was introduced to the Coronavirus Disease 2019 (COVID-19), creating a new historic public health crisis. The District met this challenge through many actions, including:

- Added Incident Decision Units to isolate and treat patients with the disease;
- Established protocols for addressing positive Behavioral Health patients;
- Forming rapid testing capabilities;
- Acquired personal protective equipment despite disrupted supply chains;
- Created telehealth visits for ambulatory care to provide safe patient access; and
- Implemented work-from-home options to provide social distancing for support staff.

These efforts required increased costs while revenue was lessened by fewer emergency department and ambulatory visits and cancelled or forgone elective procedures. Additionally, an Executive Order by the Governor of Arizona, declared a public health emergency and paused all non-essential or elective surgeries from March 21, 2020 through April 30, 2020.

Through the passage of the Families First Coronavirus Response Act (Families First) and the Coronavirus Aid, Relief and Economic Security (CARES) Act, Congress provided financial support to hospitals and health care providers during the pandemic for financial stabilization. Additional information related to the financial support are included in the District's financial statements (Note 16).

Financial Highlights

From a patient activity perspective, fiscal year 2020 total admissions grew by about 3.6% over fiscal year 2019 volumes while observation admissions increased by 7.1% over fiscal year 2019. The acute average length of stay increased slightly during the year to 5.0 days, driven by an increase in the case mix index to 1.72 from 1.68 in fiscal year 2019.

In the highly competitive Emergency Department and Ambulatory areas, fiscal year 2020 visits were up by 14.4% and 0.9%, respectively, from fiscal year 2019. Surgical case volumes in fiscal year 2020 were down by 5.1% from fiscal year 2019 partly due to the COVID-19 outbreak.

Care Reimagined

In 2017, the District Board set a roadmap for our organization's future by receiving the final report resulting from the Proposition 480 implementation planning initiative. This plan, known as Care Reimagined, will ensure our organization continues to be recognized for high-quality care, innovation, and service. It creates a better model of patient care and medical education that improves access, quality, cost, and outcomes for patients and increases the supply of future health care professionals.

The implementation of this capital plan is well underway; as of June 30, 2020, $390,329,000 of the bond proceeds have been expended. During Fiscal Year 2020, the majority of project funds were expended on the Roosevelt campus for the construction of the new hospital scheduled to be complete in October 2023. The Comprehensive Health Center-Peoria (Peoria), project was substantially complete as of June 30, 2020, and its opening delayed to January 2021 due to COVID-19. Peoria will include an outpatient surgery center, endoscopy suites, dialysis services, primary and specialty clinics, and a family learning center.

In October 2018, the District issued the third bond tranche in the amount of $422,125,000 General Obligation Bonds, Series C (2018). The District is authorized to issue $935,000,000, in aggregate, principal amount toward the project. At June 30, 2020, $331,875,000 of the authorized amount remains unissued.

Proposition 449

In November 2020, Proposition 449 was approved by the voters of the County to authorize the District to continue the levy of a property tax for twenty years to support its operations. The tax will expire in August 2025 without prior voter approval.

Overview of the Financial Statements

The District's financial statements consist of three statements – statements of net position; statements of revenues, expenses, and changes in net position; and statements of cash flows. These statements provide information about the activities of the District, including resources held by the District that are restricted for specific purposes by creditors, contributors, grantors, or enabling legislation. The District is accounted for as a business-type activity and presents its financial statements using the economic resources measurement focus and the accrual basis of accounting.

The statements of net position and statements of revenues, expenses, and changes in net position report the District's net position and changes in it. The District's total net position – the difference between assets plus deferred outflows of resources and liabilities plus deferred inflows of resources – is one measure of the District's financial health or financial position. Over time, increases or decreases in the District's net position are an indicator of whether its financial health is improving or deteriorating. Other nonfinancial factors, such as changes in the District's patient base, changes in legislation and regulations, measures of the quantity and quality of services provided to its patients, and local economic factors, should also be considered to assess the overall financial health of the District.

The statements of cash flows report cash receipts, cash payments, and net changes in cash and cash equivalents resulting from four defined types of activities. It provides answers to such questions as, where did cash come from, what was cash used for, and what was the change in cash and cash equivalents during the reporting period.

The District's Net Position

The District's net position represents the difference between its assets plus deferred outflows of resources and liabilities plus deferred inflows of resources reported on the statements of net position. The District's net position at June 30, 2020, 2019, and 2018 was $277,982,455, $258,251,356, and $207,168,312, respectively, as shown in Table 1.

Table 1: Assets, Deferred Outflows of Resources, Liabilities, Deferred Inflows of Resources, and Net Position

	Year Ended June 30			
	2020	**2019**	**Dollar Change**	**% Change**
Assets				
Current assets	**$ 547,204,175**	$ 689,363,400	$ (142,159,225)	(21)%
Other assets	**175,203,778**	167,737,590	7,466,188	4%
Capital assets	**501,967,393**	359,840,756	142,126,637	39%
Total assets	**1,224,375,346**	1,216,941,746	7,433,600	1%
Deferred outflows of resources	**48,799,387**	65,048,262	(16,248,875)	(25)%
Liabilities				
Current liabilities	**185,465,444**	163,282,578	22,182,866	14%
Risk claims payable, less current portion	**10,660,315**	11,177,826	(517,511)	(5)%
Net pension and OPEB liability	**311,945,423**	300,585,929	11,359,494	4%
Long-term debt	**463,170,813**	501,163,873	(37,993,060)	(8)%
Total liabilities	**971,241,995**	976,210,206	(4,968,211)	(1)%
Deferred inflows of resources	**23,950,283**	47,528,446	(23,578,163)	(50)%
Net position				
Unrestricted deficit	**(213,062,448)**	(128,763,175)	(84,299,273)	65%
Net investment in capital assets	**242,926,918**	212,962,293	29,964,625	14%
Restricted for bonds	**245,576,963**	171,579,684	73,997,279	43%
Restricted for grants	**2,541,022**	2,472,554	68,468	3%
Total net position	**$ 277,982,455**	$ 258,251,356	$ 19,731,099	8%

Table 1: Assets, Deferred Outflows of Resources, Liabilities, Deferred Inflows of Resources, and Net Position (continued)

	Year Ended June 30			
	2019	2018	Dollar Change	% Change
Assets				
Current assets	$ 689,363,400	$ 420,931,978	$ 268,431,422	64%
Other assets	167,737,590	73,803,435	93,934,155	127%
Capital assets	359,840,756	254,112,284	105,728,472	42%
Total assets	1,216,941,746	748,847,697	468,094,049	63%
Deferred outflows of resources	65,048,262	38,134,646	26,913,616	71%
Liabilities				
Current liabilities	163,282,578	141,176,075	22,106,503	16%
Risk claims payable, less current portion	11,177,826	10,032,177	1,145,649	11%
Net pension and OPEB liability	300,585,929	304,258,185	(3,672,256)	(1)%
Long-term debt	501,163,873	76,300,266	424,863,607	557%
Other long-term liabilities	–	7,963,326	(7,963,326)	(100)%
Total liabilities	976,210,206	539,730,029	436,480,177	81%
Deferred inflows of resources	47,528,446	40,084,002	7,444,444	19%
Net position				
Unrestricted deficit	(128,763,175)	(100,932,414)	(27,830,761)	28%
Net investment in capital assets	212,962,293	201,174,379	11,787,914	6%
Restricted for bonds	171,579,684	104,203,956	67,375,728	65%
Restricted for grants	2,472,554	2,722,391	(249,837)	(9)%
Total net position	$ 258,251,356	$ 207,168,312	$ 51,083,044	25%

The District's significant assets as of June 30, 2020, 2019, and 2018 were cash and cash equivalents (including restricted cash), investments, patient accounts receivable, receivables from Arizona Health Care Cost Containment System (AHCCCS), other receivables, and capital assets. Current assets decreased by $142,159,225 or 21% from June 30, 2019 to June 30, 2020, primarily as a result of a decrease in total short-term investments of $274,641,997, partially off-set by an increase in cash and restricted cash of $148,965,737. The proceeds of investments sold or matured during the year were used to fund operations and capital purchases, with the remaining amount

increasing cash balances at June 30, 2020. The AHCCCS receivable also contributed to the decrease in the amount of $28,409,442 as a result of an accelerated distribution of GME funds from AHCCCS. Current assets increased $268,431,422 or 64% from June 30, 2018 to June 30, 2019, primarily as a result of an increase in restricted short-term investments, which is due to proceeds from tax levies and bond issuance. Other assets increased $7,466,188 or 4% during the year ended June 30, 2020 primarily in restricted cash-bonds, and $93,934,155 or 127% from June 30, 2018 to June 30, 2019 mainly in restricted cash. Capital assets increased $142,126,637 or 39% during the year ended June 30, 2020 and $105,728,472 or 42% during the year ended June 30, 2019, which were due to the purchase and renovation of a hospital building, various land purchases and other capital expenditures related to new construction and equipment expenditures under Care Reimagined.

Total current liabilities increased by $22,182,866 or 14% primarily due to the receipt of the accelerated payments from Medicare. Long-term debt decreased $37,993,060 or 8% from June 30, 2019 to June 30, 2020, primarily was a result of principal payments on the General Obligation Bonds. There was an increase in long-term debt of $424,863,607 or 557% during the year ended June 30, 2019, which was due to a bond issuance, offset by principal payments. The net pension and OPEB liability increased $11,359,494 or 4% during the year ended June 30, 2020 and decreased $3,672,256 or 1% during the year ended June 30, 2019. The changes in the net pension and OPEB liability are primarily due to the change in assumptions used by the actuaries and contributions made to the pension assets.

Operating Results and Changes in the District's Net Position

For the years ended June 30, 2020 and 2019, the District's net position increased by $19,731,099 or 8% and $51,083,044 or 25%, respectively. These are made up of several different components, as shown in Table 2.

Table 2: Operating Results and Changes in Net Position

	Year Ended June 30			
	2020	**2019**	**Dollar Change**	**% Change**
Operating revenues:				
Net patient service revenue	**$ 454,144,793**	$ 427,301,404	$ 26,843,389	6%
AHCCCS medical education revenue	**42,516,595**	38,607,817	3,908,778	10%
Other	**52,295,096**	41,904,850	10,390,246	25%
Total operating revenues	**548,956,484**	507,814,071	41,142,413	8%
Operating expenses				
Salaries and wages	**267,919,233**	242,211,381	25,707,852	11%
Employee benefits	**81,795,822**	48,286,608	33,509,214	69%
Purchased services	**138,223,397**	122,387,122	15,836,275	13%
Medical claims and other expenses	**59,751,185**	52,736,053	7,015,132	13%
Supplies and other expenses	**90,233,509**	79,134,622	11,098,887	14%
Depreciation	**31,806,516**	27,902,991	3,903,525	14%
Total operating expenses	**669,729,662**	572,658,777	97,070,885	17%
Operating loss	**(120,773,178)**	(64,844,706)	(55,928,472)	86%
Nonoperating revenues (expenses)				
Property tax receipts	**143,303,021**	119,074,910	24,228,111	20%
Noncapital grants	**11,915,514**	12,466,739	(551,225)	(4)%
Noncapital subsidies from State	**3,547,896**	3,547,896	–	0%
Other nonoperating revenues and expenses, net	**(12,868,425)**	(16,009,627)	3,141,202	(20)%
Investment income, net	**8,344,261**	10,325,302	(1,981,041)	(19)%
Interest expense	**(13,737,990)**	(13,477,470)	(260,520)	2%
Total nonoperating revenues, net	**140,504,277**	115,927,750	24,576,527	21%
Increase in net position	**19,731,099**	51,083,044	(31,351,945)	(61)%
Net position, beginning of year	**258,251,356**	207,168,312	51,083,044	25%
Net position, end of year	**$ 277,982,455**	$ 258,251,356	$ 19,731,099	8%

Table 2: Operating Results and Changes in Net Position (continued)

	Year Ended June 30			
	2019	**2018**	**Dollar Change**	**% Change**
Operating revenues:				
Net patient service revenue	$ 427,301,404	$ 437,158,739	$ (9,857,335)	(2)%
AHCCCS medical education revenue	38,607,817	39,721,412	(1,113,595)	(3)%
Other	41,904,850	33,438,311	8,466,539	25%
Total operating revenues	507,814,071	510,318,462	(2,504,391)	0%
Operating expenses				
Salaries and wages	242,211,381	224,211,477	17,999,904	8%
Employee benefits	48,286,608	40,103,682	8,182,926	20%
Purchased services	122,387,122	122,003,416	383,706	0%
Medical claims and other expenses	52,736,053	49,315,987	3,420,066	7%
Supplies and other expenses	79,134,622	74,594,191	4,540,431	6%
Depreciation	27,902,991	24,703,577	3,199,414	13%
Total operating expenses	572,658,777	534,932,330	37,726,447	7%
Operating loss	(64,844,706)	(24,613,868)	(40,230,838)	163%
Nonoperating revenues (expenses)				
Property tax receipts	119,074,910	113,702,828	5,372,082	5%
Noncapital grants	12,466,739	12,770,173	(303,434)	(2)%
Noncapital subsidies from State	3,547,896	3,547,896	–	0%
Other nonoperating revenues and expenses, net	(16,009,627)	(12,352,080)	(3,657,547)	30%
Investment income, net	10,325,302	2,231,613	8,093,690	363%
Interest expense	(13,477,470)	(1,939,102)	(11,538,368)	595%
Total nonoperating revenues, net	115,927,750	117,961,327	(2,033,577)	(2)%
Increase in net position	51,083,044	93,347,459	(42,264,415)	(45)%
Net position, beginning of year	207,168,312	113,820,853	93,347,459	82%
Net position, end of year	$ 258,251,356	$ 207,168,312	$ 51,083,044	25%

Operating Losses

The first component of the overall change in the District's net position is its operating loss – generally, the difference between total operating revenues and total operating expenses incurred to perform services. Net patient service revenue includes inpatient, outpatient and emergency services provided to patients. Net patient service revenue for the year ended June 30, 2020, was $454,144,793, which was an increase from the prior year net patient service revenue of $427,301,404. Net patient service revenue increased $26,843,389 or 6% in the year ended June 30, 2020, due to increased patient activity, improved payor mix, and continuous improvement in cash collections in the business office. Net patient service revenue was fairly consistent for the year ended June 30, 2019 compared to June 30, 2018, decreasing by $9,857,335 or 2%.

Other operating revenues included four significant sources of income during the years ended June 30, 2020, 2019 and 2018: (1) the receipt of $3,870,564, $3,196,013, and $4,683,635, respectively, of AHCCCS and Medicare disproportionate share funding to assist in providing additional resources to offset some of the costs associated with serving lower-income and medically complex residents of Maricopa County, (2) the receipt of $42,516,595, $38,607,817, and $39,721,412, respectively, from AHCCCS for medical education support, (3) the receipt of $2,189,782, $2,302,959, and $2,423,157, respectively, from AHCCCS for trauma services, and (4) the receipt of $20,580,000, $17,417,472, and $18,755,931, respectively, from our 340(b) program partnership with contracted pharmacies.

Total operating revenues in fiscal year 2020 were $548,956,484 in comparison with the prior year of $507,814,071, due in great part to the quality of gross revenue and improved payor mix as noted above.

