Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

5:30 p.m.

Agenda

Council Members	AGENDA
Scott Jacobson, Chairman Eileen Sullivan, Vice Chairman Earl Arbuckle, Treasurer Nelly Clotter-Woods, Member Chris Hooper, Member Salina Imam, Member Norma Muñoz, Member William O'Neill, Member Wayne Tormala, Member Jane Wilson, Member Mary Rose Garrido Wilcox, District Board, Non-Voting Member	**Valleywise Community Health Centers Governing Council** **Mission Statement of the Federally Qualified Health Centers** Serve the population of Maricopa County with excellent, comprehensive health and wellness in a culturally respectful environment.

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

Wednesday, December 6, 2023
5:30 p.m.

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

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

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

5:30 **Call to Order**

Roll Call

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

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

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

General Session, Presentation, Discussion and Action:

5:40 1. Approval of Consent Agenda: 5 min

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

a. Minutes:

i. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated November 1, 2023

ii. **Approve** Valleywise Community Health Centers Governing Council meeting minutes dated November 8, 2023

b. Contracts:

i. **Acknowledge** a Master Services Agreement (90-23-177-1) for professional medical, administrative, clinical and teaching services between the Maricopa County Special Health Care District dba Valleywise Health, and District Medical Group including, Statement of Work # 2, FQHC Services

ii. **Acknowledge** a new agreement (MCO-20-045-MSA) between Envolve Dental, Inc., and the Maricopa County Special Health Care District dba Valleywise Health, to allow members to receive dental services through Valleywise Health dental providers

c. Governance:

i. **Appoint** Essen Otu to the Valleywise Community Health Centers Governing Council

d. Medical Staff:

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

_____End of Consent Agenda_____

5:50 2. Discuss, Review and **Approve** the Quality Improvement/Quality Assurance Plan for the Federally Qualified Health Centers for Calendar Year 2024 15 min

Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

6:05 3. Discuss, Review and **Approve** Submission to Health Resources and Services Administration for a Change in Scope to add the Valleywise Health Mobile Health Unit as a Site on Form 5B 5 min

Michelle Barker, DHSc, Chief Executive Officer, Federally Qualified Health Centers

6:10 4. Presentation on Valleywise Health Mobile Health Unit 15 min

Salvador Avina, Project Manager

6:25 5. Discuss, Review and **Accept** the Maricopa County Special Health Care District dba Valleywise Health, annual audit for fiscal year ending June 30, 2023, including information related to the Federally Qualified Health Centers 10 min

Claire Agnew, CPA, MBA, Chief Financial Officer

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

6:35 6. Federally Qualified Health Centers' Chief Executive Officer's Report including Ambulatory Operational Dashboards 10 min
Michelle Barker, DHSc, Chief Executive Officer, Federally Qualified Health Centers

6:45 7. Maricopa County Special Health Care District Board of Directors Report 5 min
Mary Rose Garrido Wilcox, Director, District 5, Maricopa County Special Health Care District Board of Directors

6:50 8. Valleywise Health's President and Chief Executive Officer's Report 5 min
Steve Purves, FACHE, President and Chief Executive Officer, Valleywise Health

6:55 9. Governing Council Member Closing Comments/Announcements 5 min
Valleywise Community Health Centers Governing Council

7:00 10. Review Staff Assignments 5 min
Denise Kreidler, Deputy Clerk of the Board

Old Business:

November 1, 2023
Provide the number of seriously mentally ill cases received from data reported off depression screening surveys

Future agenda item: graduate medical education and medical licensing

7:05 **Adjourn**

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.

Consent Agenda

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.a.i.

Minutes
November 1, 2023

Valleywise Community Health Centers Governing Council Meeting
Virginia G. Piper Charitable Trust Pavilion
2609 East Roosevelt Street, Phoenix, AZ 85008
2nd Floor, Auditoriums 1 and 2
November 1, 2023, 5:30 p.m.

DRAFT

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

Non-Voting Member Absent: Mary Rose Garrido Wilcox, Maricopa County Special Health Care District Board of Directors

Others/Guest Presenters:
Michelle Barker, DHSc, Chief Executive Officer of the Federally Qualified Health Centers
Steve Purves, FACHE, President and Chief Executive Officer, Valleywise Health
Michael D. White, MD, MBA, Chief Clinical Officer – *participated remotely*
Claire Agnew, CPA, MBA, Chief Financial Officer
Melanie Talbot, Chief Governance Officer
Ijana Harris, JD, General Counsel
Matthew Meier, MBA, Vice President, Financial Services
Crystal Garcia, RN, MBA, Vice President, Specialty Services, Quality and Safety

Recorded by:
Denise Kreidler, Deputy Clerk of the Board
Cynthia Cornejo, Senior Deputy Clerk of the Board

Call to Order:

Chairman Jacobson called the meeting to order at 5:31 p.m.

Roll Call

Ms. Kreidler called roll. Following roll call, she noted that all nine voting members of the Valleywise Community Health Centers Governing Council were present, which represented a quorum.

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

Call to the Public

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

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda:

   a. Minutes:

      i. Approve Valleywise Community Health Centers Governing Council Meeting Minutes dated October 4, 2023

      ii. Approve Valleywise Community Health Centers Governing Council Meeting Minutes dated October 18, 2023

   b. Contracts:

      i. INTENTIONALLY LEFT BLANK

   c. Governance:

      i. Appoint Nelly Clotter-Woods to the Valleywise Community Health Centers Governing Council

      ii. Approve Revisions to the Sliding Fee Discount Program/Policy Including Revisions to the Sliding Fee Discount Schedule

   d. Medical Staff:

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

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

VOTE: 9 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Tormala, Ms. Wilson
0 Nays
Motion passed.

2. Approve Community Health Needs Assessment for Valleywise Health

Dr. Barker reviewed the Executive Summary and stated that it was the core of the Community Health Needs Assessment (CHNA). The summary shows the demographics of Valleywise Health's patient population within the Federally Qualified Health Centers (FQHCs) primary service areas. It gives the basic demographic profile of the population and then subsequently identifies each disease states selected. None of the information contained in the report was new but rather just in a different format.

NOTE: Vice Chairman Sullivan joined the meeting in person at 5:47.

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

2. Approve Community Health Needs Assessment for Valleywise Health, cont.

MOTION: Mr. Hooper moved to approve the Community Health Needs Assessment. Ms. Imam seconded.

Mr. Tormala asked for clarification of how the CHNA was translated into the priorities of the FQHCs.

Dr. Barker explained that data received from Maricopa County Department of Public Health was broken down and reviewed for all the different health needs based on inpatient, morbidity, mortality, and discharge information from hospitals. That data was compiled and presented to the Governing Council with disease states, in priority for review, to determine how the Governing Council wanted to address them. The priorities were narrowed down into areas that the FQHCs could have the most impact. Once the CHNA was approved, the Governing Council would develop a strategic plan for the FQHCs, related to each of the six primary categories.

VOTE: 9 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Mr. Hooper, Ms. Imam, Ms. Muñoz, Mr. O'Neill, Mr. Tormala, Ms. Wilson
0 Nays
Motion passed.

3. Discuss and Review Federally Qualified Health Centers Uniform Data System (UDS) Quality Metrics for the Third Quarter of Calendar Year 2023

Ms. Garcia provided an overview of the FQHCs Uniform Data System (UDS) quality metrics overall scorecard and shared the results for the third quarter of calendar year (CY) 2023, highlighting the various metrics and reviewing the data from this time last year.

Ms. Garcia noted that body mass index (BMI) screening was drastically improved from CY 2022. Third quarter CY 2023 was 92.11% with a 31.07% variance from the current target goal of 61.04 percent.

Diabetes/hemoglobin A1c metrics was slightly different because the lower the number the better. The metric was right at 30.76% in September. The current target goal was 30.42 percent.

Ms. Garcia said cervical cancer screening was meeting the benchmark. Two action plans in place to ensure continued success. One was to capture an abnormal screening in the health maintenance record within the EPIC medical record system, and the other was to continue bulk mail outs.

Breast cancer screenings for the third quarter CY 2023 was 60.17% with a 9.89% positive variance from the current target goal of 50.28 percent.

Childhood immunization was better than benchmark. A logic change from how the data was pulled last year from Valleywise Health's electronic medical record that affected all FQHCs was corrected. The measure for the third quarter of CY 2023 was 38.40% with a 5.17% positive variance from the current target goal of 33.23 percent.

Weight assessment and counseling for nutrition and physical activity for children and adolescent for the third quarter CY 2023 was better than benchmark from where the FQHCs were last year at this time at 74.47% with a 4.66% positive variance from the current target goal of 69.81 percent.

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

3. Discuss and Review Federally Qualified Health Centers Uniform Data System (UDS) Quality Metrics for the Third Quarter of Calendar Year 2023, cont.

Ms. Garcia mentioned colorectal cancer screening did not meet benchmark from this time last year. However, it was due to the change in screening age from 50 years of age to 45 years of age and over. She reviewed the action plans in place to improve the results.

Mr. Arbuckle asked if the screenings were referral based, and if so, did Valleywise Health get that information back into Valleywise Health's statistics.

Ms. Garcia responded that if the screening referral was placed through EPIC, the information should flow back into the data when pulled for UDS.

Mr. O'Neill asked how the measures were being met and what plans were in place to ensure continued improvement.

Ms. Garcia stated that the collaboration between physicians and leadership lead to positive outcomes in meeting the benchmarks.

Ms. Wilson asked who was responsible for making the changes in the requirements/benchmarks.

Ms. Garcia reported the changes in requirements/benchmarks were provided through best practices and Health Resources and Services Administration (HRSA).

Ms. Garcia discussed the controlling high blood pressure measure. In July 2023, the benchmark was 60.15%, however in August 2023, the benchmark increased to 63.40 percent. She explained that best practice alerts were established for blood pressure rechecks. Blood pressure audits by Clinical Resource Leaders (CRLs) in the FQHCs were implemented to monitor the new process.

Depression screening has improved drastically from this time last year. In September, the FQHCs met benchmark at 70.21 percent. Data for the individual FQHCs not meeting benchmark continues to be reviewed to determine any causes so they can be addressed.

Ms. Garcia reported that ischemic vascular disease (IVD) screening was meeting the benchmark at 76.83% for the month of September. The measurement would continue to be monitored. Random chart reviews were conducted to assess why patients were not meeting the measure.

Ms. Garcia stated that tobacco use screening and cessation intervention was meeting the benchmark at 89.49% for the month of September. This measurement consistently met benchmark.

HIV screenings exceeded the benchmark that was set. The FQHCs continue to do very well with this measure.