Total operating expenses in fiscal year 2020 were $669,729,662, which is an increase of $97,070,885 (17%) over the prior year operating expenses of $572,658,777. Of the total increase, $59,217,066 or 61% of the increase is related to increased salaries and wages and employee benefits expense due to higher patient volumes, a higher case mix index and related additional patient days (18.9% increase). Depreciation increased by $3,903,525 related to routine capital additions and renovation of the Maryvale Hospital.

Total operating expenses in fiscal year 2019 were $572,658,777, which is an increase of $37,726,447 (7%) over the prior year operating expenses of $534,932,330. Of the total increase, $8,087,429 or 21% is related to the opening of the Maryvale Hospital in April 2019. Additionally, salaries increased due to higher patient volumes, higher case mix index and related additional patient days (6.2% increase). Depreciation increased by $3,199,414 related to routine capital

additions and the acquisition and renovation of the Maryvale Hospital. Total operating expenses decreased by $94,271,880 in fiscal year 2018 primarily due to the decrease in medical claims and other expenses of $126,387,345, which was a result of the sale of the health plan membership.

Nonoperating Revenues and Expenses

Nonoperating revenues and expenses consist primarily of property tax receipts, both for maintenance and operation, bond debt service, and CARES Act funding. These amounts were $80,459,388 and $62,843,633, respectively, for the year ended June 30, 2020, $76,921,021 and $42,153,889, respectively, for the year ended June 30, 2019, and $73,820,558 and $39,882,270, respectively, for the year ended June 30, 2018. The increase in the property tax receipts of 20% and 5% for the years ended June 30, 2020 and 2019, respectively, was primarily due to additional tax levies to cover the increase in bond debt service costs. Also included in nonoperating revenues are noncapital grants and noncapital subsidies from the state. These amounts were $11,915,514 and $3,547,896, respectively, for the year ended June 30, 2020, $12,466,739 and $3,547,896, respectively, for the year ended June 30, 2019, and $12,770,173 and $3,547,896, respectively, for the year ended June 30, 2018. These noncapital grants were consistent year-over-year. Other nonoperating revenues and expenses for the year ended June 30, 2020 and 2019 consisted primarily of investment income, interest expense and other nonoperating expenses. Investment income and interest income for the year ended June 30, 2020 were consistent with the prior year. Investment income for the year ended June 30, 2019 increased from the prior year by $8,093,690 due to the purchase of additional short-term investments. Interest expense for the year ended June 30, 2019 increased from the prior year by $11,538,368 due to issuance of $422,125,000 of general obligation bonds.

The District's Cash Flows

Changes in the District's cash flows are consistent with changes in operating losses and nonoperating revenues and expenses discussed earlier. Net cash used in operating activities for the years ended June 30, 2020, 2019, and 2018 was $38,656,524, $69,230,854, and $12,167,515, respectively.

Capital Assets

As of June 30, 2020 and 2019, the District had $501,967,393 and $359,840,756, respectively, invested in capital assets, net of accumulated depreciation. For the years ended June 30, 2020, 2019, and 2018, the District purchased capital assets amounting to $173,318,601, $133,631,463, and $54,496,214, respectively.

Debt

As of June 30, 2020, 2019, and 2018, the District had bonds payable of $493,170,813, $538,541,763 and $112,000,000, respectively. As set forth in the voter approved Proposition 480 language, bond proceeds are used to purchase various equipment and to fund various improvement projects on the District's existing acute, behavioral health facilities and outpatient health centers. A portion of the bond proceeds, $36,000,000, was used to reimburse the District's general fund for prior capital asset purchases. At June 30, 2018, the District had notes payable to Maricopa County in the amount of $1,414,972. The District did not have any notes payable to Maricopa County at June 30, 2020 and 2019. For the years ended June 30, 2020, 2019, and 2018, the District had capital lease and other long-term obligations totaling $507,041, $1,260,762, and $1,979,716, respectively, to various other entities.

Contacting the District's Financial Management

This financial report is designed to provide the District's patients, suppliers, community members, and creditors with a general overview of the District's finances and to show the District's accountability for the money it receives. Questions about this report and requests for additional financial information should be directed to District Administration by telephoning (602) 344-8425.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Net Position

	June 30 2020	June 30 2019
Assets		
Current assets:		
Cash and cash equivalents	**$ 210,048,255**	$ 77,820,581
Short-term investments	**50,913,029**	106,237,284
Restricted cash – bonds	**70,373,184**	53,635,121
Restricted short-term investments – bonds	**69,958,826**	289,276,568
Patient accounts receivable, net of allowances	**91,656,453**	88,602,464
Receivable from AHCCCS for medical education, net	**10,198,375**	38,607,817
Other receivables	**17,912,959**	10,287,323
Due from related parties	**1,204,159**	1,680,183
Supplies	**8,837,983**	8,217,459
Prepaid expenses	**16,100,952**	14,998,600
Total current assets	**547,204,175**	689,363,400
Other assets:		
Long-term investments	**–**	49,793,027
Restricted cash – bonds	**175,203,778**	117,944,563
Total other assets	**175,203,778**	167,737,590
Capital assets:		
Land	**25,342,118**	25,342,118
Depreciable capital assets, net of accumulated depreciation	**476,625,275**	334,498,638
Total capital assets, net of accumulated depreciation	**501,967,393**	359,840,756
Total assets	**1,224,375,346**	1,216,941,746
Deferred outflows of resources		
Contributions made after measurement date	**29,900,925**	26,299,277
Difference between expected and actual experience	**5,787,664**	8,300,275
Changes in assumptions	**2,708,042**	9,703,066
Change in proportion and differences between employer contributions and proportionate share of contributions	**10,402,756**	20,745,644
Total deferred outflows of resources	**$ 48,799,387**	$ 65,048,262

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Net Position (continued)

	June 30 2020	June 30 2019
Liabilities and net position		
Current liabilities:		
Current maturities of long-term debt	**$ 30,507,041**	$ 38,638,652
Accounts payable	**51,920,034**	47,187,750
Accrued payroll and expenses	**32,597,614**	26,306,854
Risk claims payable	**1,484,931**	2,650,000
Overpayments from third-party payors	**33,783,500**	10,799,859
Other current liabilities	**35,172,324**	37,699,463
Total current liabilities	**185,465,444**	163,282,578
Risk claims payable less current portion	**10,660,315**	11,177,826
Net pension and OPEB liability	**311,945,423**	300,585,929
Long-term debt	**463,170,813**	501,163,873
Total liabilities	**971,241,995**	976,210,206
Deferred inflows of resources		
Difference between expected and actual experience	**776,644**	2,379,274
Change in assumptions	**12,389,925**	26,620,261
Difference between projected and actual investment earnings	**7,804,600**	8,896,932
Change in proportion and differences between employer contributions and proportionate share of contributions	**2,979,114**	9,631,979
Total deferred inflows of resources	**23,950,283**	47,528,446
Net position:		
Unrestricted deficit	**(213,062,448)**	(128,763,175)
Net investment in capital assets	**242,926,918**	212,962,293
Restricted for bonds	**245,576,963**	171,579,684
Restricted for grants	**2,541,022**	2,472,554
Total net position	**$ 277,982,455**	$ 258,251,356

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Revenues, Expenses and Changes in Net Position

	June 30	
	2020	**2019**
Operating revenues:		
Net patient service revenue	**$ 454,144,793**	$ 427,301,404
AHCCCS medical education revenue	**42,516,595**	38,607,817
Other revenue	**52,295,096**	41,904,850
Total operating revenues	**548,956,484**	507,814,071
Operating expenses:		
Salaries and wages	**267,919,233**	242,211,381
Employee benefits	**81,795,822**	48,286,608
Purchased services	**138,223,397**	122,387,122
Other expenses	**59,751,185**	52,736,053
Supplies	**90,233,509**	79,134,622
Depreciation	**31,806,516**	27,902,991
Total operating expenses	**669,729,662**	572,658,777
Operating loss	**(120,773,178)**	(64,844,706)
Nonoperating revenues (expenses):		
Property tax receipts	**143,303,021**	119,074,910
Noncapital grants	**11,915,514**	12,466,739
Noncapital subsidies from State	**3,547,896**	3,547,896
Other nonoperating revenues and expenses, net	**(12,868,425)**	(16,009,627)
Investment income, net	**8,344,261**	10,325,302
Interest expense	**(13,737,990)**	(13,477,470)
Total nonoperating revenues, net	**140,504,277**	115,927,750
Increase in net position	**19,731,099**	51,083,044
Net position, beginning of year	**258,251,356**	207,168,312
Net position, end of year	**$ 277,982,455**	$ 258,251,356

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Cash Flows

	Year Ended June 30 2020	2019
Operating activities		
Receipts from and on behalf of patients	**$ 451,090,804**	$ 414,308,113
Payments to suppliers and contractors	**(286,363,752)**	(248,831,451)
Payments to employees	**(315,815,926)**	(310,351,015)
Other operating receipts	**122,605,977**	83,957,296
Other operating payments	**(10,173,627)**	(8,313,797)
Net cash used in operating activities	**(38,656,524)**	(69,230,854)
Noncapital financing activities		
Property tax receipts supporting operations	**80,459,388**	76,921,021
Noncapital contributions and grants received	**11,915,514**	12,466,739
Noncapital subsidies and other nonoperating payments	**(9,320,529)**	(12,461,731)
Net cash provided by noncapital financing activities	**83,054,373**	76,926,029
Capital and related financing activities		
Property tax receipts for debt service	**62,843,633**	42,153,889
Principal payments on long-term debt and capital leases	**(46,124,672)**	(39,133,926)
Purchase of capital assets	**(173,933,153)**	(133,631,463)
Bond proceeds	**–**	463,541,763
Interest paid on long-term debt	**(13,737,990)**	(1,472,479)
Net cash (used in) provided by capital and related financing activities	**(170,952,182)**	331,457,784
Investing activities		
Proceeds from sale of investments	**324,435,024**	470,070,257
Purchases of investments	**–**	(798,197,445)
Interest from investments	**8,344,261**	10,325,302
Net cash provided by (used in) investing activities	**332,779,285**	(317,801,886)
Increase in cash and cash equivalents including restricted cash	**206,224,952**	21,351,073
Cash and cash equivalents including restricted cash, beginning of year	**249,400,265**	228,049,192
Cash and cash equivalents including restricted cash, end of year	**$ 455,625,217**	$ 249,400,265

Maricopa County Special Health Care District
d/b/a Valleywise Health

Statements of Cash Flows (continued)

	Year Ended June 30 2020	2019
Reconciliation of operating loss to net cash used in operating activities		
Operating loss	**$ (120,773,178)**	$ (64,844,706)
Depreciation	**31,806,516**	27,902,991
Changes in operating assets and liabilities:		
Patient, other accounts receivable, and other assets	**17,729,816**	(10,628,400)
Due from related parties	**476,024**	239,993
Supplies and prepaid expenses	**(1,722,876)**	(2,498,909)
Overpayments from third-party payors	**22,983,641**	839,745
Risk claims payable	**(1,682,580)**	785,649
Accounts payable and accrued expenses	**12,526,113**	(21,027,217)
Net cash used in operating activities	**$ (38,656,524)**	$ (69,230,854)

See accompanying notes.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Notes to Financial Statements

June 30, 2020

1. Nature of Operations and Summary of Significant Accounting Policies

Nature of Operations and Reporting Entity

Maricopa County Special Health Care District d/b/a Valleywise Health (the District or VW) is a health care district and political subdivision of the state of Arizona. The District is located in Phoenix, Arizona, and is governed by a five-member Board of Directors elected by voters within Maricopa County, Arizona (the County).

The District was created in November 2003 by an election of the voters of the County. In November 2004, the voters first elected the District's governing board. An Intergovernmental Agreement (IGA) between the District and the County was entered into in November 2004, which, among other things, specified the terms by which the County transferred essentially all of the assets, liabilities, and financial responsibility of the medical center facility to the District effective January 1, 2005. The District operates a medical center facility (the Medical Center), which was formerly owned and operated by the County; freestanding inpatient behavioral health facilities located on the Medical Center campus and in Maryvale, Arizona and Mesa, Arizona; a specialty clinic located on the Medical Center campus; and various outpatient health centers throughout Maricopa County. The District has the authority to levy ad valorem taxes. The District had no significant operations prior to January 1, 2005. In conjunction with the IGA, the County and the District entered into a 20-year lease for the Medical Center real estate.

On September 3, 2013, a second Amended and Restated Intergovernmental Agreement (the Amended IGA) was entered into by the District whereby all the land and real property located at the Maricopa Medical Center and Desert Vista campuses (the Property) subject to the prior 20-year lease were donated to the District. The Property was recorded at its fair value at date of donation, determined by a third-party valuation services firm, totaling $117,075,000. The Property donated consisted of land of $9,000,000, buildings of $104,375,000 and land improvements of $3,700,000.

The Amended IGA also provided for the District's purchase of supplies from the County and the sublease of certain space to the County, and for the County to be able to purchase supplies and utilize the District's services, among other items.

If the Property is not used for county hospital purposes, the Property shall (at the election of the County) revert to the County.

Effective October 1, 2019, as a part of a rebranding initiative, the District, which was formerly known as Maricopa Integrated Health System, is now officially called Valleywise Health.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Basis of Accounting and Presentation

The District prepares its financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB). The financial statements of the District have been prepared on the accrual basis of accounting using the economic resources measurement focus. Revenues, expenses, gains, losses, assets, and liabilities from exchange and exchange-like transactions are recognized when the exchange transaction takes place, while those from government-mandated and voluntary non-exchange transactions (principally federal and state grants and appropriations from the County) are recognized when all applicable eligibility requirements are met. Operating revenues and expenses include exchange transactions and interest on capital assets-related debt are included in nonoperating revenues and expenses. The District first applies its restricted net position when an expense or outlay is incurred for purposes for which both restricted and unrestricted net position are available. The District primarily earns revenues by providing inpatient and outpatient medical services.

Cash and Cash Equivalents and Restricted Cash

For purposes of the statements of cash flows, the District considers all liquid investments, including those that are restricted, with original maturities of three months or less, to be cash equivalents. At June 30, 2020 and 2019, the District had approximately $455,625,000 and $249,400,000, respectively, of cash and cash equivalents and restricted cash. Restricted cash includes cash and cash equivalents that are restricted for use and includes approximately $70,373,000 and $53,635,000 as of June 30, 2020 and 2019, respectively, of tax proceeds restricted for debt service on the general obligation bonds and approximately $175,204,000 and $117,945,000 as of June 30, 2020 and 2019, respectively, of bond proceeds restricted for use under the bond agreement. A portion of the restricted cash has been classified as a long-term asset as the funds will be used to purchase long-term assets.

Investments

The District records its investments in accordance with GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools,* and GASB Statement No. 72, *Fair Value Measurement and Application.*

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

The District categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles in the United States (U.S. GAAP). These guidelines recognize a three-tiered fair value hierarchy, as follows:

- Level 1: Unadjusted quoted prices for identical investments in active markets
- Level 2: Observable inputs other than quoted market prices
- Level 3: Unobservable inputs

Risk Management

The District is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries; medical malpractice; and natural disasters. The District participated in the County's self-insurance program through December 3, 2012. The IGA between the District and County was amended to reflect that the District would no longer participate in the County's self-insurance program effective December 4, 2012, except for workers' compensation claims. The Amended IGA also stipulated that the County would provide a mutually agreed-upon amount to fund estimated outstanding losses and estimated future claim payments for the period January 1, 2005, through December 3, 2012. In return, the District accepted responsibility for the payment and management of these claims on an ongoing basis.

The District, through its Risk Management Department, is now responsible for identifying and resolving exposures and claims that arise from employee work-related injury, third-party liability, property damage, regulatory compliance, and other exposures arising from the District's operations. Effective December 4, 2012, the District's Board of Directors approved and implemented risk management, self-insurance, and purchased insurance programs under the Maricopa Integrated Health System Risk Management Insurance and Self-Insurance Plan (the Insurance Plan). As authorized under the Insurance Plan, the District purchases excess insurance over the District's self-insured program to maintain adequate protection against the District's exposures and claims filed against the District. It is the District's policy to record the expense and related liability for professional liability, including medical malpractice and workers' compensation, based upon annual actuarial estimates.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Patient Accounts Receivable

The District reports patient accounts receivable for services rendered at estimated net realizable amounts due from third-party payors, patients, and others. The District provides an allowance for uncollectible accounts based upon a review of outstanding receivables, historical collection information, and existing economic conditions. The District bills third-party payors directly and bills the patient when the patient's liability is determined. Patient accounts receivable are due in full when billed. Accounts are considered delinquent and subsequently written off based on individual credit evaluation and specific circumstances of the account.

Supplies

Supplies inventories are stated at the lower of cost or market, determined using the first-in, first-out method.

Capital Assets

Capital assets are recorded at cost at the date of acquisition, or fair value at the date of donation if acquired by gift. The dollar threshold to capitalize capital assets is $5,000. Depreciation is computed using the straight-line method over the estimated useful life of each asset. Assets under capital lease obligations and leasehold improvements are amortized over the shorter of the lease term or the assets' respective estimated useful lives. The following estimated useful lives are being used by the District:

Land improvements	2–25 years
Buildings and leasehold improvements	5–40 years
Equipment	3–20 years

Compensated Absences

District policies permit most employees to accumulate vacation and sick leave benefits (personal leave) that may be realized as paid time off or, in limited circumstances, as a cash payment. Expense and the related liability are recognized as personal leave benefits and are earned whether the employee is expected to realize the benefit as time off or as a cash payment. Employees may accumulate up to 240 hours of personal leave, depending on years of service, but any personal

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

leave hours in excess of the maximum amount that are unused by the calendar year-end are converted to the employee's extended illness bank (EIB). Generally, EIB benefits are used by employees for extended illness or injury, or to care for an immediate family member with an extended illness or injury. EIB benefits are cumulative but do not vest and, therefore, are not accrued. However, upon retirement, employees with accumulated EIB in excess of 1,000 hours are entitled to a $3,000 bonus. The total compensated absence liabilities are computed using the regular pay and termination pay rates in effect at the statement of net position date plus an additional amount for compensation-related payments such as social security and Medicare taxes, computed using rates in effect at that date.

Net Position

Net position of the District is classified into three components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the outstanding balances of borrowings used to finance the purchase or construction of those assets. Restricted net position consists of noncapital assets that must be used for a particular purpose as specified by creditors, grantors, or donors external to the District. Unrestricted net position consists of the remaining assets plus deferred outflows of resources less remaining liabilities plus deferred inflows of resources that do not meet the definition of net investment in capital assets, or restricted net position.

Net Patient Service Revenue

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered and includes estimated retroactive adjustments and a provision for uncollectible accounts. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such estimated amounts are revised in future periods as adjustments become known. The District participates in the Federally Qualified Health Center (FQHC) program and receives supplemental payments from AHCCCS. The payments are made based on information filed with AHCCCS on the Annual Reconciliation and Rebase Data (ARRD) report. The District is currently in contact with AHCCCS regarding the Federal Fiscal Year (FFY) 2019 ARRD report filing and payment reconciliation. AHCCCS had made some changes in the reconciliation process between AHCCCS, the health plans and the providers. AHCCCS final decision is not expected until fiscal year 2021.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Charity Care

The District provides services at amounts less than its established rates to patients who meet the criteria of its charity care policy. The criteria for charity care take into consideration the patient's family size and income in relation to federal poverty guidelines and type of service rendered. The total net cost of charity care provided was approximately $45,110,000 and $38,027,000 for the years ended June 30, 2020 and 2019, respectively. Charity care cost is based on the percentage of total direct operating expenses less other operating revenue divided by the total gross revenue for the Medical Center. This percentage is applied to the amount written off as charity care to determine the total charity care cost. The net cost of charity care is total charity care cost less any payments received. Payments received were approximately $15,604,000 and $14,284,000 for the years ended June 30, 2020 and 2019, respectively.

Property Taxes

On or before the third Monday in August, the County levies real property taxes and commercial personal property taxes on behalf of the District, which become due and payable in two equal installments. The first installment is due on the first day of October and becomes delinquent after the first business day of November. The second installment is due on the first day of March of the next year and becomes delinquent after the first business day of May.

The County also levies mobile home personal property taxes on behalf of the District that are due the second Monday of the month following receipt of the tax notice and become delinquent 30 days later. A lien assessed against real and personal property attaches on the first day of January after assessment and levy.

Proposition 480 allows the County to levy additional property taxes for principal and interest debt service related to general obligation bonds (see Note 10).

Income Taxes

The District is a health district and political subdivision of the state of Arizona and is exempt from federal and state income taxes.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

Pension and Postemployment Benefits Other than Pensions (OPEB)

The District participates in the Arizona State Retirement System (ASRS) pension plan for employees. For purposes of measuring the net pension and OPEB liability, deferred outflows of resources and deferred inflows of resources related to pension and OPEB, and pension and OPEB expense, information about the fiduciary net position of ASRS and additions to/deductions from ASRS's fiduciary net position have been determined on the same basis as they are reported by ASRS. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit plan terms. Investments are reported at fair value.

New Accounting Pronouncements

The GASB issued Statement No. 84, *Fiduciary Activities*, in January 2017. The standard establishes criteria for identifying fiduciary activities of all state and local governments. The standard identifies four fiduciary funds that should be reported, if applicable: (1) pension (and other employee benefit) trust funds, (2) investment trust funds, (3) private-purpose trust funds, and (4) custodial funds. The standard is effective for the District as of July 1, 2020. The District is evaluating the impact of adopting the accounting standard.

The GASB issued Statement No. 87, *Leases*, in June 2017. The standard requires recognition of certain lease assets and liabilities for leases that previously were classified as operating leases. The guidance establishes a single model for lease accounting based on the principle that leases are financing the right to use an underlying asset. The standard is effective for the District as of July 1, 2021. The District is evaluating the impact of adopting the accounting standard.

The GASB issued Statement No. 89, *Accounting for Interest Cost Incurred before the End of a Construction Period*, in June 2018. The standard requires that interest cost incurred before the end of a construction period be recognized as an expense in the period in which the cost is incurred for financial statements prepared using the economic resources measurement focus. As a result, interest cost incurred before the end of a construction period will not be included in the historical cost of a capital asset reported in a business-type activity or enterprise fund. The standard is effective for the District as of July 1, 2021. The District is evaluating the impact of adopting the accounting standard.

1. Nature of Operations and Summary of Significant Accounting Policies (continued)

The GASB issued Statement No. 96, *Subscription-Based Information Technology Arrangements*, in May 2020. The standard requires recognition of certain subscription-based information technology arrangements (SBITAs) as intangible assets and corresponding subscription liabilities for SBITAs that previously were classified as operating arrangements. The guidance establishes a model based on the standards established in Statement No. 87, *Leases*, to treat SBITAs as financing the right to use an underlying subscription asset. The standard is effective for the District as of July 1, 2022. The District is evaluating the impact of adopting the accounting standard.

2. Net Patient Service Revenue

Net patient service revenue is presented net of provision for uncollectible accounts of approximately $39,137,000 and $42,397,000 for the years ended June 30, 2020 and 2019, respectively.

The District has agreements with third-party payors that provide for payments to the District at amounts different from its established rates. These payment arrangements include the following:

- Medicare – Inpatient acute care services, certain inpatient non-acute care services, and substantially all outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, acuity, and other factors. Inpatient psychiatric services are paid based on a blended cost reimbursement methodology and prospectively determined rates. The District is reimbursed for certain services at tentative rates with final settlement determined after submission of annual cost reports by the District and audits thereof by the Medicare fiscal intermediary. The Medicare fiscal intermediary has audited the District's cost reports through June 30, 2017.

- AHCCCS – Inpatient acute services are paid at prospectively determined rates. Inpatient psychiatric services are paid on a per diem basis. Outpatient services rendered to AHCCCS program beneficiaries are primarily reimbursed under prospectively determined rates.

- The District has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

2. Net Patient Service Revenue (continued)

Approximately 55% and 56% of net patient service revenues were from participation in the Medicare and state sponsored AHCCCS programs for the years ended June 30, 2020 and 2019, respectively. Laws and regulations governing the Medicare and AHCCCS programs are complex and subject to interpretation and change. As a result, it is reasonably possible that recorded estimates will change materially in the near term.

3. AHCCCS Safety Net Care Pool

The District participated in the AHCCCS Safety Net Care Pool (SNCP) program that provided reimbursement to Safety Net Hospitals for uncompensated cost incurred in providing services to Medicaid and uninsured/underinsured patients. The program was terminated by AHCCCS effective December 31, 2013. Amounts recorded under the SNCP program are subject to final settlement by AHCCCS.

4. Deposits and Investments

The District's deposits are held by the County in separate accounts, and the District can draw them upon demand. A compensating balance is maintained in these accounts at a sufficient amount so that earnings on these accounts offset the fees charged for services. Any amounts above the compensating balance are swept daily overnight into a commercial paper investment account.

Fair Value Measurements

The District categorizes its fair value measurements within the fair value hierarchy established by U.S. GAAP. The hierarchy is based on the inputs used in valuation and gives the highest priority to unadjusted quoted prices in active markets and requires that observable inputs be used in the valuation when available. The disclosure of fair value estimates in the hierarchy is based on whether the significant inputs into the valuations are observable. In determining the level of the hierarchy in which the estimate is disclosed, the highest level, Level 1, is given to unadjusted quoted prices in active markets and the lowest level, Level 3, to unobservable inputs.

4. Deposits and Investments (continued)

In instances where inputs used to measure fair value fall into different levels, fair value measurements in their entirety are categorized based on the lowest level of input that is significant to the valuation. The District's assessment of the significance of particular inputs to these measurements requires judgment and considers factors specific to each investment. The table below shows the fair value leveling of the District's investments:

	June 30, 2020			
	Level 1	**Level 2**	**Level 3**	**Total**
Government agencies	**$ –**	**$ 26,290,367**	**$ –**	**$ 26,290,367**
Government bonds	**–**	**34,604,183**	**–**	**34,604,183**
Corporate bonds	**–**	**24,622,662**	**–**	**24,622,662**
Short-term bills and notes – U.S. agencies	**35,354,643**	**–**	**–**	**35,354,643**
	$ 35,354,643	**$ 85,517,212**	**$ –**	**$ 120,871,855**

	June 30, 2019			
	Level 1	**Level 2**	**Level 3**	**Total**
Government agencies	$ –	$ 26,114,305	$ –	$ 26,114,305
Government bonds	–	215,506,747	–	215,506,747
Corporate bonds	–	24,235,902	–	24,235,902
Short-term bills and notes – U.S. agencies	179,449,925	–	–	179,449,925
	$ 179,449,925	$ 265,856,954	$ –	$ 445,306,879

4. Deposits and Investments (continued)

Interest Rate Risk

Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. At June 30, 2020, the District's funds were held in cash, cash equivalents, and restricted cash and carrying value equates to fair value.

The District had the following investments with the respective weighted-average maturity in years:

	June 30, 2020	
	Fair Value	**Weighted-Average Maturity**
Government agencies	**$ 26,290,367**	**0.42**
Government bonds	**34,604,183**	**0.19**
Corporate bonds	**24,622,662**	**0.41**
Short-term bills and notes – U.S. agencies	**35,354,643**	**0.19**
	$ 120,871,855	**1.21**

Credit Risk

Credit risk is the risk that the counterparty to an investment will not fulfill its obligation. At June 30, 2020, the District's funds were held by Northern Trust Bank. The District has adopted an investment policy that authorizes the following instruments for investment: (1) negotiable direct obligations of, or obligations the principal and interest of which are unconditionally guaranteed by, the United States government; (2) obligations of federal agencies and instrumentalities; (3) interest-bearing notes, bonds, debentures, and other such evidence of indebtedness with a fixed maturity of any domestic listed corporation within the United States that when purchased carry ratings in one of the three highest classifications of at least two nationally recognized debt rating agencies; and (4) municipal bond investments that carry ratings in one of the top two classifications of at least two nationally recognized rating agencies or secured by bond insurance.

4. Deposits and Investments (continued)

The District's investment securities have the following credit ratings as shown below:

	June 30, 2020	
	Fair Value	**Credit Rating***
Government agencies	**$ 26,290,367**	**Aaa**
Government bonds	**34,604,183**	**Aaa**
Corporate bonds	**8,630,205**	**Aa2**
Corporate bonds	**15,992,457**	**A1**
Short-term bills and notes – U.S. agencies	**35,354,643**	**Aaa**
	$ 120,871,855	

*Moody's ratings

5. Patient Accounts Receivable

The District grants credit without collateral to its patients, many of whom are area residents and are insured under third-party payor agreements. Patient accounts receivable is presented net of allowance for uncollectible accounts of $60,481,000 and $53,639,000 for the years ended June 30, 2020 and 2019, respectively.

6. Other Receivables

At June 30, 2020 and 2019, significant components of other receivables included amounts due from third party payors, such as:

	2020	**2019**
Due from District Medical Group	**$ 1,698,000**	$ 1,343,000
340B program	**1,266,000**	1,820,000
Home Assist Health	**1,008,000**	1,000,000
Disproportionate Share Receivable	**4,352,000**	–
Other	**9,588,959**	6,124,323
Total other receivables	**$ 17,912,959**	$ 10,287,323

7. Receivables from AHCCCS for Medical Education

During the years ended June 30, 2020 and 2019, the District entered into intergovernmental agreements with AHCCCS such that AHCCCS provided available medical education funds from CMS. At June 30, 2020 and 2019, available funds from CMS for medical education totaled approximately $13,957,000 and $55,288,000, respectively. At June 30, 2020 and 2019, the amount due to the District is approximately $10,198,000, which is net of the $3,759,000 matching funds provided by the District, and $38,608,000, which is net of the $16,680,000 matching funds provided by the District, respectively.