Ms. Garcia shared information about the various taskforce teams that meet regularly to develop action items to reach and maintain benchmarks.

Mr. Arbuckle asked if there were work groups for each FQHC or if there was a separate work group that worked with all the FQHCs.

Ms. Garcia said the work group was for all FQHCs instead of individual groups for each.

Mr. O'Neill asked about the depression evaluations and wanted to know how many of those were tracked as seriously mentally ill (SMI).

Ms. Garcia reported that she would see if that specific information could be extrapolated.

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

1. Approval of Consent Agenda, cont.:

Ms. Kreidler administered the Oath of Office to Dr. Nelly Clotter-Woods for appointment of membership to the Valleywise Community Health Centers Governing Council, as required by the Governing Council bylaws.

4. Discuss and Review Federally Qualified Health Centers Patient Safety Report for the First Quarter of Fiscal Year 2024

Ms. Garcia shared the patient safety report by Federally Qualified Health Center (FQHCs) location and discussed the electronic system called Continuous Healthcare Evaluation & Quality Improvement Tool or CHEQ-IT. The system encourages reporting of any type of process issues. The Quality and Patient Safety department review and track events to identify trends and to see if there was a need for a change in processes. Reporting anonymously was an option, however, it was encouraged to share identity in the event there were follow up questions.

She briefly discussed events reported by location and the types of events such as a medication error, specimen/lab, and safety. She indicated that a review of notable occurrences was included in daily leadership huddles. Issues were addressed through the peer review process and by tracking trends, and develop actions plans, as necessary.

5. Discuss and Review Federally Qualified Health Centers National Research Corporation (NRC) RealTime Platform Patient Satisfaction Data for the First Quarter of Fiscal Year 2024

Ms. Garcia explained that the patient satisfaction data was in a slightly different format than previously presented. The organization wanted to see which areas would make the highest impact and correlation in net promoter scores, versus areas which the organization would be unable to make much of an impact with the scores under the three areas of medical practice, outpatient behavioral health and outpatient testing. Leadership worked with providers to ensure that during patient visits, providers were using the same key words contained in the survey questions to help patients correlate those key words with what the provider stated in order to help raise scores.

Ms. Garcia touched on continuity of care for patients.

6. Discuss and Review Federally Qualified Health Centers Financials and Payor Mix for the First Quarter of Fiscal Year 2024

Mr. Meier presented the FQHCs financial statistics for the first quarter of fiscal year (FY) 2024.

Visits at the Valleywise Community Health Centers were better than budget by 439 or one percent. Total operating revenues were better than budget by $258,780 or three percent. Total operating expenses had a positive variance of $46,293 or one percent. The margin before overhead allocation had a positive variance of $305,073 for the quarter.

Outpatient behavioral health visits were better than budget by 186 or three percent. Total operating revenue was better than budget by $30,189 or two percent. Total operating expenses has a negative variance of $315,751 or 28 percent. Most of that was salary related due to the expansion of behavioral health services. The margin before overhead allocation had a negative variance of $285,562 for the quarter.

Visits for the FQHCs within the Comprehensive Health Center-Phoenix missed budget by 38 visits. Total operating revenues missed budget by $88,603 or three percent. Total operating expenses had a positive variance of $182,968 or four percent. The margin before overhead allocation, for all of the FQHCs within the Comprehensive Health Center-Phoenix were better than budget for the quarter by $94,364.

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

6. Discuss and Review Federally Qualified Health Centers Financials and Payor Mix for the First Quarter of Fiscal Year 2024, cont.

Visits at Valleywise Community Health Center-Peoria had a negative variance of 976 visits or 14 percent. Total operating revenue missed budget by $198,774 or 14 percent. Total operating expenses missed budget by $91,029 or six percent with an overall a negative variance of $107,745.

Dental clinic visits were better than budget by 43 visits or one percent. Total operating revenue missed budget by $147,714 or 16 percent. Total operating expenses were better than budget by $18,726 or one percent. Total margin for the quarter had a negative variance of $166,440.

The mobile health unit was not yet operational. A driver needed to be hired.

For the quarter, visits at all FQHCs combined missed budget by 346 or less than one percent. Total operating revenues missed budget by $139,406 or one percent. Total operating expenses had a negative variance of $24,275 or less than one percent. Overall, total margin for fiscal year to date had a negative variance of $163,681.

Mr. Meier briefly reviewed the year over year payor mix which showed a decrease in number of patients on Medicaid and the offsetting increase in self-paying patients.

7. Discuss, Review and approve the Amended and Restated Maricopa County Special Health Care District's Valleywise Community Health Centers Governing Council Bylaws

Ms. Talbot reiterated the changes which were discussed at the October 18, 2023, meeting. She reported that the Co-applicant Operational Arrangement was recently updated, therefore, the Bylaws needed to align with language in the Arrangement.

She stated that the significant changes made to the Bylaws were under the responsibilities and authorities of the Governing Council. Ms. Talbot also noted the removal of the standing committees from the Bylaws. However, an option was added to allow the Governing Council to create a special advisory committee if needed.

There were minor changes to the Officer's duties related to the committees.

MOTION: Mr. Hooper moved to approve the Amended and Restated Maricopa County Special Health Care District's Valleywise Community Health Centers Governing Council Bylaws. Mr. Arbuckle seconded.

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

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

8. Discuss, Review and approve the Maricopa County Special Health Care District dba Valleywise Health, Organizational Chart for the Federally Qualified Health Centers

Dr. Barker indicated that a few adjustments were made to the organizational chart.

MOTION: Mr. Tormala moved to approve the Maricopa County Special Health Care District dba Valleywise Health, Organizational Chart for the Federally Qualified Health Centers. Ms. Muñoz seconded.

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

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

Dr. Barker reviewed the FQHCs measures dashboard for the month of September. The FQHCs average appointment fill rate was 90.6%, and the FQHCs no show rate was 16.4 percent. She reported the Net Promoter Score was at 73.5% for the month.

Dr. Barker reminded the Governing Council the HRSA operational site visit (OSV) was November 7-9, 2023. The Governing Council was scheduled to have lunch with the reviewers on November 8, 2023

Ms. Muñoz asked if the reviewers would ask Governing Council members about figures and percentages questions.

Dr. Barker indicated that the reviewers would ask about the Governing Council members' service and experience on the council.

Ms. Imam asked why medical students from oversees did not have the same medical residency opportunities compared to medical students in the United States.

Dr. White suggested a future discussion regarding graduate medical education (GME) and medical licensing.

Ms. Wilson ask how many of the residents trained at Valleywise Health were hired after graduation.

Dr. White reported that last year, eight were hired.

10. Maricopa County Special Health Care District Board of Directors Report

This item was not discussed.

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

Mr. Purves talked about Valleywise Health's academic teaching mission and reported that there were several medical schools opening in Arizona. Those schools would need to find clinical rotations, which would be good for all area hospitals. Valleywise Health continued to look for ways to maximize the clinical learning environment.

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

12. Governing Council Member Closing Comments/Announcements

There were no comments or announcement.

13. Review Staff Assignments

Ms. Kreidler reiterated the follow up requests stemming from the meeting. There was no outstanding old business.

Adjourn

MOTION: Mr. Arbuckle moved to adjourn the November 1, 2023, Valleywise Community Health Centers Governing Council Meeting. Mr. Hooper seconded.

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

Meeting adjourned at 7:30 p.m.

_____
Denise M. Kreidler
Deputy Clerk of the Board

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.a.i.

Minutes
November 8, 2023

Minutes

Valleywise Community Health Centers Governing Council Meeting
Virginia G. Piper Charitable Trust Pavilion
2609 East Roosevelt Street, Phoenix, AZ 85008
4th Floor, Classroom 1
November 8, 2023, 12:00 noon

DRAFT

Members Present:
Scott Jacobson, Chairman
Eileen Sullivan, Vice Chairman
Earl Arbuckle, Treasurer
Nelly Clotter-Woods, Member
Chris Hooper, Member
Norma Muñoz, Member
Jane Wilson, Member

Members Absent:
Salina Imam, Member
William O'Neill, Member
Wayne Tormala, Member

Non-Voting Member Absent: Mary Rose Garrido Wilcox, Maricopa County Special Health Care District Board of Directors

Others/Guest Presenters:
Chelsie Purcell, Health Resources and Services Administration, Federal Representative
Marie Thames, Health Resources and Services Administration, Team Lead, Governance Reviewer
David Adams, Health Resources and Services Administration, Clinical Reviewer
Mohammed Husain, Health Resources and Services Administration, Fiscal Reviewer
Melanie Talbot, Chief Governance Officer and Board Clerk

Recorded by: Denise Kreidler, Deputy Clerk of the Board

Call to Order:

Chairman Jacobson called the meeting to order at 12:08 p.m.

Roll Call

Ms. Kreidler called roll. Following roll call, she noted that seven of the ten voting members of the Valleywise Community Health Centers Governing Council were present, which represented a quorum.

Call to the Public

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

General Session, Presentation, Discussion and Action:

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

This meeting was required as part of the Health Resource and Services Administration (HRSA) on site visit (OSV) which was conducted every three years.

The HRSA reviewers introduced themselves.

Each Valleywise Community Health Centers Governing Council member introduced themselves.

Ms. Thames remarked that the documents that were reviewed spoke to the quality of the organization. She asked Governing Council about the process by which they were able to set priorities for the strategic plan.

Ms. Wilson reported that Governing Council met with Maricopa County Department of Public Health for the purpose of Govering Council to express opinions on the various health concerns in the community. The different health concerns were grouped as low/high impact, low/high need, etcetera, to produce those health issues that Valleywise Health staff and District Medical Group (DMG) providers felt would have the greatest impact on in the community. Now that the process was complete, and priorities were identified for Community Health Needs Assessment (CHNA), the Governing Council was now able to move forward with the development of the strategic plan.

Mr. Hooper remarked how amazed he was to see the growth of the FQHCs and how well benchmarks were met.

Ms. Thames was impressed with how Valleywise Health staff worked with county-wide organizations, consisting of many partners, in the development of the CHNA.

Expanding further on those remarks, Chairman Jacobson added that Governing Council works with the District Board to ensure the alignment between the two.

Ms. Muñoz further remarked that the sharing of perspectives and team effort played a large role in the accomplishments of the FQHCs.

Dr. Clotter-Woods mentioned that the Governing Council's questions during a meeting were either immediately addressed or followed up on by the next meeting. She commented that the Governing Council's voice was always heard.

Mr. Husain asked the Governing Council how many days in advance they were provided fiscal documents prior to a meeting and if those documents were easy to review.