8. Capital Assets

Capital assets activity for the year ended June 30, 2020, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Adjustments	Ending Balance
Capital assets not being depreciated:						
Construction-in-progress	$ 113,227,456	$ 173,933,153	$ –	$ (116,408,634)	$ –	$ 170,751,975
Capitalized software-in-progress	330,119	–	–	–	–	330,119
Land	25,342,118	–	–	–	–	25,342,118
Capital assets being depreciated:						
Buildings and leasehold improvements	243,678,432	–	(589,580)	75,939,976	–	319,028,828
Capitalized software	49,516,241	–	–	–	–	49,516,241
Equipment	187,897,838	–	(24,973)	40,468,658	–	228,341,523
Total capital assets	619,992,204	173,933,153	(614,553)	–	–	793,310,804
Less accumulated depreciation:						
Buildings and leasehold improvements	87,261,048	14,385,110	(589,580)	–	–	101,056,578
Capitalized software	46,858,275	–	–	–	(87,631)	46,770,644
Equipment	126,032,125	17,509,037	(24,973)	–	–	143,516,189
Total accumulated depreciation	260,151,448	31,894,147	(614,553)	–	(87,631)	291,343,411
Capital assets, net	$ 359,840,756	$ 142,039,006	$ –	$ –	$ (87,631)	$ 501,967,393

8. Capital Assets (continued)

Capital assets activity for the year ended June 30, 2019, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Adjustments	Ending Balance
Capital assets not being depreciated:						
Construction-in-progress	$ 54,745,770	$ 133,691,789	$ –	$ (75,210,103)	$ –	$ 113,227,456
Capitalized software-in-progress	330,119	–	–	–	–	330,119
Land	25,482,118	–	(140,000)	–	–	25,342,118
Capital assets being depreciated:						
Buildings and leasehold improvements	207,089,031	–	–	36,589,401	–	243,678,432
Capitalized software	49,516,241	–	–	–	–	49,516,241
Equipment	149,197,462	79,674	–	38,620,702	–	187,897,838
Total capital assets	486,360,741	133,771,463	(140,000)	–	–	619,992,204
Less accumulated depreciation:						
Buildings and leasehold improvements	75,622,375	11,638,673	–	–	–	87,261,048
Capitalized software	44,473,935	2,384,340	–	–	–	46,858,275
Equipment	112,152,147	13,879,978	–	–	–	126,032,125
Total accumulated depreciation	232,248,457	27,902,991	–	–	–	260,151,448
Capital assets, net	$ 254,112,284	$ 105,868,472	$ (140,000)	$ –	$ –	$ 359,840,756

9. Risk Claims Payable

The District maintains insurance through a combination of programs utilizing purchased commercial insurance and self-insurance for professional liability claims, including medical malpractice and workers' compensation claims. The District is self-insured for workers' compensation in Arizona. In connection with the aforementioned programs, the District has accrued estimates for asserted and incurred but not reported claims. The actuarially determined claims payable is approximately $12,145,000 and $13,828,000, of which $1,485,000 and $2,650,000 has been recorded as a current liability and approximately $10,660,000 and $11,178,000 has been recorded as a noncurrent liability on the accompanying statements of net position as of June 30, 2020 and 2019, respectively. Risk claims payable are undiscounted.

9. Risk Claims Payable (continued)

As of June 30, 2020, the District maintained commercial insurance as follows:

Insurance	Limits	Self-Insured Retention/Deductible
Workers' compensation	Statutory	$500,000 each claim
Medical malpractice	$25,000,000 each incident – first layer	
	Additional $10,000,000 – second excess layer	$2,000,000 each incident
	Additional $15,000,000 – third excess layer	Additional $1,000,000 one claim layer buffer

The insurance policies listed above became effective December 1, 2012 and remain current through June 30, 2020.

The following is a reconciliation of the risk claims payable as for the years ended June 30:

	2020	2019	2018
Beginning balance	**$ 13,827,826**	$ 13,042,177	$ 11,260,708
Total incurred	**4,320,165**	4,793,547	6,424,780
Total paid	**(6,002,745)**	(4,007,898)	(4,643,311)
Ending balance	**$ 12,145,246**	$ 13,827,826	$ 13,042,177

10. Long-Term Debt and Capital Leases

The following is a summary of long-term debt transactions for the District for the years ended June 30:

	Beginning Balance	Additions	Reductions	Ending Balance	Current Portion
2020					
General obligation bonds	**$ 463,541,763**	**$ –**	**$ (7,370,950)**	**$ 456,170,813**	**$ 10,000,000**
Direct placement general obligation bonds	**75,000,000**	**–**	**(38,000,000)**	**37,000,000**	**20,000,000**
Note payable and credit facility, Maricopa County	**–**	**–**	**–**	**–**	**–**
Capital lease obligations	**1,260,762**	**–**	**(753,721)**	**507,041**	**507,041**
Total long-term debt	**$ 539,802,525**	**$ –**	**$ (46,124,671)**	**$ 493,677,854**	**$ 30,507,041**
2019					
General obligation bonds	$ –	$ 464,994,983	$ (1,453,220)	$ 463,541,763	$ –
Direct placement general obligation bonds	112,000,000	–	(37,000,000)	75,000,000	38,000,000
Note payable and credit facility, Maricopa County	1,414,970	–	(1,414,970)	–	–
Capital lease obligations	1,979,718	79,674	(798,630)	1,260,762	638,652
Total long-term debt	$ 115,394,688	$ 465,074,657	$ (40,666,820)	$ 539,802,525	$ 38,638,652

General Obligation Bonds

On November 4, 2014, the voters of the County approved Proposition 480. Proposition 480 allows the District to issue up to $935,000,000 in general obligation bonds to be repaid over 30 years to fund outpatient health facilities, including improvement or replacement of existing outpatient health centers; construction of new outpatient health centers in northern, eastern, and/or western Maricopa County, behavioral health facilities, including construction of a new behavioral health hospital; and acute care facilities, including replacement of the District's public teaching hospital Maricopa Medical Center and its Level One Trauma Center and Arizona Burn Center, on the existing campus.

10. Long-Term Debt and Capital Leases (continued)

On August 6, 2015, the District closed its first offering of general obligation bonds in the amount of $106,000,000 in order to start various improvement projects on its existing outpatient health centers and behavioral health facilities. The bonds bear interest at the rate of 2.450% through maturity in fiscal year 2019. A portion of the $106,000,000 bond proceeds was also used to reimburse the District's general fund for prior capital asset purchases totaling $36,000,000. These bonds were paid off in full during fiscal year 2019.

On October 12, 2017, the District closed on its second offering of general obligation bonds in the amount of $75,000,000 in order to continue the various improvement projects. The bonds bear interest at the rate of 1.610% through maturity in fiscal year 2022. Financing for the District's first and second offering were both private placements.

On October 30, 2018, the District closed on its third offering of general obligation bonds in the amount of $422,125,000 in order to continue the various improvement projects. The bond was issued at a premium of $42,870,000. The bonds bear coupon interest at the rate of 5.00% through maturity in fiscal year 2038. Financing for the District's third offering were public placements.

Proposition 480 allows the County to levy additional property taxes for principal and interest debt service related to the general obligation bonds.

The bond purchase agreements also contain certain nonfinancial covenants, including the maintenance of property and annual reporting requirements. Management believes it is in compliance with these covenant requirements at June 30, 2020.

Note Payable and Credit Facility, Maricopa County

As part of the Amended IGA, the District issued a note payable to the County for $433,000, which was due in August 2015. This amount relates to the cost incurred by the County on behalf of the District in relation to the election held in November 2004. This note payable to the County was interest free for the first five years. The note bore interest at a rate of 1.52% through its original maturity in 2015.

The County agreed to extend the District a $15,000,000 credit facility in connection with the Amended IGA. Any amounts borrowed under the credit facility were previously payable to the County in their entirety in August 2015. Borrowings under this credit facility were $15,000,000 and were interest free for the first five years.

10. Long-Term Debt and Capital Leases (continued)

On October 7, 2015, the District and the County signed a third amendment to the original IGA dated August 10, 2005. The new agreement includes repayment of the original principal amount of $15,433,000 plus unpaid accrued interest of $1,152,000 plus accrued interest only on the principal sum of $15,433,000 beginning August 1, 2015. The payments are to be made in 12 equal installments of $1,414,000: the first installment was paid on November 30, 2015, and the 12th and final installment payment was made on August 31, 2018.

On June 25, 2020, the County agreed to extend the District a $30,000,000 line of credit through it's credit facility as a respond to the COVID-19 pandemic crisis. The District does not have any outstanding borrowings on the line of credit at June 30, 2020.

Scheduled maturities of long-term debt, excluding capital lease payments and a net premium of $34,046,000, for the years ending June 30 are as follows:

	General Obligation Bonds		Direct Placement General Obligation Bonds	
	Principal	Interest	Principal	Interest
2021	$ 10,000,000	$ 20,204,750	$ 20,000,000	$ 434,700
2022	15,500,000	19,567,250	17,000,000	136,850
2023	15,360,000	18,795,750		
2024	16,130,000	18,008,500		
2025	16,935,000	17,181,875		
2026-2030	98,260,000	71,988,750		
2031-2035	125,410,000	44,162,500		
2036-2039	124,530,000	10,848,850		
	$ 422,125,000	$ 220,758,225	$ 37,000,000	$ 571,550

Capital Lease Obligations

The District is obligated under the leases for buildings, building improvements, and equipment, through 2020, which are accounted for as capital leases. Assets under capital leases at June 30, 2020 and 2019, had a total cost of $16,942,000 and $16,942,000, respectively, with accumulated depreciation of $15,056,000 and $14,376,000, respectively.

10. Long-Term Debt and Capital Leases (continued)

The following is a schedule by year of future minimum lease payments under the capital leases, including interest at varying rates as of June 30, 2020:

	Principal	Interest
Year ending June 30:		
2021	$ 502,748	$ 13,543
2022	4,293	35
2023	–	–
	$ 507,041	$ 13,578

11. Restricted Net Position

Restricted net position at June 30, 2020 and June 30, 2019, consists of grant funds received for specific purposes that are expected to be expended during the following year in the amount of $2,541,000 and $2,473,000, respectively.

Restricted net position at June 30, 2020 and June 30, 2019, also consists of bond funds expected to be expended for specific purposes as defined in the bond agreement, in the amount of approximately $245,577,000 and $171,580,000, respectively.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities

General Information About the Pension and OPEB Plans

Plan Description

The District contributes to a cost-sharing, multiple-employer, defined benefit pension plan and OPEB plans administered by the ASRS. Benefits are established by state statute and generally provide retirement, death, long-term disability, survivor, and health insurance premium benefits. ASRS is governed by the ASRS Board according to the provisions of Arizona Revised Statutes Title 38, Chapter 5, Article 2.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

ASRS issues a Comprehensive Annual Financial Report that includes financial statements and required supplementary information. The most recent report may be obtained at www.azasrs.gov/content/annual-reports or by writing the Arizona State Retirement System, 3300 North Central Avenue, P.O. Box 33910, Phoenix, Arizona 85067-3910, or by telephoning (602) 240-2000 or (800) 621-3778.

Funding Policy

The Arizona State Legislature establishes and may amend contribution rates for active plan members, including the District. For the years ended June 30, 2020 and 2019, active plan members, including the District were required by statute to contribute at the actuarially determined rate of 12.11% (11.45% retirement, 0.49% health benefit supplement, and 0.17% long-term disability) and 11.80% (11.18% retirement, 0.46% health benefit supplement, and 0.16% long-term disability), respectively, of the members' annual covered payroll.

Benefits Provided

ASRS provides retirement, health care, and long-term disability benefits. The Defined Benefit Plan provides monthly retirement benefits to members who have reached retirement eligibility criteria, terminated employment, and applied for retirement benefits. At retirement, members have seven different payment options to choose from, including a straight-life annuity that guarantees monthly payments only for the lifetime of the member, or term certain and joint and survivor annuities that will continue to make monthly payments to a beneficiary in the event of the member's death. The amount of a member's monthly benefit is calculated based on his or her age, his or her years of service, his or her salary at retirement, and the retirement option chosen. In the event a member dies before reaching retirement eligibility criteria, the defined benefit plan will pay a lump sum or annuity to the member's beneficiary(ies). The Retiree Health Benefit Supplement (also called Premium Benefit Supplement) provides health insurance coverage for retirees and a monthly health insurance premium benefit to offset the cost of retiree health insurance. Long Term Disability provides a monthly disability benefit to partially replace income lost as a result of disability.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

Contributions

The contribution rate for the pension and OPEB plans are calculated by an independent actuary at the end of each fiscal year based on the amount of investment assets the ASRS has on hand to pay benefits, liabilities associated with the benefits members have accrued to date, projected investment returns, and projected future liabilities.

Liabilities, Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions and OPEB

At June 30, 2020, the District reported a liability of approximately $311,133,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2019. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2018, and was rolled forward using generally accepted actuarial procedures to June 30, 2019. The District's proportion of the net pension liability was based on a projection of the District's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2019 and 2018, the District's proportion was 2.14% and 2.15%, respectively.

At June 30, 2019, the District reported a liability of approximately $300,238,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2018. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2017, and was rolled forward using generally accepted actuarial procedures to June 30, 2018. The District's proportion of the net pension liability was based on a projection of the District's long-term share of contributions to the pension plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2018 and 2017, the District's proportion was 2.15% and 1.96%, respectively.

At June 30, 2020, the District reported a liability of approximately $812,000 for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2019. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2018, and was rolled forward using generally accepted actuarial procedures to June 30, 2019. The District's proportion of the net OPEB liability was based on a projection of the District's

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2019, the District's proportion was 2.17%, which represents no change from its proportion measured as of June 30, 2018.

At June 30, 2019, the District reported a liability of approximately $348,000 for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2018. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2017, and was rolled forward using generally accepted actuarial procedures to June 30, 2018. The District's proportion of the net OPEB liability was based on a projection of the District's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating employers and the state, as actuarially determined. At June 30, 2018, the District's proportion was 2.17%, which was a 0.20% change from its proportion measured as of June 30, 2017.

Within employee benefits, the District recorded pension expense of $33,010,000 and $3,841,000 for the years ended June 30, 2020 and 2019, respectively. At June 30, 2020, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions made after measurement date	**$ 28,321,668**	**$ –**
Differences between expected and actual experience	**5,620,699**	**(58,496)**
Changes in assumptions	**1,315,169**	**(12,389,925)**
Difference between projected and actual investment earnings	**–**	**(6,993,194)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**10,331,332**	**(2,977,503)**
Total	**$ 45,588,868**	**$ (22,419,118)**

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

At June 30, 2019, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions made after measurement date	$ 25,950,721	$ –
Differences between expected and actual experience	8,271,325	(1,655,165)
Changes in assumptions	7,944,858	(26,620,261)
Difference between projected and actual investment earnings	–	(7,220,024)
Change in proportion and differences between employer contributions and proportionate share of contributions	20,662,665	(9,630,844)
Total	$ 62,829,569	$ (45,126,294)

Of the amount reported as deferred outflows of resources as of June 30, 2020, $28,322,000 related to pension results from District contributions subsequent to the measurement date that will be recognized as a reduction of the net pension liability in the year ending June 30, 2021. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pension will be recognized in pension expense as follows:

Year ending June 30:	
2021	$ 3,290,908
2022	(8,972,804)
2023	(1,342,990)
2024	1,872,968

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

Within employee benefits, the District recorded OPEB expense of $1,579,000 for the year ended June 30, 2020. At June 30, 2020, the District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	**Deferred Inflows of Resources**
Contributions made after measurement date	**$ 1,579,257**	**$ –**
Differences between expected and actual expenses	**166,965**	**(718,148)**
Changes in assumptions	**1,392,873**	**–**
Difference between projected and actual investments earnings	**–**	**(811,406)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**71,424**	**(1,611)**
Total	**$ 3,210,519**	**$ (1,531,165)**

Within employee benefits, the District recorded OPEB expense of $1,202,000 for the year ended June 30, 2019. At June 30, 2019, the District reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	Deferred Outflows of Resources	**Deferred Inflows of Resources**
Contributions made after measurement date	$ 348,556	$ –
Differences between expected and actual expenses	28,950	(724,109)
Changes in assumptions	1,758,208	–
Difference between projected and actual investments earnings	–	(1,676,908)
Change in proportion and differences between employer contributions and proportionate share of contributions	82,979	(1,135)
Total	$ 2,218,693	$ (2,402,152)

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

Of the amount reported as deferred outflows of resources, $399,000 related to OPEB results from District contributions subsequent to the measurement date that will be recognized as a reduction of the net OPEB liability in the year ending June 30, 2020. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in OPEB expense as follows:

Year ending June 30:	
2021	$ (213,703)
2022	(213,703)
2023	148,873
2024	226,223
2025	50,955
Thereafter	101,452

Actuarial Assumptions

The June 30, 2018, actuarial valuation of the total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Salary increases	2.70% – 7.20% average, including inflation
Investment rate of return	7.5%

Mortality rates were based on the 2017 SRA Scale U-MP.