Ms. Wilson replied that the documentation was provided 10 days prior to the meeting and were easy to understand. She further stated that the Vice President of Financial Services would present the information at the Governing Council meetings to explain the documents in detail and answer any questions.

Mr. Hooper added that he was able to ask questions of his mentor as well as the presenters of the information.

Mr. Husain asked if Governing Council members were provided with training for their role on the Governing Council.

Ms. Wilson said there were orientation programs in place, resource material, as well as conferences available to attend.

Mr. Husain asked if Valleywise Health's Sliding Fee Discount Program (SFDP) was reviewed at least once every three years.

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

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

Governing Council members indicated that this document was reviewed at least annually.

Mr. Husain asked if Governing Council was afforded the opportunity to review the operating budget and audited financials.

Chairman Jacobson said that Governing Council reviewed those documents.

Mr. Husain said that two findings in the previous audit were resolved this year. He also remarked that Valleywise Health had many aging account receivables that were over 90 days old. He recommended more aggressive collection efforts.

Mr. Adams stated how impressed he was with the priority that the Governing Council places on the equity of care provided in the FQHCs.

In line with his remark, Ms. Wilson stated that there were always work groups to address quality benchmarks not met. If benchmarks were not being met, the Governing Council was informed. Even if benchmarks were being met, the Governing Council was informed about action plans in place to ensure meeting those benchmarks continued.

Mr. Arbuckle remarked that even if FQHCs were slightly below a benchmark for any given metrics, staff continued to strive to improve.

Ms. Wilson expressed her appreciation of the Mission Moment at each meeting, and how sharing patients' experiences with the Governing Council allows them to get a better understanding of care provided and the impact made on.

Ms. Purcell expanded on the next steps in the OSV review process.

Adjourn

MOTION: Mr. Arbuckle moved to adjourn the November 8, 2023, Valleywise Community Health Centers Governing Council Meeting. Ms. Wilson seconded.

VOTE: 7 Ayes: Chairman Jacobson, Vice Chairman Sullivan, Mr. Arbuckle, Dr. Clotter-Woods, Mr. Hooper, Ms. Muñoz, Ms. Wilson
0 Nays
3 Absent: Ms. Imam, Mr. O'Neill, Mr. Tormala
Motion passed.

Meeting adjourned at 1:18 p.m.

_____
Denise M. Kreidler
Deputy Clerk of the Board

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.b.i.

Contracts

90-23-177-1

Master Services Agreement

MASTER SERVICES AGREEMENT

by and between

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

and

District Medical Group, Inc.

MASTER SERVICES AGREEMENT

This MASTER SERVICES AGREEMENT ("Agreement") is made and entered into effective as of January 1, 2023 (the "Effective Date"), by and between Maricopa County Special Health Care District d/b/a Valleywise Health ("Valleywise"), and District Medical Group, Inc. ("DMG"). Valleywise and DMG may be referred to herein as the "Parties" and each individually as a "Party."

RECITALS

A. Maricopa County Special Health Care District, a tax levying public improvement district of the State of Arizona, owns and operates Valleywise Health, a comprehensive health care system servicing the residents of Maricopa County and surrounding areas. Valleywise Health includes Valleywise Health Medical Center and all of its affiliated inpatient, ancillary, and outpatient health services, facilities, departments, and programs, including, but not limited to, the Community Health Centers, Behavioral Health Centers, and the Comprehensive Health Center.

B. DMG is a nonprofit integrated medical group practice consisting of credentialed providers across all major medical and surgical specialties and subspecialties. DMG is dedicated to improving the health and wellbeing of individuals across Arizona through patient care, education, research, and community service initiatives.

C. For nearly two decades, Valleywise and DMG have partnered through various contractual arrangements and agreements to promote the availability, accessibility, and efficient delivery of high-quality, cost-effective health care services for the benefit of the residents of Maricopa County and surrounding areas. Valleywise has determined that it is in the best interest of the community and its patients to continue engaging DMG and its large multi-specialty group on a sole-source basis to provide professional medical, administrative, teaching, and related clinical services through DMG's licensed physicians and other DMG-employed or -contracted qualified providers.

D. Valleywise and DMG acknowledge that Valleywise operates a teaching hospital, and that the Parties are committed to maintaining accreditation of the training programs operated by Valleywise and assisting Valleywise with regard to securing additional training programs.

E. Valleywise and DMG agree that it is their mutual objective to maintain, and to continue improving the quality, efficiency, and coordination of, patient care and the quality of the medical and health care education programs offered at Valleywise. The Parties intend through this Agreement to promote increased alignment, transparency, and accountability around this shared objective, and to ensure that DMG is compensated fairly and is accountable for its performance of meaningful clinical, administrative, supervisory, and other services necessary for Valleywise's operations.

NOW, THEREFORE, in consideration of the mutual benefits to be received by the Parties and the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties to this Agreement hereby agree as follows:

AGREEMENT

ARTICLE I

DEFINITIONS

In addition to any other terms defined in this Agreement, the following terms as used throughout this Agreement will have the respective meanings set forth below:

1.1 "Agreement" means this Master Services Agreement, including all exhibits and Statements of Work executed by the Parties, as they may be amended from time to time.

1.2 "AHCCCS" means the Arizona Health Care Cost Containment System, as authorized by A.R.S. § 36-2901 et seq.

1.3 "ALTCS" means the Arizona Long Term Care System, as authorized by A.R.S. § 36-2931 et seq.

1.4 "Advanced Practice Clinician" will have the meaning set forth in the Valleywise Medical Staff Bylaws.

1.5 "Allied Health Professional" will have the meaning set forth in the Valleywise Medical Staff Bylaws.

1.6 "Contract Year" means the twelve (12)-month period during the Term of this Agreement that corresponds with Valleywise's fiscal year of July 1st to June 30th; *provided, however*, that the initial Contract Year (January 1, 2023 through June 30, 2024) shall be an eighteen (18)-month period. The first Contract Year that is a twelve (12)-month period shall commence July 1, 2024.

1.7 "Covered Services" means all of the professional medical, administrative, teaching, and other clinical services that DMG is required to provide under this Agreement.

1.8 "Day" means a calendar day, not a business or working day.

1.9 "Facility" means any inpatient, outpatient, or ancillary service facility or clinic owned or operated by Valleywise, including, but not limited to, the sites set forth on *Exhibit A*.

1.10 "Funding Source" means any federal, state, local, public agency, or other governmental funding source, or any private agency funding source, which may impose conditions on the funding that will be passed on to DMG by Valleywise or that will be used by Valleywise to fund its compensation obligations to DMG under this Agreement.

1.11 "Governmental Entity" means any foreign, federal, state, municipal, or other governmental department, commission, board, bureau, agency, or instrumentality.

1.12 "Gross Professional Fee Collections" means the total amount collected during a particular calendar month for any Covered Services rendered by Qualified Providers, for dates of

service beginning on or after January 1, 2023, but excluding collections resulting from participation in the Access to Professional Services Initiative ("APSI"), value-based payments, incentives received under the Merit Based Incentive Payments System ("MIPS") or similar alternative payment models, or any other payment or compensation received by DMG or its Qualified Providers other than on a fee-for-service basis.

1.13 "Law" means any applicable federal, state, or local statute, common law doctrine, ordinance, regulation, rule, ruling, order, writ, injunction, decree, regulatory settlement, stipulation, standard of accreditation, or guidance having the force of law, including, but not limited to, all applicable health care and insurance laws, rules, and regulations.

1.14 "Medical Staff Bylaws" means the Medical Staff Bylaws, the Medical Staff Glossary, the Medical Staff Organizational Manual, the Medical Staff Credentials Policy, the Allied Health Professional Policy, the Medical Staff Professional Practice Evaluation Policy, the Medical Staff Conflict of Interest Policy, and all medical staff rules and regulations as maintained and as may be amended by Valleywise and the medical staff from time to time.

1.15 "Payor" means any person or entity that is obligated to make payments to Valleywise or DMG pursuant to a contract or standards of participation for the provision of health care services. The term "Payor" includes, but is not limited to, Medicare, AHCCCS, ALTCS, TRICARE, and all other health care service plans, health maintenance organizations, health insurers, and/or other private, commercial, or governmental third-party payors.

1.16 "Post Graduate Training Program" means an academic program that is sponsored or co-sponsored by Valleywise and which meets all of the requirements of the Accreditation Council for Graduate Medical Education ("ACGME"), the American Osteopathic Association ("AOA"), the Council on Podiatric Medical Education ("CPME"), or other applicable accrediting body, and is in accordance with applicable Law and Valleywise Policies.

1.17 "Qualified Provider" means:

(a) A physician who is duly qualified and licensed to practice medicine in Arizona, who is board certified or board eligible, and who: (i) is a member of the Valleywise Medical Staff; (ii) is employed by, or under contract or subcontract to provide Covered Services on behalf of, DMG; and (iii) with regard to contracts between Valleywise and any Payor, has completed and returned all of the Payor's requested credentialing documentation to Valleywise and thereafter may begin to provide Covered Services to Payor's members on the 61st day following the return of all of the credentialing documentation to Valleywise;

(b) A physician who is duly qualified and licensed to practice medicine in Arizona and who is not board certified or board eligible, but who may become a member of Valleywise's Medical Staff if such physician satisfies the requirements of Valleywise's Medical Staff Bylaws and Credentialing Policy; or

(c) An Advanced Practice Clinician, Allied Health Professional, or health care provider, who: (i) is certified or licensed to practice their health care specialty in Arizona, or who is duly qualified to meet the qualifications established by Valleywise; (ii) is employed by, or under contract or subcontract with, DMG; (iii) with regard to contracts between Valleywise and any

Payor, has completed and returned all of the Payor's requested credentialing documentation to Valleywise and thereafter may begin to provide Covered Services to Payor's members on the 61st day following the return of all of the credentialing documentation to Valleywise; and (iv) provides Covered Services to Valleywise Patients within the scope of their practice as established by applicable Laws.

1.18 "Resident" means an individual duly enrolled as a resident participant in a Post Graduate Training Program or an individual enrolled in another institution's residency training program while such individual is rotating to Valleywise as part of an approved educational rotation.

1.19 "Statement of Work" or "SOW" means a detailed statement of: (i) DMG's service obligations under this Agreement and manner and means of calculating the associated compensation, including with respect to professional medical, administrative, teaching, or other clinical services; or (ii) the Parties' understandings and agreements as to matters related to or impacting the Covered Services.

1.20 "Timely Denials" means claims submitted by DMG or its third-party billing agent for Covered Services past timely filing deadlines as established by applicable Payor policies that are ultimately denied for payment for this reason.

1.21 "Valleywise Patient" means any individual who is provided health care at a Facility.

ARTICLE II

SOWS; GOVERNANCE; GENERAL OBLIGATIONS

2.1 Statements of Work. DMG will provide to Valleywise the Covered Services described in one (1) or more SOWs, which will be attached to this Agreement as sequentially numbered addenda, with each such SOW deemed incorporated herein by reference. DMG shall be the sole and exclusive provider of Covered Services to Valleywise. Each SOW will be signed by authorized representatives of both Parties and will sufficiently describe: (i) the Covered Services to be performed by DMG; (ii) the estimated schedule for performance of the Covered Services (if applicable); (iii) the manner and means of calculating compensation payable by Valleywise to DMG for the Covered Services, including the timeframe for payment, any required DMG deliverables that represent a condition precedent to payment, and reconciliation terms (if applicable); and (v) any other terms that apply to that specific SOW. Each SOW will be effective upon execution by both Parties. Any material changes to an SOW, including, but not limited to, changes in overall scope, will be in writing, and will not be effective until so evidenced by a signed writing. Notwithstanding the foregoing, annual changes in the rate of compensation payable to DMG under an SOW that do not involve changes to the underlying methodology for calculating such compensation; and changes in the operating plans which are not expected to result in a change in aggregate compensation payable under the SOW may be made and memorialized by the ELT. Each SOW may be amended, replaced, or terminated without constituting an amendment, replacement, or termination of this Master Services Agreement.

2.2 Governance. In furtherance of the parties' desire to work together, implement, and monitor the terms of this Agreement and the provision of Covered Services to Valleywise Patients by DMG, the Parties have established, and throughout the Term of this Agreement will maintain, a Valleywise-DMG Enterprise Leadership Team ("ELT"). The ELT will consist of, at a minimum, the following representatives from each Party: (i) for Valleywise, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), and Chief Clinical Officer; and (ii) for DMG, the CEO, Chief Medical Officer, and CFO. The Parties have adopted a charter setting forth the role and responsibilities of the ELT. Throughout the Term of this Agreement, the ELT will meet on at least a monthly basis, or more frequently as deemed necessary, to discuss issues relating to the provision of Covered Services to Valleywise Patients; potential new business opportunities and strategic initiatives; recruitment and retention of Qualified Providers; and other matters relating to the administration of this Agreement and the Parties' shared mission as set forth in the ELT charter.

2.3 Valleywise General Obligations.

(a) Valleywise will make space available to DMG to provide the Covered Services, including, but not limited to, telecommunication systems, utility services, information technology systems, computer hardware and software, linen and laundry services, ordinary janitorial services, furniture, office equipment and supplies, and medical equipment, instruments, supplies, devices, and drugs, that Valleywise determines are necessary and appropriate for the proper delivery of the Covered Services at the Facilities (collectively, the "Space and Items"). All Space and Items will be and remain the exclusive property of Valleywise. Valleywise will keep and maintain in good order all Space and Items necessary to provide the Covered Services, and Valleywise will absorb reasonable expenses related to the normal maintenance and repair of such Space and Items unless otherwise stated in this Agreement.

(b) Valleywise will make available to DMG and its Qualified Providers the nursing, technical, administrative, clerical, and support personnel (collectively, "Valleywise Personnel") for the proper delivery of the Covered Services that Valleywise determines are necessary and appropriate at the Facilities. Valleywise Personnel will be under the clinical supervision of DMG and its Qualified Providers when providing direct patient care services, and otherwise under the direction and control of Valleywise. Valleywise shall pay all costs and expenses incurred in connection with the Valleywise Personnel. The selection and retention of Valleywise Personnel will be made according to Valleywise personnel and procurement policies.

(c) Valleywise will make available to DMG's Qualified Providers, subcontractors, and employees, via its intranet or other suitable means, copies of all Valleywise policies and procedures, internal rules, and written standards that are applicable to the Covered Services or DMG's performance under this Agreement (collectively, "Valleywise Policies"). In the event that any Valleywise Policies are amended or new Valleywise Policies adopted, Valleywise will, to the extent reasonably practicable, provide DMG with thirty (30) Days prior notice, electronic or otherwise, of such amendments or new Valleywise Policies.

(d) Valleywise shall, without limitation, obtain and maintain all licenses, permits, and authority necessary to do business, operate the Facilities, render Covered Services, and otherwise perform work under this Agreement, and shall comply with all Laws regarding insurance, unemployment insurance, disability insurance, and worker's compensation.

2.4 DMG General Obligations.

(a) DMG shall, without limitation, obtain and maintain all licenses, permits, and authority necessary to do business, render Covered Services, and otherwise perform work under this Agreement, and shall comply with all Laws regarding insurance, unemployment insurance, disability insurance, and worker's compensation.

(b) Neither DMG nor any of its Qualified Providers, employees, or agents shall use the Space and Items, Valleywise Personnel, or any other Valleywise assets for any purpose other than the performance of Covered Services for the benefit of Valleywise and Valleywise Patients under this Agreement. DMG and its Qualified Providers, employees, and agents will use the Space and Items with due care and attention, and will promptly report all defects or potential defects to Valleywise. DMG and its Qualified Providers will participate in training regarding the proper use of the Space and Items as reasonably required by Valleywise or recommended by vendor instructions and guidelines, and will comply with Valleywise Policies and vendor instructions and guidelines relating to the Space and Items. DMG will bear the reasonable cost of any necessary repairs to the Space and Items, to the extent such repairs are necessitated by the misuse or abuse of the Space and Items by DMG or its Qualified Providers, employees, or agents, ordinary wear and tear excepted.

(c) DMG, in connection with any activity under this Agreement, shall not discriminate against any Valleywise Patient on the grounds of race, color, religion, sex, national origin, age, disability, sexual orientation, or ability to pay. DMG shall comply with all applicable provisions of the Americans with Disabilities Act of 1990. DMG shall include a clause in all of its subcontracts relevant to performance under this Agreement requiring the subcontractor's compliance with the nondiscrimination provisions as described in this Section 2.4(c).

(d) DMG agrees that it shall not use any funds (including funds received through federal contracts, grants, loans, or cooperative agreements), nor otherwise pay any third party, to influence or attempt to influence Congress or any other Governmental Entity official or other party in violation of federal, state, or local Law.

(e) If DMG performs or assists Valleywise with the performance of clinical research involving or relating to Valleywise Patients during the term of this Agreement, DMG will cooperate with Valleywise clinical research programs, policies, and procedures. DMG also will comply with Valleywise Institutional Review Board requirements, and all applicable federal and state Laws with respect to such clinical research, including, but not limited to, requirements and Laws pertaining to the protection of research subjects, informed consent, and reporting of results.

(f) DMG and its Qualified Providers may engage in activities or perform services separate and apart from this Agreement; *provided, however*, that such practice may not interfere with the performance by DMG of its obligations under this Agreement. If DMG, or any of its Qualified Providers, do engage in such outside activities or services, DMG or such Qualified Provider shall secure and maintain in force all insurance requirements consistent with the obligations contained in Section 11.1, provided that with regard to professional liability insurance, DMG and its Qualified Providers must maintain professional liability insurance with minimum coverage of $1,000,000 per occurrence and no less than $3,000,000 annual aggregate coverage

which extends to all such activities of DMG and its Qualified Providers. DMG shall furnish certificates of such coverage to the CEO of Valleywise or their designee upon request, and DMG shall further furnish Valleywise's CEO with thirty (30) Days' prior written notice of cancellation (if commercially available), non-renewal, or substantial change of the foregoing professional liability insurance coverage.

(g) DMG is solely responsible for its own corporate operation, including, but not limited to, corporate medical direction, promotion/advertising, recruiting expenses, revenue disbursement, information systems, oversight, personnel/human resources, administrative services and any and all other tasks, duties, and expenses related to or associated with its corporate operation, except as expressly stated to the contrary in this Agreement or an SOW. Recruiting of Qualified Providers to the Valleywise service area will be carried out in compliance with applicable Laws, and Valleywise shall have no financial responsibility for such expenses except as expressly set forth in this Agreement or any applicable SOW.

ARTICLE III

FINANCIAL ARRANGEMENT

3.1 Payment for Services; No Referrals. The financial arrangement between the Parties will be determined separately with respect to each Covered Service and, accordingly, will be as set forth in each SOW. In all cases, the financial arrangement will be negotiated at arm's length and will be designed to reflect reasonable, fair market value compensation for the Covered Services to be performed by DMG. The Parties acknowledge that no financial arrangement between the Parties reflects the volume or value of actual or potential referrals or other business generated between the Parties. No amount paid hereunder is intended to be, nor will it be construed to be, an inducement or payment for the referral of patients by either Party to the other Party.

3.2 Invoices and Supporting Documentation. Except as otherwise provided in an SOW, DMG will invoice Valleywise monthly for Covered Services, within fifteen (15) Days following the end of the applicable calendar month. Any such invoices will state the applicable time period for the Covered Services, a description of the Covered Services rendered as required by each SOW, and the compensation due for such Covered Services, along with any other information required pursuant to the applicable SOW. DMG will maintain, for a period of six (6) years following the date of final payment received from Valleywise under this Agreement, written records documenting the respective Covered Services provided pursuant to this Agreement, including, but not limited to, time or activity logs, work product, or other documentation appropriate to the particular Covered Services provided. DMG will promptly make all such records available to Valleywise upon request or as otherwise required pursuant to the applicable SOW.

3.3 Payment. Unless otherwise set forth in the applicable SOW, Valleywise will pay any undisputed fees owed to DMG within fifteen (15) Days following the receipt of an appropriate invoice and any supporting documentation required by the applicable SOW. Unless otherwise set forth in the applicable SOW, any reasonably disputed items by Valleywise with respect to the invoices shall be identified to DMG in writing prior to the date on which the invoice payment is due. If the Parties cannot resolve the dispute through the ELT, then the dispute shall be subject to

the dispute resolution provisions set forth in Section 12.10 of this Agreement. Responsibility for Taxes.

(a) DMG assumes sole and exclusive responsibility for payment of any federal and state income taxes, federal social security taxes, worker's compensation, and unemployment insurance benefits, if any such taxes are applicable, for its Qualified Providers, staff, and officers who are its employees, as well as any and all other mandatory governmental deductions or governmental obligations, if applicable. In addition, DMG assumes sole and exclusive responsibility for pension or retirement programs, if any, for its Qualified Providers, staff, and officers who are its employees. In connection with the obligations in this Section 3.4(a), DMG shall indemnify, defend, and hold harmless Valleywise for any and all liability that Valleywise may incur as a result of the failure of DMG to pay any such taxes or fulfill any other obligation noted in this Section 3.4(a), including any interest, fines, or penalties resulting from DMG's failure to perform under this Section 3.4(a).