The June 30, 2017, actuarial valuation of the total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Salary increases	2.70% – 7.20% average, including inflation
Investment rate of return	7.5%

Mortality rates were based on the 1994 GAM, sex-distinct, projected to 2015 using Scale BB.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

The June 30, 2018, actuarial valuation of the OPEB liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Investment rate of return	7.50%
Mortality rates	1994 GAM Scale BB
Health care trend rate	N/A

The June 30, 2017, actuarial valuation of the OPEB liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.30%
Investment rate of return	7.50%
Mortality rates	1994 GAM Scale BB
Health care trend rate	N/A

The benefits paid by the plan are not impacted by health care cost trend rates. As a result, changes in the health care cost trend rate assumption will have no impact on the net OPEB liability.

The actuarial assumptions used in the June 30, 2018 and 2017, pension and OPEB valuations were based on the results of an actuarial experience study for the period July 1, 2007 – June 30, 2012. The ASRS Board adopted the experience study, which recommended changes, and those changes were effective as of the June 30, 2013, actuarial valuation.

The long-term expected rate of return on pension and OPEB plans' investments were determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation.

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

The target allocation and best estimates of geometric real rates of return for each major asset class for the pension plan measured as of June 30, 2019, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	3.05%
Fixed income	30	1.23
Real estate	20	1.17
Total	100%	5.45%

The target allocation and best estimates of arithmetic real rates of return for each major asset class for the pension plan measured as of June 30, 2018, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	2.75%
Fixed income	30	1.15
Real estate	20	1.17
Total	100%	5.07%

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

The target allocation and best estimates of geometric real rates of return for each major asset class for the OPEB plan measured as of June 30, 2019, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	3.05%
Fixed income	30	1.23
Real estate	20	1.17
Total	100%	5.45%

The target allocation and best estimates of geometric real rates of return for each major asset class for the OPEB plan measured as of June 30, 2018, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	2.75%
Fixed income	30	1.15
Real estate	20	1.17
Total	100%	5.07%

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

Discount Rate

The discount rate used to measure the overall pension liability as of June 30, 2020 and 2019 was 7.5% and the OPEB liability as of June 30, 2020 and 2019, was 7.5%. The projection of cash flows used to determine the discount rate assumed that employee contributions will be made at the current contribution rate, contributions from the District will be made at contractually required rates (actuarially determined), and contributions from the participating employers will be made at current statutorily required rates. Based on those assumptions, the plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability and OPEB liability/asset.

Sensitivity of the District's Proportionate Share of the Net Pension Liability to Changes in the Discount Rate

The following presents the District's proportionate share of the net pension liability reported at June 30, 2020, using the discount rate of 7.5% as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower 6.5% or 1-percentage-point higher 8.5% than the current rate:

	1-Point Decrease (6.5%)	**Discount Rate (7.5%)**	**1-Point Increase (8.5%)**
District's proportionate share of the net pension liability	**$ 442,814,295**	**$ 311,132,978**	**$ 201,081,287**

The following presents the District's proportionate share of the net pension liability reported at June 30, 2019, using the discount rate of 7.5%, as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1-Point Decrease (6.5%)	**Discount Rate (7.5%)**	**1-Point Increase (8.5%)**
District's proportionate share of the net pension liability	$ 427,996,808	$ 300,238,443	$ 193,498,394

12. Pension Plan and Other Post Employment Benefit (OPEB) Liabilities (continued)

The following presents the District's proportionate share of the net OPEB liability (asset) reported at June 30, 2020, using the discount rate of 7.5% as well as what the District's proportionate share of the net OPEB liability (asset) would be if it were calculated using a discount rate that is 1-percentage-point lower 6.5% or 1-percentage-point higher 8.5% than the current rate:

	1-Point Decrease (6.5%)	**Discount Rate (7.5%)**	**1-Point Increase (8.5%)**
District's proportionate share of the net OPEB liability (asset)	**$ 4,607,215**	**$ 812,445**	**$ (2,438,631)**

The following presents the District's proportionate share of the net OPEB liability (asset) reported at June 30, 2019, using the discount rate of 7.5%, as well as what the District's proportionate share of the net OPEB liability (asset) would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1-Point Decrease (6.5%)	**Discount Rate (7.5%)**	**1-Point Increase (8.5%)**
District's proportionate share of the net OPEB liability (asset)	$ 4,062,760	$ 347,486	$ (2,835,063)

Pension and OPEB Plans Fiduciary Net Position

Detailed information about the pension and OPEB plans' fiduciary net positions are available in the separately issued ASRS Comprehensive Annual Financial Report.

13. Commitments and Contingencies

Operating Leases

The District leases various equipment and facilities under operating leases expiring at various dates through June 2020. Within other expenses, the District recorded rental expense for operating leases of $5,800,794 and $5,186,907 for the years ended June 30, 2020 and 2019, respectively.

13. Commitments and Contingencies (continued)

The following is a schedule, by year, of future minimum lease payments under operating leases as of June 30, 2020, that have initial or remaining noncancelable lease terms in excess of one year:

Year ending June 30:	
2021	$ 5,617,274
2022	2,774,222
2023	1,651,916
2024	371,929
2025	223,413

Litigation

In the normal course of business, the District is, from time to time, subject to allegations that may or do result in litigation. Some of these allegations are in areas not covered by the County's risk management program (see Note 1) or by commercial insurance; for example, allegations regarding employment practices or performance of contracts. The District evaluates such allegations by conducting investigations to determine the validity of each potential claim. Based upon the advice of legal counsel, management records an estimate of the amount of ultimate expected loss, if any, for each allegation. Events could occur that would cause the estimate of ultimate loss to differ materially in the near term.

14. Disproportionate Share Settlement

Section 1923 of the Social Security Act establishes federal requirements designed to aid entities that provide medical services to a disproportionate share of medically indigent patients. These requirements were met for the state fiscal years ended June 30, 2020 and 2019, through disproportionate share settlements established in Laws 2016 Second Regular Session Chapter 122 and Laws 2015 First Regular Session Chapter 14. AHCCCS was directed to distribute such settlements based on various qualifying criteria and allocation processes. The District recorded in other operating revenue approximately $3,871,000 and $3,196,000 in disproportionate share settlements for fiscal years 2020 and 2019, respectively.

15. Related-Party Transactions

During the years ended June 30, 2020 and 2019, net patient service revenues included approximately $4,077,000 and $4,883,000, respectively, of payments received from Maricopa County Correctional Health for medical services rendered, and approximately $2,671,000 and $3,058,000 in grant funds were received from the Maricopa County Department of Public Health in fiscal years 2020 and 2019, respectively.

16. COVID-19

The outbreak of a novel strain of the coronavirus disease 2019 (COVID-19) continues to be a concern both in the United States and globally. The District is following the guidance of state and local governments and the Centers for Disease Control and Prevention. For acute care facilities, the State of Arizona, in accordance with Federal guidelines, recommended rescheduling elective surgeries as a means of preserving the supply of protective personal equipment, limiting visitors, and identifying additional space for patient care in preparation for a potential surge. At various points during the past several months, the District engaged in these practices. As of the date of this report, the District continues to be impacted by this ongoing state of emergency.

Through the passage of the Families First Coronavirus Response Act (Families First) and the Coronavirus Aid, Relief and Economic Security (CARES) Act, Congress provided financial support to hospitals and health care providers during the pandemic for financial stabilization. This allowed for the following financial support to the District in fiscal year 2020:

- The District has attested to the receipt of distributions totaling $8,600,000 under the Provider General Distribution Relief Fund of the CARES Act and the amount is recorded in other nonoperating revenue for the year ended June 30, 2020. Subsequent to the end of the fiscal year, an additional distribution of $12,100,000 was received and attested, under the High Impact Area Relief Fund of the CARES Act. This amount was recorded in the subsequent fiscal year. These distributions will be used to offset expenses to prevent, prepare for, and respond to the coronavirus, or lost revenues that are attributable to COVID-19.

16. COVID-19 (continued)

- The District has elected to defer applicable payroll taxes from April 5, 2020 through December 31, 2020. The deferred amount was and will be accrued when earned and repayment will be due in two equal installments on December 31, 2021 and December 31, 2022. The deferred amount was approximately $3,500,000 at June 30, 2020 and was recorded under accrued expenses.

- During the month of April 2020, the District received $23,366,000 through the Accelerated and Advance Payments Program under the CARES Act. An accelerated or advanced payment is a payment by CMS intended to provide necessary funds in circumstances such as national emergencies in order to accelerate cash flow to the impacted health care providers. Pursuant to the Continuing Appropriations Act, 2021 and Other Extensions Act, repayment terms are as follows:

  – Repayment does not begin for one year starting from the date the accelerated or advance payment was issued.

  – Beginning at one year from the date the payment was issued and continuing for eleven months, Medicare payments owed will be recouped at a rate of 25%.

  – After eleven months end, Medicare payments owed will be recouped at a rate of 50% for another six months.

  – After the six months end, a letter for any remaining balance of the accelerated or advance payment will be issued.

  – This amount was recorded under unearned revenue.

- The District also received FQHC grants under the Families First and CARES Act totaling $3,976,000. Of this total, $720,000 has been recognized as nonoperating revenue in FY20.

- The District has submitted claims for uninsured patients with a COVID-19 primary diagnosis for COVID-19 testing or treatment through the Health Resources & Services Administration (HRSA), funded through the CARES Act. This program will reimburse eligible claims at Medicare rates, subject to available funding.

16. COVID-19 (continued)

- The District has taken steps to apply for Federal Emergency Management Administration (FEMA) Public Assistance funding. The amount and timing of the expected financial assistance through FEMA is not known at this time.

Other aspects of the CARES Act continue to be reviewed and evaluated for their applicability to the District. While the District has received support from the Families First and CARES Act, there is continuing uncertainty surrounding the pandemic and the constantly changing and evolving regulations. The District will continue to monitor all regulatory changes and pursue all available opportunities for supplemental relief and or funding.

17. Subsequent Events

Effective July 1, 2020, the District elected to levy a secondary property tax on all taxable property in the defined surrounding area at the rate necessary to generate approximately $84,241,000 of annual tax revenue. The tax revenue is to be used to support operations of the District.

Effective July 1, 2020, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $17,850,000 and $287,000 for the second-year principal and interest debt service, respectively, related to the $75,000,000 second bond offering.

Effective July 1, 2020, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $16,275,000 and $20,953,000 for the first-year principal and interest debt service, respectively, related to the $422,125,000 third bond offering.

In August 2020, the District opened a new Community Health Center in the South Phoenix/Laveen area, as part of the Care Reimagined project. The new health center will be offering primary care services within the surrounding community.

In September 2020, through the Arizona Health Education Alliance, the District started the family medicine residency program in the South Central Community Health Center.

In November 2020, the District opened another Community Health Center in the North Phoenix area, as part of the Care Reimagined project. The new health center offers primary care services within the surrounding community.

17. Subsequent Events (continued)

In November 2020, Proposition 449 was approved by the voters of the County to authorize the District to continue the levy of a property tax for twenty years to support its operations. The tax will expire in August 2025 without prior voter approval.

Required Supplementary Information

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of District's Proportionate Share of the Net Pension Liability

Last 10 Fiscal Years*

	2020	2019	2018	2017	2016	2015
District's proportion or the net pension liability	**2.14%**	2.15%	1.96%	2.11%	2.15%	2.25%
District's proportionate share of the net pension liability	**$ 311,132,978**	$ 300,238,443	$ 304,619,435	$ 339,937,627	$ 334,641,881	$ 332,820,645
District's covered payroll	**$ 225,450,955**	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
District's proportionate share of the net pension liability a percentage of its covered payroll	**138.00%**	141.66%	161.30%	173.76%	170.32%	163.16%
Plan fiduciary net position as a percentage of the total pension liability	**73.24%**	73.40%	69.92%	67.06%	68.35%	69.49%

*The amounts presented for each fiscal year were determined as of the end of the prior fiscal year. Ten years of information is not yet available.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of District's Proportionate Share of the Net OPEB Liability

Last 10 Fiscal Years*

	2020	2019	2018
District's proportion or the net OPEB liability	**2.17%**	2.17%	1.97%
District's proportionate share of the net OPEB liability	**$ 812,445**	$ 347,486	$ (361,250)
District's covered payroll	**$ 225,450,955**	$ 211,945,416	$ 188,850,966
District's proportionate share of the net OPEB liability as a percentage of its covered payroll	**0.36%**	0.15%	-0.19%
Plan fiduciary net position as a percentage of the total OPEB liability	**98.07%**	99.13%	101.03%

*The amounts presented for each fiscal year were determined as of the end of the prior fiscal year.
Ten years of information is not yet available.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Contributions — Pension Plan

Last 10 Fiscal Years

	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
Contractually required contribution	**$ 29,501,737**	$ 25,950,721	$ 22,402,719	$ 20,360,215	$ 21,226,490	$ 21,396,442	$ 21,827,065	$ 20,672,347	$ 19,095,094	$ 16,554,642
Contributions in relation to the contractually required contribution	**(29,501,737)**	(25,950,721)	(22,402,719)	(22,259,196)	(21,387,917)	(21,690,643)	(20,471,268)	(21,015,008)	(19,414,629)	(16,927,376)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ (1,898,981)	$ (161,427)	$ (294,201)	$ 1,355,797	$ (342,661)	$ (319,535)	$ (372,734)
District's covered payroll	**$ 236,809,991**	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176	$ 201,678,461	$ 193,644,075	$ 183,733,181
Contributions as a percentage of covered payroll	**12.46%**	11.51%	10.57%	10.78%	10.85%	10.89%	10.70%	10.25%	9.86%	9.01%

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Contributions — OPEB

Last 10 Fiscal Years

	2020	2019	2018	2017	2016	2015	2014	2013	2012	2011
Contractually required contribution	**$ 1,565,944**	**$ 1,396,082**	$ 1,273,313	$ 1,321,018	$ 1,213,587	$ 1,395,848	$ 1,715,385	$ 1,796,348	$ 1,682,437	$ 1,544,408
Contributions in relation to the contractually required contribution	**(1,565,944)**	**(1,396,082)**	(1,273,313)	(1,321,018)	(1,213,587)	(1,395,848)	(1,715,385)	(1,796,348)	(1,682,437)	(1,544,408)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –
District's covered payroll	**$ 236,809,991**	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176	$ 201,678,461	$ 193,644,075	$ 183,733,181
Contributions as a percentage of covered payroll	**0.66%**	0.62%	0.60%	0.70%	0.62%	0.71%	0.84%	0.89%	0.87%	0.84%

Reports Required by the Uniform Guidance

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of Maricopa County Special Health Care District d/b/a Maricopa Integrated Health System (the District), which comprise the statement of financial position as of June 30, 2020, and the related statements of activities, and cash flows for the year then ended, and the related notes to the financial statements, and have issued our report thereon dated December 9, 2020.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered the District's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

December 9, 2020

Report of Independent Auditors on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance

Management and the Board of Directors
Maricopa County Special Health Care District
d/b/a Valleywise Health

Report on Compliance for Each Major Federal Program

We have audited Maricopa County Special Health Care District d/b/a Valleywise Health (the District)'s compliance with the types of compliance requirements described in the U.S. Office of Management and Budget (OMB) *Compliance Supplement* that could have a direct and material effect on each of the District's major federal programs for the year ended June 30, 2020. the District's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for each of the District's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the District's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the District's compliance.