(b) Valleywise assumes sole and exclusive responsibility for payment of any federal and state income taxes, federal social security taxes, worker's compensation, and unemployment insurance benefits, if any such taxes are applicable, for its providers, staff, and officers who are its employees, as well as any and all other mandatory governmental deductions or governmental obligations, if applicable. In addition, Valleywise assumes sole and exclusive responsibility for pension or retirement programs, if any, for its providers, staff, and officers who are its employees. In connection with the obligations in this Section 3.4(b), Valleywise shall indemnify, defend, and hold harmless DMG for any and all liability that DMG may incur as a result of the failure of Valleywise to pay any such taxes or fulfill any other obligation noted in this Section 3.4(b), including any interest, fines, or penalties resulting from Valleywise's failure to perform under this Section 3.4(b).

3.5 Availability of Funds. The provisions of this Agreement relating to payment for services by Valleywise will become effective when funds assigned for the purpose of compensating DMG as herein provided are actually available to Valleywise for disbursement in each of Valleywise's fiscal years during the Term of this Agreement. Valleywise's CEO, on behalf of and in consultation with Valleywise's Board of Directors, shall determine the availability of funds under this Agreement. The CEO shall keep DMG fully informed as to the availability of funds and shall provide DMG with ninety (90) Days written notice of any unavailable funds, in whole or in part, for Covered Services to be provided pursuant to this Agreement. DMG shall not be obligated to render any Covered Services to be provided pursuant to this Agreement while funds are unavailable if DMG completes an orderly transition of Valleywise Patients to another qualified provider. However, with the mutual consent of the CEO and DMG, DMG may continue to render Covered Services hereunder and be paid therefore from available Valleywise reserves pending resolution of any availability of funding issues during the Term of this Agreement.

3.6 Grants & Other Contracts.

(a) DMG shall notify the Valleywise CEO or named designee, as soon as practicable, but in no event less than fourteen (14) Days prior to, its intent to apply for any contract or grant which would potentially increase the amount of goods or services to be supplied by Valleywise. Any such contract or grant awarded to DMG requiring an increase in goods or

services to be supplied by Valleywise must receive the prior written approval of the Valleywise CEO or named designee, which approval shall not be unreasonably withheld. DMG will reimburse Valleywise for any and all direct and indirect expenses related to Valleywise's supply of goods and services under a grant, plus a fifteen percent (15%) administrative charge.

(b) DMG, during the Term of this Agreement, must immediately notify the Valleywise CEO in writing of the award of any contract or grant to DMG or to any of its Qualified Providers (on behalf of DMG) (excluding any grant awarded by Valleywise) where the award of such contract or grant or the performance thereof by DMG would have the effect of: (i) compensating DMG more than once for the same or similar services rendered to Valleywise Patients; or (ii) decreasing the quantity or quality of services to Valleywise Patients. If the Valleywise CEO or designee determines that the award of a contract or grant to DMG or any of its Qualified Providers, agents, or employees would have the effect of: (i) compensating DMG more than once for the same or similar services rendered to Valleywise Patients; or (ii) a change in the quantity or quality of services to Valleywise Patients, the CEO shall advise DMG of such a determination and the CEO and DMG shall negotiate a settlement with regard to the grant.

(c) The Valleywise CEO or designee shall notify DMG, as soon as reasonably practicable, of the intent of Valleywise to apply for any contract or grant which would increase the volume of Covered Services to be supplied by DMG pursuant to this Agreement. DMG will not be obligated to provide such additional services without DMG's prior written approval.

(d) If Valleywise and DMG desire to apply for the same grant, both Parties agree to cooperate fully in the grant application process.

(e) Despite anything to the contrary herein, this Section 3.6 shall not apply with respect to any contracts or grants that result in payments to Qualified Providers or to DMG's employees or agents with respect to (i) value-based care; (ii) MIPS or similar alternative payment models; (iii) APSI; or (iv) services provided by DMG or its employees or agents which are outside the scope of this Agreement.

ARTICLE IV

STANDARDS FOR COVERED SERVICES

4.1 Covered Service Standards. The Parties will perform or support performance of the Covered Services in accordance with applicable Law, the Valleywise Medical Staff Bylaws, and Valleywise Policies.

(a) Qualified Providers shall supervise all Advanced Practice Clinicians and Allied Health Professionals in accordance with the Medical Staff Advanced Practice Clinicians and Allied Health Professionals Policy, other relevant Valleywise Policies, and applicable Laws, including, but not limited to, licensure and reimbursement rules. DMG's Qualified Providers shall, in accordance with applicable Laws, the Medical Staff Advanced Practice Clinicians and Allied Health Professionals Policy, and other relevant Valleywise Policies, document supervision of Advanced Practice Clinicians and Allied Health Professionals in the patient's medical chart,

including countersignature of orders and review of patient evaluation and treatment where required.

(b) DMG will provide all Covered Services under this Agreement to all Valleywise Patients without regard to the source of payment or the patient's ability to pay.

4.2 Professional Service. DMG represents and warrants that, to the extent the Covered Services described herein include professional services, such Covered Services will be rendered exclusively by Qualified Providers. The requirements for Qualified Providers shall be as follows:

(a) Prior to any physician or other practitioner furnishing services at a Facility or to Valleywise Patients, DMG shall assure that such physician or other practitioner submits to Valleywise a completed application for Valleywise Medical Staff membership and clinical privileges (as applicable), and is awarded clinical privileges or other applicable authorization to deliver patient care services to Valleywise Patients as a Qualified Provider. As part of that process, DMG will supply the following to Valleywise for every Qualified Provider applicant: (i) completed Valleywise Medical Staff credentialing checklist and copy of curriculum vitae; (ii) basic demographic information; (iii) copy of current Arizona license to practice; (iv) U.S. Drug Enforcement Administration number (if applicable); (v) certificate of malpractice coverage; (vi) copy of board certification or explanation of board eligibility or other status, if applicable; and (vii) any other information that is required of an applicant by the Valleywise Medical Staff Bylaws, by Law, or by any accreditation agency with authority over Valleywise. DMG will immediately notify Valleywise in writing upon becoming aware that a Qualified Provider applicant has or is being subjected to an involuntary or voluntary termination, suspension, restriction, or limitation of their professional license in any jurisdiction, of their DEA number, of any clinical privileges they may hold at any other health care facility, or of their medical malpractice insurance.

(b) DMG shall require that its Qualified Providers notify DMG in writing as soon as practical, but in any event within three (3) Days, after a Qualified Provider receives notice of any change in their professional status, including but not limited to, their voluntary resignation or involuntary termination from any other health care facility, any restriction on their medical staff privileges at any other health care facility, licensure, or qualifications to participate in any state or federal health care program. DMG shall notify Valleywise in writing as soon as reasonably practicable, but in any event within three (3) Days, after DMG receives notice of any change to one of its Qualified Providers' professional status as referenced in the prior sentence.

(c) DMG represents and warrants that neither DMG nor any of its officers or Qualified Providers have been suspended, excluded, debarred, sanctioned, or otherwise declared ineligible for participation in Medicare, Medicaid, or other federal or state health care programs, or convicted of any criminal offense related to health care. DMG shall promptly inform Valleywise (and require its Qualified Providers to immediately inform Valleywise) in writing in the event that either DMG or any of its officers or Qualified Providers is suspended, excluded, debarred, sanctioned, or otherwise declared ineligible to participate in Medicare, Medicaid, or other federal or state health care programs. Qualified Providers provided by DMG shall maintain, as a condition of this Agreement, active membership on the Valleywise Medical Staff.

(e) DMG's Qualified Providers shall complete applications and produce reasonably required professional credentialing documentation to become or remain providers in relation to Valleywise contracts with other purchasers, providers, Payors, and/or plans, and such credentialing shall be completed prior to the provision of Covered Services to Valleywise Patients. DMG shall ensure that Qualified Providers whose Covered Services are billed to Payors by Valleywise have the required provider or program participation numbers and have been fully credentialed prior to the provision of Covered Services to Valleywise Patients.

(f) Qualified Providers provided by DMG shall maintain as a condition of this Agreement current state licensure, certification, or equivalent experience, as applicable, for their particular health care profession, and shall maintain appropriate credentials at the Facilities at which they provide services to Valleywise Patients. DMG represents and warrants that it, and its Qualified Providers, are not under any sanctions, restrictions, or provisional status from any applicable federal or state licensing, certifying, or credentialing agency.

(g) DMG will assure that all Qualified Providers and any other employees, contractors, or agents of DMG providing services at the Facilities are at all times in full compliance with Valleywise employee health standards for immunizations and TB testing. Valleywise will provide, if DMG elects, the option for DMG's employees and independent contractors to use the Valleywise Employee Health Services Department to receive immunizations, TB testing, and TB mask testing as necessary to satisfy Valleywise requirements. Access to the Valleywise Employee Health Services Department will be provided at thirty-eight percent (38%) of full charge rates, as such rates may be established or updated from time to time by Valleywise and provided to DMG upon request. Valleywise will invoice DMG by the fifth (5^{th}) Day of the month following the month that services were provided. DMG will remit payment to Valleywise within thirty (30) Days of receipt of the invoice, or Valleywise may offset such amount from the compensation payable to DMG for Covered Services pursuant to this Agreement.

4.3 Medical Records. In connection with the provision of Covered Services hereunder, DMG will maintain accurate, complete, up-to-date medical records for each Valleywise Patient who receives services from DMG's Qualified Providers, in accordance with all applicable federal and state Laws, including those applicable to Medicare, AHCCCS, ALTCS, TRICARE, and other Payors, as well as the Valleywise Medical Staff Bylaws.

(a) DMG's Qualified Providers are required to complete and to sign, where required, all medical records and reports in a timely fashion consistent with Valleywise Medical Staff Bylaws, Valleywise Policies, and applicable Laws. Medical records include, but are not limited to, written and/or dictated history and physical examinations, discharge summaries, and reports. The attending physician assigned to supervise and oversee a Resident will be accountable for assuring the Resident completes timely dictation of discharge summaries and operative reports. If a Resident fails to meet these time requirements, the attending physician supervising that Resident must complete the dictation within twenty-four (24) hours of the attending physician's notice of non-compliance for operative reports, and within five (5) Days of the attending physician's notice of non-compliance for discharge summaries.

(b) DMG's obligation to comply with the requirements imposed under this Section 4.3 shall be contingent upon Valleywise's ability to: (i) provide DMG's Qualified

Providers with necessary patient medical records in a timely fashion; and (ii) provide the necessary Valleywise Personnel, Space and Items, and other resources necessary to allow the Qualified Providers to complete records as required under this Section 4.3.

(c) Any concerns or deficiencies with respect to timely and appropriate completion of medical records by DMG's Qualified Providers shall be addressed in the first instance in accordance with the Valleywise Medical Staff Bylaws and associated processes. To the extent Valleywise's Medical Staff processes do not adequately resolve the issue, the ELT shall meet and confer in good faith regarding the matter and potential solutions, including adoption of a corrective action plan or other remedial measures by DMG.

4.4 Regulatory Compliance & Quality Management Cooperation.

(a) Valleywise and DMG each have developed and implemented their own compliance programs, including policies, standards, and guidelines relating to such compliance programs (collectively, the "Compliance Programs"). During the Term, each Party shall continue to implement its Compliance Program and shall obligate its employees and contractors, including DMG's Qualified Providers, to comply with its Compliance Program. Qualified Providers furnishing services in Facilities to Valleywise Patients shall also comply with Valleywise's Compliance Program applicable to their activities. The Parties agree to cooperate in good faith to identify and resolve compliance issues of mutual concern. If the Parties develop differences regarding resolution of any such matters, or if either Party determines in good faith that it risks a waiver of any defense, privilege, or other legal protection or benefit otherwise available to such Party, then such matters will be resolved as set out in Section 12.10.

(b) DMG will require its Qualified Providers to participate in the Valleywise Medical Staff's quality management, utilization management, and performance improvement programs, and any similar programs required by any accrediting agency or Governmental Entity, including without limitation, DNV, the Centers for Medicare and Medicaid Services ("CMS"), AHCCCS, ALTCS, and the Arizona Department of Health Services. DMG agrees to work collaboratively with Valleywise in the collecting and reporting of quality or performance improvement data and in the development of indicators to be measured.

4.5 Deficiency in Covered Services.

(a) Should DMG fail to cause its Qualified Providers to adequately perform the Covered Services, or otherwise meet its obligations under this Agreement, Valleywise will give DMG written notice of the deficiency (each, a "Deficiency"). DMG will thereafter have thirty (30) Days from receipt of written notice from Valleywise in which to correct the Deficiency before the Deficiency may be considered to be a breach of this Agreement. If the Deficiency remains for seven (7) or more Days after DMG's receipt of such notice, then beginning with the seventh Day after DMG's receipt of such notice: (i) Valleywise may reduce the compensation paid by Valleywise to DMG retroactive to the first date of the Deficiency, in an amount equal to the value of the Covered Services giving rise to the Deficiency ("Service Value"); and (ii) in addition, Valleywise has the right, but not the obligation, to correct the Deficiency, including, without limitation, by contracting with locum tenens physicians or independent contractors or by employing physicians or otherwise, in which case the compensation paid by Valleywise to DMG

under this Agreement shall also be reduced by the additional costs incurred by Valleywise in correcting the Deficiency that exceed the Service Value.

(b) In the event DMG fails to correct the Deficiency within six (6) months after receipt of notice of the Deficiency, Valleywise may, in its sole discretion, by giving written notice to DMG, terminate that portion of the Agreement, including all or a portion of any SOW (subject to the provisions of Article X, below), relating to the Deficiency and the amount of compensation paid by Valleywise under this Agreement shall be adjusted by the Service Value. Notwithstanding the provisions of this Section 4.5(b), DMG will implement an interim remedy that must be approved by Valleywise within sixty (60) Days after DMG's receipt of the notice of Deficiency.

(c) In the event DMG corrects the Deficiency prior to the expiration of the six (6) months referred to in Section 4.5(b), but after Valleywise has taken steps to correct the Deficiency, DMG shall be responsible for coordination of the transition of service to alternate providers so that there is no Deficiency during the transition period and shall be liable for all costs associated with any such transition, including but not limited to, costs related to the accommodation of any reasonable actions Valleywise may have taken to correct the Deficiency.

(d) If prior to the time Valleywise corrects the Deficiency, (i) DMG is adjudged bankrupt, or proceedings are filed by or against DMG under federal bankruptcy or state insolvency statutes, and such proceeding is not dismissed within thirty (30) Days, or (ii) DMG takes advantage of any insolvency statute or similar statute, or makes an assignment for the benefit of creditors, or is placed in the hands of a receiver or a trustee in bankruptcy and the receivership is not discharged within thirty (30) Days of such appointment, then DMG agrees that it will waive any noncompete provision or restriction on DMG's Qualified Providers that were providing the Covered Services that were the subject of the underlying Deficiency.

4.6 No Work Stoppages. DMG agrees that during the Term, DMG shall not engage, or encourage any other person to engage, in any sit-in strike, sit-down strike, work slow-down, or other activity that is not protected under the National Labor Relations Act, as amended, the administrative regulations and rulings promulgated thereunder, and/or applicable case law, and that prevents DMG from performing Covered Services. The provisions of this Section 4.6 shall not be construed in a manner that would preclude or prohibit DMG from terminating this Agreement in accordance with the provisions of Article X. DMG shall not be relieved of its obligation to provide Covered Services under this Agreement by reason of any employee sit-in, strike, sit-down strike, work slow-down, or other similar activity.

ARTICLE V

BILLING & OVERHEAD REIMBURSEMENT

5.1 DMG Billing.

(a) Except as otherwise set forth in an SOW relating to Valleywise's Federally Qualified Health Centers and other designated ambulatory care Facilities, DMG will have the right to bill Valleywise Patients or their responsible Payors for any Covered Services rendered by its Qualified Providers to such patients in accordance with this Agreement. DMG shall bill

Valleywise Patients or their responsible Payors in a manner consistent with such patient's coverage and the type of services rendered. DMG shall bill within the time designated by federal or state Law or the relevant Payor contract and shall use DMG's best efforts to bill and collect promptly all sums appropriately available from Valleywise Patients and Payors for the Covered Services performed under this Agreement. To the extent provided in an applicable SOW fees collected by DMG for Covered Services rendered to Valleywise Patients during the Term of this Agreement shall be deemed to have been collected on behalf of and for the benefit of Valleywise, and shall be offset against or deducted from the compensation otherwise payable to DMG by Valleywise in accordance with the applicable SOW.

(b) DMG shall establish its own fee schedule for professional services and agrees that its fees will be reasonable and not in excess of fees customarily charged in the community for similar services. Valleywise shall have the right to request a copy of DMG's fee schedule and billing policies. DMG agrees to comply with applicable Laws (including, without limitation, any related guidance issued by Payors regulating such activity) and with Valleywise Policies concerning billing for professional services for uninsured or underinsured patients as may be adopted, amended, or modified from time to time by Valleywise.

(c) In consideration of its performance of billing and collection activities for Covered Services on Valleywise's behalf pursuant to this Agreement, and given that DMG has currently outsourced almost all of the revenue cycle function, the Parties agree that Valleywise shall compensate DMG for the contracted third party costs to perform the revenue cycle function at a fixed rate of 5.66% of Gross Professional Fee Collections (the "Billing Fee"). Further, as Gross Professional Fee Collections offset payment owed to DMG for Covered Services, APSI payments received by DMG in connection with Covered Services and excess Timely Denials will also offset payment to DMG for Covered Services. Excess Timely Denials shall be measured as 30% of all Timely Denials (that are considered final per the Payor's policies) exceeding the following percentages during these applicable timelines:

- Between January 1, 2023 and June 30, 2023 - 5% of gross revenue;
- Between July 1, 2023 and December 31, 2023 – 4% of gross revenue; and
- January 1, 2024 and for the remainder of this Master Services Agreement – 3% of gross revenue

(d) In consideration of charge capture services; prior authorization services; reporting and analytics; payer management; and supervision and management of a third-party vendor engaged to perform billing and collection for the Covered Services on DMG's behalf (the "Administration Fee"), Valleywise shall compensate DMG in the amount of:

Collection Range	**Administration Fee**
Up to $39,000,000	3.77% of Gross Professional Fee Collections
$39,000,000 - $42,900,000	3.43% of Gross Professional Fee Collections
$42,900,000 - $47,200,000	3.11% of Gross Professional Fee Collections

(e) DMG shall invoice Valleywise monthly for the Billing Fee and the Administration Fee, within fifteen (15) Days following the end of each calendar month. The invoice shall set forth the cash collections received for that month and the resulting Billing Fee and Administration Fee. Valleywise shall pay the Billing Fee and Administration Fee, to the extent not reasonably disputed, to DMG by wire transfer, ACH or direct deposit to an account designated in writing by DMG, by the fifteenth (15^{th}) Day following the receipt by Valleywise of each invoice. Any reasonably disputed items by Valleywise with respect to the invoices shall be identified to DMG in writing prior to the date on which the invoice payment is due. If the Parties cannot resolve the dispute, then the dispute shall be resolved by the ELT.

5.2 Facility Billing. Valleywise will have the exclusive right to bill Patients or responsible Payors for facility or technical services rendered by its Facilities, including those associated with the Covered Services. All fees collected for such facility or technical services will be the sole and exclusive property of Valleywise.

5.3 Billing/Data Assistance. Subject to the duty to protect the confidentiality of patient information, each Party agrees to assist the other in all billing activities by providing information reasonably required in order to facilitate billing for Covered Services and associated facility and technical services. DMG and its Qualified Providers agree to cooperate with Valleywise and its Facilities in documenting Covered Services, providing supplemental information, executing documents, and completing records as required for Valleywise to promptly and accurately bill for its facility or technical services, or, where applicable under an SOW, Covered Services furnished by DMG and its Qualified Providers. Valleywise agrees to provide DMG, or, if applicable, its subcontractor pursuant to a mutually agreed upon Business Associate Agreement with such contractor, electronic access to demographic, insurance data, and other information required to bill for the Covered Services. DMG agrees that all patient information obtained by DMG from Valleywise shall be retained in confidence by DMG and shall only be used by DMG for the purposes of treatment, payment, and/or health care operations; to meet its obligations under this Agreement; or otherwise in a manner consistent with the terms of the Business Associate Agreement executed between the Parties and appended as *Exhibit B* to this Agreement.