Opinion on Each Major Federal Program

In our opinion, the District complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended June 30, 2020.

Report on Internal Control Over Compliance

Management of the District is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the District's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the District's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or combination of deficiencies, in internal control over compliance, such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

_____, 2020

Supplementary Information

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Expenditures of Federal Awards

Year Ended June 30, 2020

Federal Grantor/Program Title/*Pass-Through Grantor*	Assistance Listing Number	Pass-Through Entity Identifying Number	Research and Development Cluster	Health Center Program Cluster	Other Expenditures	Total Expenditures
U.S. Department of Defense						
Military Medical Research and Development – *American Burn Association*	12.420	36-2654533	$ 161,600	$ –	$	$ 161,600
Total U.S. Department of Defense			**161,600**	**–**	**–**	**161,600**
U.S. Department of Transportation						
Highway Safety Cluster						
State and Community Highway Safety – *Arizona Governor's Office of Highway Safety*	20.600	HS-FY 2016	$ –	$ –	$ 20,029	$ 20,029
Total Highway Safety Cluster			–	–	20,029	20,029
Total U.S. Department of Transportation			**–**	**–**	**20,029**	**20,029**
U.S. Department of Health and Human Services						
Community Programs to Improve Minority Health Grant Program	93.137		–	–	256,784	256,784
Coordinated Services and Access to Research for Women, Infants, Children, and Youth	93.153		–	–	552,610	552,610
Health Center Program (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing Primary Care)	93.224		–	1,218,112	–	1,218,112
Vital Hepatitis Prevention and Control – *Arizona Department of Health Services*	93.270	86-6004791	–	–	60,266	60,266
Centers for Disease Control and Prevention Investigations and Technical Assistance – *Maricopa County Department of Human Health*	93.283	ADHS14-064590	–	–	509,330	509,330
COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured	93.461		–	–	455,924	455,924
Refugee and Entrant Assistance Discretionary Grants – *Mercy Maricopa Integrated Care*	93.576	90RX0275	–	–	49,869	49,869
Accountable Health Communities – *Center for Medicare and Medicaid Services*	93.650	1P1CMS331609-01-00	–	–	17,834	17,834
Opioid STR – *Mercy Maricopa Integrated Care*	93.788	H79TI081709	–	–	117,900	117,900
National Bioterrorism Hospital Preparedness Program – *Arizona Department of Health Services*	93.889	ADHS13-048506	–	–	94,000	94,000
HIV Emergency Relief Project Grants – *Maricopa County Department of Human Health*	93.914	H89HA11478	–	–	2,161,835	2,161,835
HIV Care Formula Grants - *Arizona Department of Health Services*	93.917	ADHS17-145508	–	–	2,104,113	2,104,113
Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease	93.918		–	–	587,957	587,957
HIV Prevention Activities Health Department Based – *Arizona Department of Health Services*	93.940	5U62PS003635	–	–	135,914	135,914
Block Grants for Prevention and Treatment of Substance Abuse – *Mercy Maricopa Integrated Care*	93.959	YH17-0001-03	–	–	343,859	343,859
Maternal and Child Health Services Block Grant to the States – *Arizona Department of Health Services*	93.994	HG761224	–	–	212,868	212,868
Total U.S. Department of Health and Human Services			**–**	**1,218,112**	**7,661,063**	**8,879,175**
Total Expenditures of Federal Awards			**$ 161,600**	**$ 1,218,112**	**$ 7,681,092**	**$ 9,060,804**

See notes to Schedule of Expenditures of Federal Awards.

Maricopa County Special Health Care District
d/b/a Valleywise Health

Notes to Schedule of Expenditures of Federal Awards

Year Ended June 30, 2020

Note 1

Federal awards expended are reported on the accrual basis of accounting in conformity with accounting principles generally accepted in the United States as described in the notes to the financial statements. The information in this schedule is presented in accordance with the requirements of Title 2 *U.S. Code of Federal Regulations Part 200, Uniform Administrative Requirements, Costs Principles, and Audit Requirements for Federal Awards* (Uniform Guidance).

The Uniform Guidance provides for a 10% de minimis indirect cost rate election; however, the District did not make this election and uses a negotiated indirect cost rate.

Valleywise Health did not pass any federal awards through to subrecipients during the year ended June 30, 2020.

Note 2

Federal expenditures of $9,060,804 are included in the financial statements as noncapital grants.

Note 3 (Unaudited)

For the year ended June 30, 2020, Valleywise Health received personal protective equipment from various federal agencies totaling approximately $114,000.

Schedule Required by the Uniform Guidance

Maricopa County Special Health Care District
d/b/a Valleywise Health

Schedule of Findings and Questioned Costs

For the Year Ended June 30, 2020

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	**Unmodified**			
Internal control over financial reporting:				
Material weakness(es) identified?		**Yes**	X	**No**
Significant deficiency(ies) identified?		**Yes**	X	**None reported**
Noncompliance material to financial statements noted?		**Yes**	X	**No**

Federal Awards

Internal control over major federal programs:				
Material weakness(es) identified?		**Yes**	X	**No**
Significant deficiency(ies) identified?		**Yes**	X	**None reported**
Type of auditor's report issued on compliance for major federal programs:	**Unmodified**			
Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)?		**Yes**	X	**No**

Schedule of Findings and Questioned Costs (continued)

Section I – Summary of Auditor's Results (continued)

Identification of major federal programs:

CFDA Number	Name of Federal Program or Cluster
93.224, 93.527	Health Center Program Cluster
93.917	HIV Care Formula Grants

Dollar threshold used to distinguish between Type A and Type B programs: $ 750,000

Auditee qualified as low-risk auditee? X **Yes** ____ **No**

Section II – Financial Statement Findings

None noted.

Section III – Federal Award Findings and Questioned Costs

None noted.

Summary Schedule of Prior Audit Findings

Uniform Guidance finding 2018-001

Grant Program/CFDA #: Research & Development Cluster/CFDA # 93.360

Federal Agency/Pass-Through Entity: Johns Hopkins University

Federal Award#: IDSEP160031-01-01

Auditee Status Update:

Corrected November 2017 - MIHS revised and updated its written Policies and Procedures related to this function and notified appropriate staff. Due to a limitation on Kronos access, the timekeeper generates the time detail report every pay period, has each manager approve the timecards via email and updates Kronos with all the corrections/changes if necessary. Each timesheet is approved by the timekeeper each pay period, based on time detail reports, prior to payroll processing. Individual research managers now monitor this process on a regular basis throughout the fiscal year.

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.c.x.

Governance:
American Rescue Plan Act Funding
Budget Modification

Office of the Senior Vice President & CEO FQHC Clinics

2601 East Roosevelt Street • Phoenix • AZ• 85008

Date: October 6, 2021

To: Valleywise Community Health Centers Governing Council

From: Barbara Harding, BAN, RN, MPA, PAHM, CCM
Sr VP Amb. Services & CEO FQHC Clinics

Subj: Budget Modification Submission for Health Services and Resources Administration Notice of Award No. H8FCS41092 American Rescue Plan Act Award

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The American Rescue Plan Act Award budget approved on May 17, 2021 included $195,000 for Electrocardiograph (EKG) machines. We are able to utilize other funding for this medical equipment. We are requesting that the Governing Council approve using this amount for additional personnel that have been identified based on the needs and requests of clinical staff: Promotoras, Community Health Worker/Cultural Navigator, Driver, and Respiratory Therapist.

October 6, 2021

Health Resources & Services Administration (HRSA) American Rescue Plan Act (H8F) Funding for Health Centers Proposed Revised Budget

Barbara Harding, SVP Ambulatory Care Services
CEO FQHC Clinics

HRSA American Rescue Plan Act Award Funding for Health Centers Proposed Budget

On April 1, HRSA awarded more than $6 billion from the American Rescue Plan to Community Health Centers nationwide. The American Rescue Plan Act provides one-time funding (H8F) for a 2-year period of performance to support health centers funded under the Health Center Program to prevent, mitigate, and respond to COVID-19 and to enhance health care services and infrastructure.

Of the 23 health centers in Arizona that were awarded funding, the Maricopa County Special Health Care District received the largest award in the amount of $16,899,500.

The proposed budget includes a wide range of in-scope activities generated by an interdisciplinary team of staff with oversight by senior leadership. The activities will allow enhancement of accessibility of comprehensive primary care services; expansion of staffing to address the behavioral health, chronic conditions, and other needs of those who have been out of care; purchase of mobile units; and minor improvements to infrastructure.

Proposed American Rescue Plan Act Budget Clinical Equipment

Clinical Equipment	Cost
DEXIS Titanium Sensors	$28,000
Laboratory Centrifuge Replacements	$30,000
Point-of-care Medical and Diagnostic Testing Equipment	$32,451
~~Electrocardiography Machines (EKG)~~ Able to utilize other funding source	~~$195,000~~
Spirometry Equipment	$59,521
Respirator Testing and Supplies	$19,822
Single Label Printers	$11,880
End User Workstations	$340,218
Total	~~$716,892~~ $521,892

Proposed American Rescue Plan Act Budget Information Technology

Information Technology	Cost
Enhanced Digital Applications for the Patient Access Center	$466,000
Telehealth Enhancement for Interactive Audio/Video Platform	$300,000
Electronic Health Record Upgrades	$1,612,120
Network Capability Improvements	$147,003
Telehealth Web Cameras	$8,000
HL7 Interface for System Data Transmission	$281,782
Total	$2,814,905

Proposed American Rescue Plan Act Budget Facilities & Support Areas

Facility & Support Areas	Cost
Full-Service Refugee Health Clinic	$1,082,853
Mammography Mobile Unit	$1,244,698
COVID-19 Mobile Unit	$478,709
HVAC Replacements at South Central and Avondale Clinics	$106,000
New Flooring at Avondale, South Central, Guadalupe and Chandler Clinics	$393,940
Family Learning Center at New Mesa Clinic	$33,071
Total	$3,339,271

Proposed American Rescue Plan Act Budget Personnel

Personnel	Cost
Licensed Medical Social Workers for Referrals	$1,071,360
Behavioral Health Clinicians for Integrated Behavioral Health Expansion in Refugee Health, Women's Health, Pediatrics, and Internal Medicine	$744,000
Spanish-Speaking Registered Nurses (1), Promotoras and Cultural Navigators	$684,480
Case Management Extenders for Patient Outreach	$267,840
Integrated Behavioral Health Referral Specialists	$456,320
Behavioral Health Technicians for Social Determinants of Health	$1,091,200
Patient Access Specialists	$300,000
Data Strategist	$398,400
Contracted IT Staff	$1,636,932
Promotoras, Community Health Worker/Cultural Navigator, Driver, and Respiratory Therapist	$195,000
Total	~~$6,650,532~~ $6,845,532

Proposed American Rescue Plan Act Budget Summary

Award Period	Clinical Equipment	Information Technology	Facilities & Support	Personnel	Indirect Costs	Total
4/1/21 to 3/31/23	~~$716,892~~ $521,892	$2,814,905	$3,339,271	~~$6,650,532~~ $6,845,532	$3,377,900	$16,899,500

Thank you!

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.d.i.

Medical Staff:
FQHC Medical Staff and Allied Health Professional Staff Credentials

Recommended by Credentials Committee: July 6, 2021
Recommended by Medical Executive Committee: July 13, 2021
Submitted to MSHCDB: August 25, 2021

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**	**SPECIALTY/PRIVILEGES**	**APPOINTMENT DATES**	**COMMENTS**
Vicky Christy Khoury, M.D.	Courtesy	Pediatrics	09/01/2021 to 08/31/2023	
Jared Andrew Kusma, M.D.	Courtesy	Pediatrics	09/01/2021 to 08/31/2023	
Clinton Joseph Metzger, M.D.	Courtesy	Pediatrics	09/01/2021 to 08/31/2023	
Tina Pattara-Lau, M.D.	Courtesy	Obstetrics & Gynecology	09/01/2021 to 08/31/2023	
Sarah Anne Sherer, M.D.	Active	Pediatrics	09/01/2021 to 08/31/2023	
Freya Spielberg, M.D.	Active	Family & Community Medicine	09/01/2021 to 08/31/2023	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
J. Kevin Carmichael, M.D.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Pediatrics, Adolescent and Adult Cognitive/Procedural Core Privileges.
Kristyn Marie Wendelschafer, D.O.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Subdermal Contraceptive Capsule (insertion and removal) Privileges.

REAPPOINTMENT/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**SPECIALTY/PRIVILEGES**	**APPOINTMENT DATES**	**COMMENTS**
John J. Chen, D.D.S.	Courtesy	Dentistry	09/01/2021 to 08/31/2023	
Patricia J. Habak, M.D.	Active	Obstetrics/Gynecology	09/01/2021 to 08/31/2023	
Jeffrey James Miller, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	
Joseph D. Mott, M.D.	Courtesy	Obstetrics/Gynecology	09/01/2021 to 08/31/2023	
Travis Powell, M.D.	Active	Obstetrics/Gynecology	09/01/2021 to 08/31/2023	
David B. Wisinger, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	
Sandra K. Yuh, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	

Recommended by Credentials Committee: July 6, 2021
Recommended by Medical Executive Committee: July 13, 2021
Submitted to MSHCDB: August 25, 2021

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Warren Charles Carll, D.O.	Internal Medicine	Addition: Basic Ambulatory Pulmonary Core & Pulmonary Core Privileges; Critical Care Core Privileges; Endobronchial/Intra-Thoracic Ultrasound (EBUS/TBNA); Point-of-Care Ultrasound; Procedural Sedation	Focused Professional Practice Evaluation: Retrospective Review ("FPPE") of cases to meet FPPE requirements for privileges granted.
Jeffrey James Miller, M.D.	Internal Medicine	Withdrawal: Basic Critical Care Privileges	Voluntary Relinquishment of Privileges due to non-utilization of privileges

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Hemananda Kumar Muniraman, M.D.	Pediatrics	Courtesy to Inactive	Resigned effective July 31, 2021

Definitions:

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

Recommended by Credentials Committee: August 3, 2021
Recommended by Medical Executive Committee: August 10, 2021
Submitted to MSHCDB: August 25, 2021

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**	**SPECIALTY/PRIVILEGES**	**APPOINTMENT DATES**	**COMMENTS**
Zerahlynn Maico Ballanca, M.D.	Active	Family & Community Medicine	09/01/2021 to 08/31/2023	
Ricardo Herrera, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	
Leticia Moedano, M.D.	Active	Family & Community Medicine	09/01/2021 to 08/31/2023	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Tracy Anne Contant, M.D.	OB/GYN	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Gynecology Core Privileges.
Kaitlin Nelson Elsenheimer, M.D.	OB/GYN	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Gynecology Core Privileges.
Robert L. Johnson, M.D.	OB/GYN	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Obstetrics Core Privileges.
Andrew Joseph Rivara, M.D.	OB/GYN	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Gynecology Core Privileges.