5.4 Billing Reports. During the Term of this Agreement, DMG shall provide reports to Valleywise on at least a monthly basis detailing the following: total accounts receivable (AR), days in AR, charge lag (initial claims only), total charges, total collections, gross collection rate (collections/charges), denial write-off (as % of gross charges), timely filing write-off, and timely filing write-off (as a % of gross charges). For so long as DMG subcontracts with a third-party vendor to perform billing and collection activities related to the Covered Services, the Parties agree that Valleywise shall have the right to participate in at least one (1) meeting per calendar quarter with DMG and such third-party vendor, including, but not limited to, for purposes of discussing the reports provided pursuant to this Section 5.4.

5.5 Payor Contracts.

(a) For all Covered Services, DMG and its Qualified Providers shall participate with all Payors as determined by Valleywise in its sole discretion, whether currently in existence or added after the Effective Date. In the event that DMG or its Qualified Providers do not have

Payor contracts as required by Valleywise, then Valleywise shall reasonably assist DMG in procuring such Payor contracts for itself and its Qualified Providers. DMG and its Qualified Providers shall at all times be and remain participating providers in Medicare and AHCCCS.

(b) In the event Valleywise enters into or agrees to participate in Payor arrangements that provide for or require a global or bundled payment, or other alternative payment arrangements, with federal health care programs or any other Payors that includes the Covered Services, DMG will negotiate with Valleywise in good faith on the amount of the global, bundled, or other alternative payment to be allocated to DMG for the Covered Services.

5.6 Valleywise Billing Support. Valleywise and its staff shall cooperate and provide timely assistance to DMG and its third-party vendor(s) engaged in billing and collection to maximize the capture of services; to create appropriate templates; and to provide support generally for the efficient, timely, and accurate completion of medical charts, coding, and billing.

5.7 Fixed Overhead Fees. In addition to the other compensation payable under this Agreement and under the SOWs, Valleywise shall pay to DMG the following annual amounts as compensation for management and oversight of the Covered Services, including ancillary support services for the provision of the Covered Services (the "Overhead Fee") in each Contract Year. Valleywise's payment of the Overhead Fee to DMG shall be made in equal monthly installments, within fifteen (15) Days after Valleywise's receipt of an invoice from DMG.

Contract Year	Overhead Fee
Contract Year 2024 (January 1, 2023 through June 30, 2024)	$19,635,234
Contract Year 2025	$13,417,410
Contract Year 2026	$13,752,845
Contract Year 2027	$14,096,666
Contract Year 2028	$14,449,083

ARTICLE VI

REGULATORY AND LEGAL PROCEEDINGS

6.1 Regulatory Complaints and Proceedings. Each Party will timely and accurately respond to any complaints or investigations made by any Governmental Entity with respect to the Covered Services or the Parties' performance under this Agreement; *provided, however*, that each Party will provide a copy of such response to the other Party for its prior review and comment unless otherwise prohibited by Law and to the extent reasonably practicable.

6.2 Legal Proceedings. Each Party will notify the other Party promptly of any lawsuit, arbitration, or other dispute resolution proceedings to the extent known that are instituted with respect to any matter relating to the Covered Services or the Parties' performance under this Agreement (collectively, "Legal Proceeding(s)"), and, if permitted by the Legal Proceedings and applicable Law, promptly furnish to the other Party copies of all initial pleadings (e.g., complaints or demands for arbitration). Each Party will assume and control the investigation, contest, defense, and/or settlement of all Legal Proceedings with respect to itself or its employees or personnel.

Notwithstanding anything in this Section 6.2 to the contrary, internal disputes between a Party and its respective employees or other personnel shall not be treated as "Legal Proceedings" requiring disclosure to the other Party pursuant to this Agreement.

6.3 Cooperation with Legal Proceedings. Each Party hereto will cooperate fully with the other in all reasonable respects with regard to any Legal Proceeding brought by a third-party, including, but not limited to, cooperation in such other Party's defense, including making available its respective officers and employees for interviews and meetings with Governmental Entities or counsel, and furnishing any additional assistance, information, and documents as may be reasonably requested by a Party from time to time, in each case at the cost of the requesting Party. If, at any time after the Effective Date, any further action is necessary or desirable to effectuate the purposes of this Section 6.3, each Party, as the case may be, will execute and deliver or cause to be executed and delivered such instruments and other documents as will be mutually agreed upon, and will take or cause to be taken all such further lawful and necessary action as mutually agreed upon, including amending this Agreement; executing additional ancillary, delegation, or other agreements; or taking such steps and measures as reasonably required, advisable, or necessary pursuant to applicable Law.

6.4 Final Authority. The Parties recognize that each Party retains the final authority with respect to the resolution of any complaints, investigations, or proceedings by Governmental Entities into the activities of such Party and any Legal Proceeding relating to the activities of such Party, with respect to which it will take into account the recommendations of the other Party.

6.5 Initiation of Litigation. Neither Party will have the authority to institute any legal action or proceedings on behalf of the other Party.

ARTICLE VII

RESTRICTIVE COVENANTS

7.1 Non-Solicitation of Personnel. Each Party agrees that during the Term of this Agreement and for one (1) year thereafter, except with the prior written consent of the other Party, such Party will not solicit or enter into an employment or other contractual agreement with any employees or personnel of the other Party with whom such Party has come into contact as a result of the provision of Covered Services pursuant to this Agreement; *provided, however*, that the terms of this Section 7.1 will not apply to any Party's solicitation through general advertisements or job listings (whether in newspapers, the internet, or otherwise) that are not specifically directed at employees or personnel of the other Party (and the subsequent entering into of an employment or other contractual agreement as a result thereof).

7.2 Non-Solicitation of Patients. Neither Party will advise, counsel, or solicit any Valleywise Patient or any other patient away from the other Party. Nothing in this Agreement, however, shall preclude either Party from making medically necessary or appropriate referrals of Valleywise Patients or other patients to persons or entities that are not Parties to this Agreement.

7.3 Reciprocal Right of First Refusal. From time to time, a Party to this Agreement may desire to: (i) obtain health care or health care-related services other than the services delivered

under this Agreement, where such health care services can be delivered by the other Party; (ii) provide to a third party, other than a Payor, the health care services it is contracted to provide under this Agreement; or (iii) enter into any professional health care services agreement with a third party with an expected annual gross value greater than One Million Dollars ($1,000,000) (each, a "ROFR Activity"). In the case of any desired ROFR Activity, the following requirements will apply:

(a) The Party desiring to undertake any ROFR Activity will promptly notify the other Party of its desire and the nature of the proposal, and if necessary, both Parties will execute a confidentiality agreement regarding the terms and conditions of any such proposal. For forty-five (45) Days following receipt of notice, the Parties will discuss and negotiate in good faith regarding the possibility that the other Party might supply the additional health care services or participate with the desiring Party in providing the health care services or participating in the health care services venture, arrangement, or agreement. The Parties will also consider whether the desiring Party's participation in the new health care service arrangement will be detrimental to that Party's ability to fulfill its obligations under this Agreement. The discussions and deliberations required by this Section 7.3(a) shall take place within ELT.

(b) If at the end of the forty-five (45) Day period, the Parties are unable to reach an agreement regarding these issues (with such determinations with respect to ability to reach agreement to be made by each Party in its discretion), the Party desiring the health care services or the health care services venture, arrangement, or agreement may solicit bids from or negotiate with third parties for the provision of the health care services or the other proposed arrangement.

(c) To the extent the Parties agree to expand any of the services delivered under this Agreement or otherwise participate together in arrangements not contemplated by this Agreement, they will enter into an amendment to this Agreement or appropriate SOW describing such services or arrangements. Neither Party will be legally obligated to the other with respect to the additional services or arrangements until a new SOW or an amendment to this Agreement is negotiated and executed regarding the additional services or arrangements.

ARTICLE VIII

AUDITS & COMPLIANCE MONITORING; COOPERATION

8.1 Audits & Audit Disallowances. Valleywise reserves the right to audit DMG's performance under this Agreement pursuant to the provisions of the District Procurement Code, in addition to auditing any payments made to DMG by Valleywise pursuant to this Agreement.

(a) If at any time it is determined by Valleywise that a payment in whole or in part was made to DMG for Covered Services not authorized, not provided, or not adequately substantiated, or if DMG was overpaid for Covered Services rendered pursuant to this Agreement, Valleywise shall notify DMG in writing of such determination.

(b) If DMG disputes Valleywise's determination, as set forth above, such dispute shall be resolved in accordance with the provisions of Section 12.10.

(c) Nothing in this Agreement shall authorize Valleywise to audit payments made to DMG relating to any services, personnel, or costs of DMG that are outside the scope of this Agreement, unrelated to the Covered Services delivered by and obligations of DMG under this Agreement, and which are not directly reimbursed by Valleywise.

(d) Notwithstanding the above, if after an audit by any Governmental Entity or accrediting authority, sanctions are imposed upon either Party solely as a result of the conduct of the other Party, the Party whose conduct resulted in the sanctions will reimburse the other Party for the full amount of the sanctions, including any interest, costs, fees, fines, and penalties related thereto. Where such sanctions are imposed upon either or both Parties as a result of the Parties' common or joint actions or omissions, DMG and Valleywise will apportion financial responsibility for the sanction between themselves as they may agree; *provided, however*, that if the Parties cannot agree upon an apportionment between themselves, the matter of the allocation of any repayment, costs, fees, interest, fines, and penalties, if any, will be submitted to the dispute resolution process, in accordance with Section 12.10.

8.2 Agreement Compliance Monitoring. In addition to the audit rights set forth in Section 8.1, above, Valleywise shall have the right to monitor DMG's performance, obligations, duties, services, and activities under the terms of this Agreement.

(a) Valleywise, including any of its affiliates, counsel, consultants and advisors, accountants, or designated representatives, shall have full access to, and the right to copy and make use of, any and all of DMG's books and records pertaining to this Agreement upon reasonable notice, subject to all applicable Laws regarding the confidentiality of such records. Without limiting the foregoing, DMG shall make available to Valleywise all books, records, and documentation relevant to DMG's performance under this Agreement, including, but not limited to: (i) Facility, department, or service line staffing schedules; (ii) DMG's credentials file for each Qualified Provider; and (iii) such other records as Valleywise may reasonably request or require to support that Covered Services were rendered consistent with the terms of this Agreement and/or that the payments made by Valleywise to DMG are consistent with fair market value.

(b) DMG represents and warrants that its financial, operational, medical, academic, and clinical records system will provide accurate, timely, complete, organized, and legible information to support the performance of its duties and compliance with standards under this Agreement.