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**SPECIALTY/PRIVILEGES**	**APPOINTMENT DATES**	**COMMENTS**
David L. Greenspan, M.D.	Courtesy	Obstetrics / Gynecology	09/01/2021 to 08/31/2023	
Robert Kenneth Horsley, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	
Hope Kurk, M.D.	Active	Pediatrics	09/01/2021 to 08/31/2023	
Bradley James Monk, M.D.	Courtesy	Obstetrics / Gynecology	09/01/2021 to 08/31/2023	
Tarreq Mohammad Noori, M.D.	Active	Internal Medicine	09/01/2021 to 08/31/2023	

Recommended by Credentials Committee: August 3, 2021
Recommended by Medical Executive Committee: August 10, 2021
Submitted to MSHCDB: August 25, 2021

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Robert Kenneth Horsley, M.D.	Internal Medicine	Addition: High Resolution Anoscopy (HRA) privileges	FPPE: Retrospective review of two (2) cases with acceptable results, reflective of the scope of privileges requested and completed.
Jeffrey James Miller, M.D.	Internal Medicine	Withdrawal: Basic Critical Care Privileges	Voluntary Relinquishment of Privileges due to non-utilization of privileges

STAFF STATUS CHANGE			
NAME	**DEPARTMENT**	**CHANGE FROM/TO**	**COMMENTS**
Abraham Cholakathu Kuruvilla, M.D.	Family & Community Medicine	Courtesy to Emeritus	In recognition of outstanding and noteworthy contributions to the medical sciences and long-standing service to the hospital.
Douglas P. Nelson, M.D.	Internal Medicine	Medical Leave of Absence ("MLOA") Extension	Extension of MLOA to October 1, 2021

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Brent Anthony Feudale, M.D.	Pediatrics	Courtesy to Inactive	Resigned effective June 22, 2021
Katherine Elizabeth Gross, M.D.	Internal Medicine	Active to Inactive	Resigned effective August 30, 2021
Nahid Hiermandi, D.O.	Pediatrics	Courtesy to Inactive	Resigned effective June 30, 2021

Definitions:

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

Recommended by Credentials Committee: July 6, 2021
Recommended by Medical Executive Committee: July 13, 2021
Submitted to MSHCDB: August 25, 2021

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
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.

ALLIED HEALTH PROFESSIONALS – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Comfort Chidinma Uche, F.N.P.	Family & Community Medicine	Practice Prerogatives on file	9/01/2021 to 8/31/2023	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Nicole Marshall Mitten, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Nurse Practitioner Family & Community Cognitive/Procedural Core Privileges.
Madeline Irene Powers, C.N.M.	OB/GYN	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Certified Nurse Midwife Core Procedural/Cognitive Privileges.

ALLIED HEALTH PROFESSIONALS – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Brittany Marie Divito, F.N.P.	Family & Community Medicine	Practice Prerogatives on file	9/01/2021 to 8/31/2023	

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Brittany Marie Divito, F.N.P.	Family & Community Medicine	Withdrawal: Subdermal Contraceptive Capsule	Voluntary Relinquishment of Privileges due to non-utilization of privileges

General Definitions:

Allied Health Professional Staff	An Allied Health Professional (AHP) means a health care practitioner other than a Medical Staff member who is authorized by the Governing Body to provide patient care services at a MIHS facility, and who is permitted to initiate, modify, or terminate therapy according to their scope of practice or other applicable law or regulation. Governing Body authorized AHPs are: Certified Registered Nurse Anesthetists; Certified Registered Nurse Midwife; Naturopathic Physician; Optometrists; Physician Assistant; Psychologists (Clinical Doctorate Degree Level); Registered Nurse Practitioners.
Practice Prerogatives	Scopes of practice summarizing qualifications for the respective category, developed with input from the physician director of the clinical service and the observer/sponsor/responsible party of the AHP, Department Chair, and other representatives of the Medical Staff, Hospital management, and other professionals.

Supervision Definitions:

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

Recommended by Credentials Committee: August 3, 2021
Recommended by Medical Executive Committee: August 10, 2021
Submitted to MSHCDB: August 25, 2021

VALLEYWISE HEALTH
CREDENTIALS AND ACTION ITEMS REPORT
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.

ALLIED HEALTH PROFESSIONALS – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Jessica Ann Enyeart, A.G.N.P.	Internal Medicine	Practice Prerogatives on file	09/01/2021 to 08/31/2023	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**DEPARTMENT/SPECIALTY**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Brittney Savannah Gillespie, P.A.-C.	Family and Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Subdermal Contraceptive Capsule Privileges.
Kortni Ruth Jones, P.A.-C.	Family and Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Physician Assistant Family & Community Cognitive/Procedural Core Privileges.

ALLIED HEALTH PROFESSIONALS – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Brittney Savannah Gillespie, P.A.-C.	Family & Community Medicine	Practice Prerogatives on file	09/01/2021 to 08/31/2023	
Dena Lynne Mills, F.N.P.	Family & Community Medicine	Practice Prerogatives on file	09/01/2021 to 08/31/2023	

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Brittney Savannah Gillespie, P.A.-C.	Family & Community Medicine	Withdrawal: 1. Minor Surgery; 2. IUD Removal/Insertion; 3. Therapeutic Procedures including Arthrocentesis	Voluntary Relinquishment of Privileges due to non-utilization of privileges
Dena Lynne Mills, F.N.P.	Family & Community Medicine	Withdrawal: 1. Minor Surgery; 2. IUD Removal/Insertion; 3. Subdermal Contraceptive Capsule; 4. Women's Health	Voluntary Relinquishment of Privileges due to non-utilization of privileges

Recommended by Credentials Committee: August 3, 2021
Recommended by Medical Executive Committee: August 10, 2021
Submitted to MSHCDB: August 25, 2021

RESIGNATIONS (Information Only)			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Diane Miller Cortez, C.N.M.	Obstetrics / Gynecology	Allied Health Professional to Inactive	Resigned effective July 31, 2021

General Definitions:

Allied Health Professional Staff	An Allied Health Professional (AHP) means a health care practitioner other than a Medical Staff member who is authorized by the Governing Body to provide patient care services at a MIHS facility, and who is permitted to initiate, modify, or terminate therapy according to their scope of practice or other applicable law or regulation. Governing Body authorized AHPs are: Certified Registered Nurse Anesthetists; Certified Registered Nurse Midwife; Naturopathic Physician; Optometrists; Physician Assistant; Psychologists (Clinical Doctorate Degree Level); Registered Nurse Practitioners.
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.

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 1.d.ii.

Medical Staff:
Revisions to Policy 39026 T

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

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 Allied Health Professional Credentials Policies, to further define the process for credentialing and re-credentialing members of the Medical Staff and Allied Health Professional staff in compliance with NCQA and HRSA (as used by the FQHC) standards, DNV, CMS, and health plan delegation agreements.

Definitions:

Allied Health Professional (AHP): A Licensed Independent Practitioner (LIP), a Category I provider, or an Advanced Practice Professional, a Category II provider other than a Medical Staff member who is authorized to provide patient care services in the Hospital who has been granted clinical privileges/practice prerogatives.

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, Dentists, Clinical Psychologists, 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

NCQA: National Committee for Quality Assurance

Participating Practitioners: Medical Staff and Allied Health Professional Staff as defined in the Medical Staff Credentialing Policy and Allied Health Professional 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 Allied Health Professional 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 and Allied Health Professional Credentials Policies.

Procedure:

SECTION 1 – INITIAL CREDENTIALING/APPOINTMENT PROCEDURES

1.1 Verification of Information

The information that shall be collected and verified by representatives 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.

~~**1.1.11**~~**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.

~~**1.1.12**~~**1.1.14** Clinical staff member's (LIPs) identity is verified through government issued picture identification.

~~**1.1.13**~~**1.1.15** All Medical Staff and Allied Health Professional 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.

~~**1.1.14**~~**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.

~~**1.1.15**~~**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.

~~1.1.16~~1.1.18 Medical Staff and Allied Health Professionals 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 and Allied Health Professional Staff Credentialing 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.

2.2.1~~**0**~~**20** 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.~~**11**~~**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.~~**12**~~**14** Medical Staff and Allied Health Professionals 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.

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 representative 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 seventy-five (75) 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 seventy-five (75) 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 Allied Health Professional 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 Allied Health Professional Staff Credentialing 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 representative 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 representative 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 representative who obtained the update. When email or fax confirmation is obtained from the applicant or applicable/primary source, the MSS representative will attach to the completed Application / Primary Source Verification (PSV) Update form.

8.3 **Authorization to Modify Information:** Only the MSS representative (in consultation with the Director of Medical Staff Services) will have the authority to

access, modify, and/or delete information when circumstances for modification are deemed appropriate, including but not limited to discrepancies identified by the applicant, MSS representative, Department Chair, or CCO.

8.4 Securing Information: All credentialing information is protected from unauthorized modification. The MSS representative 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 representative 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 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 representative, 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.

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, 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.

References:

Valleywise Health Medical Staff Bylaws, Medical Staff Credentialing Policy, Allied Health Professional Staff Manual, 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 -**

Revised with Minor Changes - ~~X~~

Revised with Major Changes -X

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

Policy updated in accordance with CMS regulations to meet requirements of querying the NPPES and the Social Security Death Master File Index at time of initial credentialing and recredentialing. Theses verifications are already being done but needed to update the policy to match our credentialing processes.

List associated form(s): (If applicable)

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

Committee: Credentials Committee	**~~06~~09/21**
Committee: Medical Executive Committee	**~~06~~09/21**
Reviewed for EPIC:	**00/00**
Other: Maricopa County Special Health Care District Board	**~~06~~09/21**
Other:	**00/00**
Other:	**00/00**

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 2.

Valleywise Community Health Center - Mesa
Dental Clinic Closure

Situation-Background-Assessment-Recommendation

Title: Accelerated Closure of the Mesa Dental Clinic

Effective Date – 9/22/2021

The SBAR (Situation-Background-Assessment-Recommendation) technique provides a framework for communication between members of the health care team. This technique is used to communicate and address critical issues to support immediate attention and action.

S — Situation

McDowell Dental Clinic Clinic is anticipating temporary clinic shutdown do to concurrent and unplanned Dentist staff vacancies from 11/29/2021 - 4/22/2021.

B — Background

McDowell Dental clinic has two assigned dentists. The first dentist is projected to be out on extended FMLA from 11/29/2021 - 2/21/2022. The second dentist will be on Active Duty status 12/11/2021- 04/22/2022. There will be no dentist support from 12/13/2021 - 2/21/2022.

A — Assessment

Valleywise Health Dental Services has to provide internal staffing coverage with available staffing when possible. Mesa Dental Clinic is not transitioning to the new Mesa Community Health Center and is budgeted to permanently close Jan 2022. Mesa dental staffing is budgeted to relocate to the Chandler Dental Clinic. The Chandler Dentist was planning to retire upon completion of the Mesa team relocation to Chandler. In lieu of the staffing shortage at the McDowell Dental Clinic, The Chandler dentist has volunteered to push back his retirement to 4/22/2022 in order to cover the staffing need. McDowell payer mix is predominantly Ryan White Delta Dental Commercial / Grant based and is the second busiest dental clinic at Valleywise Health

R — Recommendation

Accelerate the budgeted Mesa Dental Clinic closure from Jan 2022 to November 30, 2021 to efficiently mitigate overall Valleywise Health Dental Service productivity losses.

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 3.

District Board Member Appointment
(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 4.

Committee Reports

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 4.a.

Compliance and Quality Committee Report
(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 4.b.

Executive Committee Report
(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 4.c.

Finance Committee Report - Financial Highlights

VALLEYWISE HEALTH
FEDERALLY QUALIFIED HEALTH CENTERS
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending August 31, 2021

OPERATING REVENUE

(a) Visits

	Actual	Budget	Variance	%Variance
Month-to-Date	27,331	25,044	2,287	9.1%
Year-to-Date	51,315	47,911	3,404	7.1%

Visits greater than budget for the month by 2,287 or 9.1%. Current month visits greater than prior month by 3,347 or 14.0%. The VCHC's were greater than budget by 1,350 or 9.9%, the Outpatient Behavioral Health clinics were greater than budget by 174 or 13.9%, VCHC-Phoenix was greater than budget by 448 or 7.4%, VCHC-Peoria was greater than budget by 55 or 2.4% and Dental greater than budget by 260 or 14.1%.

(b) Net Patient Service Revenue

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 5,488,540	$ 4,939,936	$ 548,604	11.1%
Year-to-Date	$ 10,250,425	$ 9,450,612	$ 799,812	8.5%
Month-to-Date Per Visit	$ 201	$ 197	$ 4	1.8%
Year-to-Date Per Visit	$ 200	$ 197	$ 3	1.3%

Net patient service revenue is greater than budget by $548.6K for MTD. On a per visit basis, net patient service revenue is greater than budget by 1.8% for MTD. The VCHC's were greater than budget by $477.5K or 16.4%, the Outpatient Behavioral Health clinics were greater than budget by $19.0K or 6.6%, the VCHC-Phoenix was greater than budget by $34.1K or 3.4%, the VCHC-Peoria was greater than budget by $13.1K or 3.0% and Dental greater than budget by $5.0K or 1.7%.

(c) Other Operating Revenue

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 622,948	$ 248,147	$ 374,801	151.0%
Year-to-Date	$ 818,716	$ 495,784	$ 322,933	65.1%

Other operating revenue is greater than budget by $374.8K for MTD.

(d) PCMH Revenue

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 6,404	$ 6,271	$ 133	2.1%
Year-to-Date	$ 12,840	$ 12,543	$ 297	2.4%

Patient Centered Medical Home Revenue is greater than budget by $133.00 for MTD.

(e) Total operating revenues

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 6,117,892	$ 5,194,355	$ 923,537	17.8%
Year-to-Date	$ 11,081,981	$ 9,958,939	$ 1,123,042	11.3%
Month-to-Date Per Visit	$ 224	$ 207	$ 16	7.9%
Year-to-Date Per Visit	$ 216	$ 208	$ 8	3.9%

Total operating revenues are greater than budget by $923.5K for MTD. On a per visit basis, total operating revenue is greater than budget by $16.00 for MTD.

VALLEYWISE HEALTH
FEDERALLY QUALIFIED HEALTH CENTERS
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending August 31, 2021

OPERATING EXPENSES

(f) Salaries and Wages

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 1,931,574	$ 1,748,633	$ (182,941)	-10.5%
Year-to-Date	$ 3,762,764	$ 3,394,075	$ (368,689)	-10.9%
Month-to-Date FTEs	358	389	30	7.8%
Year-to-Date FTEs	360	379	19	5.0%

Salaries and wages were greater than budget by $182.9K for MTD. FTEs were less than budget by 30 for MTD. The average salaries and wages per FTE were greater compared to the previous month by $317.87.

(h) Employee Benefits

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 654,065	$ 590,012	$ (64,053)	-10.9%
Year-to-Date	$ 1,301,829	$ 1,146,001	$ (155,827)	-13.6%
Month-to-Date Per FTE	$ 1,826	$ 1,519	$ (307)	-20.2%
Year-to-Date Per FTE	$ 3,620	$ 3,027	$ (594)	-19.6%

Employee benefits are greater than budget by $64.1K MTD.

Benefits as a % of Salaries

	Actual	Budget	Variance	%Variance
Month-to-Date	33.9%	33.7%	-0.1%	-0.4%
Year-to-Date	34.6%	33.8%	-0.8%	-2.5%

(i) Medical Service Fees

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 1,764,631	$ 1,849,387	$ 84,756	4.6%
Year-to-Date	$ 3,375,428	$ 3,685,438	$ 310,011	8.4%

Medical service fees were less than budget for the month by $84.8K MTD.
The VCHC's were less than budget by $17.8K or 1.6%, OP Behavioral Health less than budget by $5.1K or 33.1%, VCHC - Phoenix was less than budget by $10.3K or 2.2% and VCHC-Peoria was less than budget by $51.5K or 23.8%.

(j) Supplies

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 206,564	$ 216,833	$ 10,269	4.7%
Year-to-Date	$ 418,736	$ 416,236	$ (2,500)	-0.6%
Month-to-Date Supplies per Visit	$ 8	$ 9	$ 1	12.7%
Year-to-Date Supplies per Visit	$ 8	$ 9	$ 1	6.1%

Supplies expenses were greater than budget by $10.3K MTD. VCHC-Phoenix less than budget in Pharmaceuticals by $5.6K, VCHC-Peoria less than budget in Other Medical Supplies by $1.8K

(k) Purchased Services

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 11,297	$ 19,407	$ 8,109	41.8%
Year-to-Date	$ 31,229	$ 38,212	$ 6,983	18.3%

Purchased services were less than budget by $8.1K MTD.

VALLEYWISE HEALTH
FEDERALLY QUALIFIED HEALTH CENTERS
FINANCIAL STATEMENT HIGHLIGHTS
For the month ending August 31, 2021

OPERATING EXPENSES (continued)

(l) Other Expenses

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 80,390	$ 83,543	$ 3,153	3.8%
Year-to-Date	$ 184,256	$ 186,766	$ 2,511	1.3%

For the month, other expenses were less than budget by $3.2K MTD.

(n) Allocated Ancillary Expense

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 708,521	$ 638,504	$ (70,017)	-11.0%
Year-to-Date	$ 1,406,336	$ 1,213,874	$ (192,462)	-15.9%

Allocated ancillary expenses were less than budget by $70.0K MTD.

(o) Total operating expenses

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 5,360,839	$ 5,146,518	$ (214,320)	-4.2%
Year-to-Date	$ 10,494,602	$ 10,080,998	$ (413,604)	-4.1%
Month-to-Date Per Visit	$ 196	$ 205	$ 9	4.8%
Year-to-Date Per Visit	$ 205	$ 210	$ 6	2.9%

Total operating expenses were greater than budget by $214.3K MTD. On a per visit basis, the current month was 4.8% favorable.

(p) Margin (before overhead allocation)

	Actual	Budget	Variance	%Variance
Month-to-Date	$ 757,053	$ 47,836	$ 709,217	1482.6%
Year-to-Date	$ 587,379	$ (122,060)	$ 709,439	581.2%
Month-to-Date Per Visit	$ 28	$ 2	$ 26	1350.2%
Year-to-Date Per Visit	$ 11	$ (3)	$ 14	549.3%

Total margin (before overhead allocation) is greater than budget by $709.2K for MTD.

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 4.d.

Strategic Planning and Outreach Committee Report
(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 5.

FQHC Clinics' CEO Report

Office of the Sr Vice President & CEO FQHC Clinics

2525 East Roosevelt Street • Phoenix • AZ• 85008

DATE: October 6, 2021

TO: Valleywise Community Health Centers Governing Council

FROM: Barbara Harding, BAN, RN, MPA, PAHM, CCM
Sr VP Amb Services & CEO FQHC Clinics

SUBJECT: CEO Report

Visit Metrics: August

The FQHC Clinics continue with a positive clinic variance in the second month of the Fiscal Year. Fiscal Year to Date (FYTD) August visit targets were 7.1%. Below are the breakdowns of specific clinics:

Valleywise Community Health Centers (FQHC) maintained a positive variance FYTD visit target goals at 9.5%. McDowell Clinic was not in target Month To Date (MTD) at (9.5%), FYTD, (11.5%). South Phoenix/Laveen was not in target MTD, (6.1%), FYTD, (6.8%). Staffing challenges and illness continue to be the primary barriers for attaining targets.

Valleywise Comprehensive Health Center – Peoria FQHC Clinic is building their panels in the new market. MTD visits were 2.4%.

Valleywise Comprehensive Health Center – Phoenix continues to have a positive FYTD, 1.7%. Peds Primary Care has a strong MTD performance, 45.6%.

Diabetes Education had 11.5 productive days that were not productive due to PTO/Professional Development. No shows to appointments are also impacting the targeted visits. The FYTD variance for Diabetes Education was (34.1%).

Internal Medicine fell short of their visit target for the month with a negative variance (9.3%). This is attributed to workforce shortages.

Integrated Behavioral Health (IBH) services attained a positive variance of 7.2% for August. However, a few clinics struggled to meet targets including:

- Guadalupe (100.0%) – position in recruitment with candidate identified
- BH Psychiatry MTD (18.5%) – still working to establish caseload and improve productivity

Valleywise Community Health Centers (FQHC) Dental Clinics continue to rebound working to meet target goals given the past year performance gaps created by the service limitations of the COVID-19 pandemic. August 2021 reported a positive visit variance of MTD 14.1%, FYTD 13.7%.

Operation Allies Welcome:
Updates on Afghan Arrivals (Humanitarian Parolees) to AZ

- 23,000 Afghans currently have arrived in the U.S. and are residing on military bases undergoing domestic screening, TB tests, vaccinations, including COVID-19 vaccination
- ~ 1,000 – 3,000 Afghan new arrivals are anticipated for the state of AZ across the next 3 months. At this time, we do not know the cadence of their arrivals, but we need to be prepared for substantial increase in patient volume to streamline referrals and facilitate care coordination
- In addition to Afghan new arrivals, AZ is also preparing for refugee new arrivals in general, based on previous estimates of new arrivals to the state of AZ

Immigration Statuses of Arriving Afghans First off, arriving Afghans fall into one of three immigration statuses:

1. Special Immigrant Visa (SIV) holders. These individuals are eligible for the same PRM, ORR, and mainstream benefits and services as refugees, including Reception and Placement, ORR programming, the refugee health screening, Refugee Medical Assistance and Refugee Case Assistance, Medicaid, TANF, etc.
2. Special Immigrant SQ/SI parolees. These individuals are also eligible for the above services and benefits, including mainstream and ORR benefits.
3. Parolees without SIV SQ/SI status. Currently, these individuals are not eligible for ORR or mainstream benefits, including RMA, RCA, Medicaid, TANF, WIC etc. This group will make up the bulk of arrivals we receive in AZ. A parallel Reception and Placement program called the Afghan Parolee Support (APS) Program has been created and funded by PRM for RAs to provide the same Reception and Placement services to these parolees that refugees receive. This is only for the first 90 days after arrival. After that, as it stands today, there are no more PRM services that parolees are eligible for. The only mainstream service parolees are eligible for on arrival in AZ is Emergency Federal AHCCCS which only covers very acute health emergencies.

   In the beginning of the evacuation, most arriving Afghans were SIV or SIV-parolees. As things intensified and processing in Kabul wasn't possible, Afghans were evacuated without status and most Afghans coming in now are in this third category of non-SIV parolees. For more on these three statuses see ORR's Dear Colleague Letter 21-18 (08/26/21).

BPHC REACH

HRSA Health Center Program

Primary Health Care Priorities

Vision: Every high-need community has access to the health center model of care.

- **Goal:** Increase access to the health center model of care in the nation's highest need communities and populations.

Vision: All health center patients have access to patient-centered services that address both clinical and social barriers to health.

- **Goal:** Increase access to a comprehensive range of services for health center patients.

Vision: Health centers lead the nation in delivering high quality care that advances health equity for underserved and vulnerable populations.

- **Goal:** Activate and accelerate evidence-based, innovative models of care delivery to improve health outcomes, reduce health disparities, and advance health equity for underserved and vulnerable populations.

Vision: Health centers operate state of the art facilities that optimize service delivery in medically underserved communities.

- **Goal:** Upgrade, modernize, and expand facilities to support expanded access to high quality care, advance health center performance, and enable and support evolving health care delivery models.

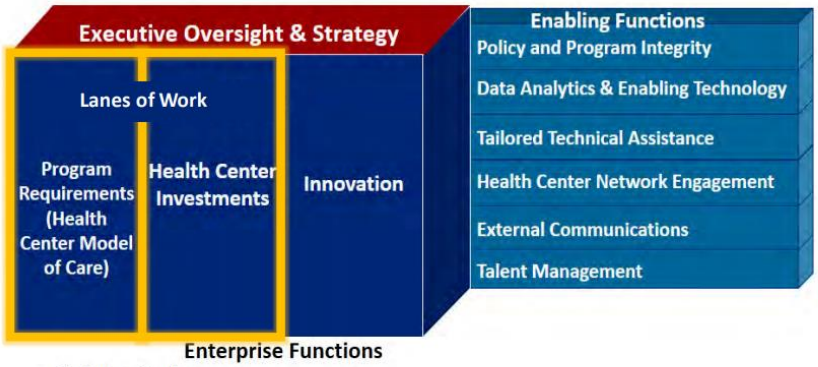
HRSA Health Center Program

Key Organizational Changes

- Transition Health Services Offices resources and focus (and renaming accordingly) to Health Center Program compliance and funding oversight
- Realignment of Office of Policy and Program Development's (OPPD) Capital Oversight staff to new Office of Health Center Investment Oversight (other capital-focused staff will remain in OPPD to support the Loan Guarantee Program and future capital investments)
- Focus on health equity and health center innovation through BPHC's new Quality Improvement Fund
- Realignment of certain functions of Office of Strategic Business Operation's (OSBO) Organizational Development Division to Office of the Associate Administrator's (OAA) Division of Workforce Management
- Standup of new business data analytics function in OSBO and across BPHC

HRSA Health Center Program

BPHC Operating Model



- Customer Service
- Internal Communications
- BPHC Workplace Culture
- Other Business Functions (e.g., Systems, Travel)

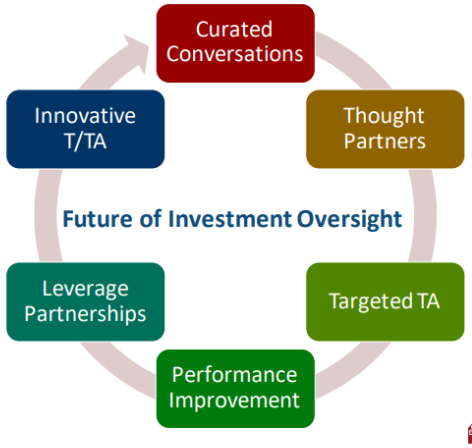
HRSA Health Center Program

Office of Health Center Investment Oversight

Purpose: Create a measurable and lasting impact to improve **health outcomes, health equity, and Health Center Program performance** through effective oversight of Health Center Program funding

New Functional Areas

- Strategic Services
- Infrastructure Improvement
- Clinical Performance Improvement
- Emergent Health Response
- Service Expansion



HRSA Health Center Program

Office of Health Center Program Monitoring

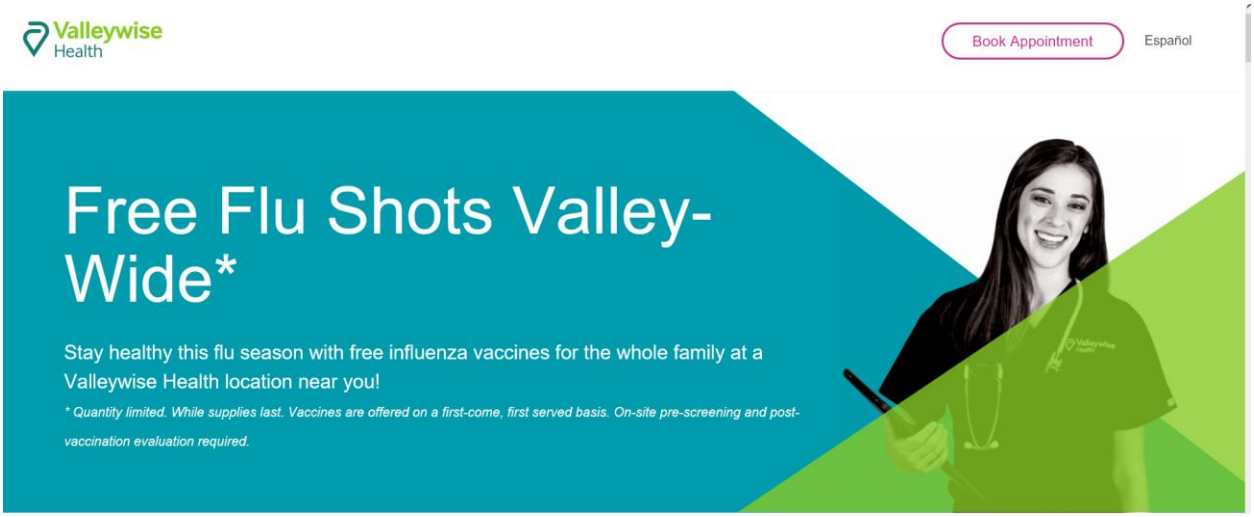
Purpose: Promote and support the health center model of care; engages health centers and other stakeholders to optimize organizational performance, improve primary care outcomes, and advance health equity.

New Functional Areas

- Compliance Evaluation
- Health Center Engagement
- Technical Assistance/Assessments
- Program Data and Risk Analysis
- Strategic Operations

Supports Health Center Model of Care

HRSA Health Center Program



Stay healthy this flu season with free influenza vaccines for the whole family at a Valleywise Health location near you!
* Quantity limited. While supplies last. Vaccines are offered on a first-come, first served basis. On-site pre-screening and post-vaccination evaluation required.

How:
Walk-up or drive thru. No appointment required.

Who:
All adults and children 6 months and older

When: **Saturday, October 9, 2021**
07:00 AM - 11:00 AM

Locations

FQHC Clinic - Chandler	811 S Hamilton St Chandler AZ 85225
FQHC Clinic - North Phoenix	2025 W Northern Ave Phoenix AZ 85021
FQHC PRIMARY CARE PEORIA	8088 W Whitney Dr Peoria AZ 85345
FQHC Clinic - South Phoenix Laveen	5650 S 35th Ave Phoenix AZ 85041

When: **Monday thru Friday, October 4 - 8, 2021**
07:30 AM – 4:30 PM

Location

FQHC Clinic - Guadalupe	5825 E Calle Guadalupe Guadalupe AZ 85283

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 6.

Valleywise Health's President and CEO Report

(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 7.

Closing Comments and Announcements

(No Handout)

Valleywise Community Health Centers Governing Council Meeting

October 6, 2021

Item 8.

Staff Assignments
(No Handout)