(c) Except to the extent otherwise provided in this Agreement, DMG agrees to retain all financial books, records, and other documents relevant to the Covered Services provided by DMG pursuant to this Agreement for at least the period required under applicable state or federal Law, and shall in all events maintain all such records for a period no less than six (6) years after the later of the following: (i) final payment by Valleywise under this Agreement and final reconciliation of all items subject to reconciliation under the terms of this Agreement at the end of the Term; (ii) resolution of any audit disputes pursuant to this Agreement; or (iii) resolution of any dispute under Section 12.10. DMG will not, and will cause its subcontractors to not, dispose of, alter, or destroy any books and records relating to the Covered Services except in accordance with DMG's or such subcontractor's established record retention policies and applicable Law.

(d) Nothing in this Agreement shall authorize Valleywise to audit and copy records of DMG relating to any services, personnel, or costs of DMG that are outside the scope of this Agreement, unrelated to the Covered Services delivered by and obligations of DMG under this Agreement, and which are not directly reimbursed by Valleywise.

(e) DMG shall cooperate with and allow duly authorized federal and state agents (including authorized representatives of any Governmental Entity) access to and the right to copy DMG's records relevant to this Agreement to the fullest extent provided by Law.

(f) No later than one hundred twenty (120) days after the end of each of DMG's fiscal year(s), DMG shall provide Valleywise with the independent auditor's report rendered in connection with DMG's audited financial statements with supporting financial information for DMG's Covered Services provided under this Agreement; *provided, however*:

(i) In the event DMG is in receipt of a qualified or "going concern" (as defined by auditing standards generally accepted in the United States of America) independent auditor's report rendered in connection with DMG's audited financial statements, DMG shall notify Valleywise in writing within three (3) Days of receipt of the same; and

(ii) In the event DMG is in possession of information indicating or reasonably believes that its financial condition at that time is such that a qualified or "going concern" (as defined by auditing standards generally accepted in the United States of America) auditor's report rendered in connection with DMG's audited financial statements would be probable, DMG shall notify Valleywise in writing within three (3) Days of such.

8.3 Valleywise's Recoupment Rights.

(a) In addition to any other remedies set forth in this Agreement or available at Law, Valleywise has the right to recoup, offset, or withhold from DMG any monies for Covered Services that DMG has not yet provided, for Covered Services not authorized or not adequately substantiated, or where such monies should not have been paid to DMG under the terms of this Agreement or any other contract that Valleywise may have with any Payor.

(b) If DMG disputes Valleywise's determination made according to Section 8.3(a), above, such dispute shall be resolved in accordance with the provisions of Section 12.10. If the process described in Section 12.10 results in a determination in favor of Valleywise, DMG shall pay Valleywise the required amount, plus interest at the rate provided in A.R.S. § 44-1201, and thereafter, DMG will not challenge such determination or the action by Valleywise.

8.4 Cooperation in Performance. DMG shall fully cooperate with, and shall instruct its Qualified Providers and subcontractors to fully cooperate with, Valleywise and other Valleywise contractors and subcontractors, and DMG shall carefully plan and perform its work to coordinate with the work of other Valleywise contractors or subcontractors. DMG shall not commit or permit any act that will interfere with the performance of work by Valleywise, or any other contractors or subcontractors, except where necessary to protect patients from danger. Differences of medical opinion among Valleywise or Valleywise contractors and their subcontractors shall be settled in accordance with the Medical Staff Bylaws.

ARTICLE IX

CONFIDENTIALITY & PRIVACY; INTELLECTUAL PROPERTY

9.1 Use of Confidential Information. The Parties hereby acknowledge that each Party will have access to confidential and proprietary information concerning the other Party and its businesses, and acknowledge that each Party has taken, and will continue to take, reasonable actions to ensure that such information is not made available to the public and otherwise continues to be maintained in a confidential and proprietary manner. Each Party agrees that neither such Party nor its Representatives will at any time (during the Term hereof or thereafter) disclose to any person (except Valleywise, DMG, and their respective affiliates, officers, directors, employees, agents, consultants, and advisors (each a "Representative"), in each case, who reasonably require such information in order to perform their duties in connection with this Agreement), directly or indirectly, or make any use of, for any purpose other than those contemplated by this Agreement, any confidential or proprietary information of the other Party. Neither Party may use any confidential information of the other Party except for the purpose of performing this Agreement.

9.2 Disclosure. Subject to the terms and conditions set forth herein, a Party may disclose confidential or proprietary information of the other Party in the following circumstances (or as otherwise provided by this Agreement):

(a) If such information is or becomes generally publicly known and available, through no act or omission by such Party or on its behalf or by any of its Representatives;

(b) In response to a court order or formal discovery request after notice to the other Party is given and after providing such Party an opportunity to object to or intervene in such order or request, if permitted by Law; *provided, however*, that such disclosure will be limited to that information specifically required by such court order or formal discovery request;

(c) If a proper request is made by any Governmental Entity, after notice to the other Party is given and after providing such Party an opportunity to object to such request, if permitted by Law; *provided, however*, that such disclosure will be limited to that information specifically required by such Governmental Entity;

(d) To the auditors, actuaries, or outside counsel of such Party, provided that such auditors, actuaries, or outside counsel are subject to confidentiality obligations pursuant to the terms of their respective engagements with such Party; or

(e) As otherwise required by applicable Law.

9.3 Privacy Requirements.

(a) In providing the Covered Services, DMG will, and will cause its employees and contractors to, comply in all material respects with all applicable confidentiality and security obligations in connection with the collection, use, disclosure, maintenance, and transmission of personal, private, health, or financial information (collectively "Nonpublic Personal Information"), that arise under: (i) those applicable Laws that are currently in place or which may become effective during the term of this Agreement, including the privacy and security regulations

promulgated by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and (ii) each Party's privacy policies as provided to the other Party prior to the Effective Date and as such policies may be amended upon notice to the other Party from time to time.

(b) DMG will, for so long as it retains Nonpublic Personal Information, maintain administrative, technical, and physical safeguards in accordance with applicable Laws and commercially reasonable industry standard: (i) to protect the integrity, security, and confidentiality of Nonpublic Personal Information; (ii) to protect against any anticipated threats or hazards to the integrity, security, or confidentiality of such records; and (iii) to protect against unauthorized access to or use of such records or information.

(c) The Parties acknowledge that, in rendering Covered Services pursuant to this Agreement, DMG may at times be a Business Associate of Valleywise (as defined by HIPAA and its implementing privacy regulations at 45 C.F.R. Parts 160 and 164, Subparts A and E, and security regulations at 45 C.F.R. Parts 160, 162 and 164, Subpart C). Accordingly, DMG agrees to be bound by and comply with the Business Associate Agreement attached as *Exhibit B* hereto.

9.4 Intellectual Property Rights. In addition to DMG's compliance with Valleywise Policies governing intellectual property:

(a) Any copyrightable or patentable work specifically ordered in writing by Valleywise from DMG or a Qualified Provider and specifically acknowledged as a work-made-for-hire, including a specific citation to this Section 9.4 ("Work") shall be considered a work-made-for hire and Valleywise shall own all right, title, and interest thereto, unless otherwise agreed to by the Parties. DMG, on behalf of itself and its Qualified Providers, further acknowledges that Valleywise shall be considered the author of the Work for the purposes of copyright, shall own all rights in and to the copyright of the Work, and shall have the right to register and renew the copyright in its name or the name of its nominee(s). To the extent ownership of the Work does not vest in Valleywise as a work-made-for-hire, DMG and/or the applicable Qualified Provider hereby irrevocably grants, assigns, and transfers to Valleywise all of DMG's and/or such Qualified Provider's right, title, and interest in and to the Work, including all renewals and extensions that may be secured under applicable Laws. DMG and/or its Qualified Providers also hereby assigns to Valleywise and/or waives any and all claims that DMG and/or its Qualified Providers may now or hereafter have in any jurisdiction to so-called "moral rights" or rights of "droit moral" in connection with the Work.

(b) Other than the Work, any and all inventions, processes, systems, discoveries, know-how, patentable creations, whether or not registrable or patentable, conceived or first reduced to practice as a result of the work performed or Covered Services provided under this Agreement shall be the sole and exclusive property of Valleywise, as applicable, and no assignment, transfer of ownership, or conveyance to DMG, and/or any Qualified Provider, or inventor or any other third party is intended hereunder.

(c) The Parties agree to give recognition to each other for their support of any program when publishing program material or releasing program-related public information.

ARTICLE X

DURATION; TERMINATION

10.1 Duration. The term of this Agreement will commence as of the Effective Date and will continue for five and one-half (5 ½) years immediately thereafter (the "Initial Term"). Upon expiration of the Initial Term, this Agreement may be renewed for one (1) additional term of five (5) years (a "Renewal Term" and together with the Initial Term, the "Term"), by mutual written agreement of the Parties. If either Party wishes not to renew this Agreement at the conclusion of the Initial Term, such Party must provide the other Party with written notice, at least two hundred seventy (270) Days prior to the expiration of the Initial Term, of its intent not to renew the Agreement. Unless the SOW provides a different term for that SOW, all SOWs entered into hereunder will have a term corresponding to the date of expiration and/or renewal of this Agreement.

10.2 Agreement Review. The Parties agree that at least sixty (60) Days prior to the beginning of each Contract Year during the Term, they will meet to discuss if any modifications, amendments, or adjustments to this Agreement or any SOW are warranted.

10.3 Renegotiation for Change in Law. If any provisions of this Agreement or an applicable SOW are the subject of a change in applicable Law, or the interpretation of such Law by a Governmental Entity charged with their enforcement, the Parties will enter into good faith negotiations, over a period of not less than sixty (60) Days, regarding potential modifications or amendment of such provisions. If, notwithstanding such good faith negotiations, the Parties are unable to reach an agreement on modified or amended provisions, either Party may terminate this Agreement or an applicable SOW upon thirty (30) Days written notice to the other Party.

10.4 Renegotiation Due to Lack of Funds. If any action is taken during the Term of this Agreement by any Governmental Entity to suspend or to decrease its fiscal obligations under or in connection with services or payments that are the subject of this Agreement in such a manner as to have (as determined by Valleywise's CEO) a substantial impact on Valleywise's ability to perform under the terms of this Agreement, then Valleywise shall provide prompt (and at least one hundred eighty (180) Days' prior) written notice to DMG, and upon written notice to DMG, the Parties will meet in good faith to consider modification of the terms of this Agreement (including termination of those Covered Services affected by lack of governmental funding) consistent with applicable Law. In the event the Parties cannot reach a mutually agreeable solution within thirty (30) Days, then either Party may terminate its obligations under or in connection with this Agreement following the expiration of the one hundred eighty (180)-Day period, or, subject to Section 10.9(d), any applicable SOW. In the event of termination pursuant to this Section 10.4, Valleywise shall be liable for payment only for Covered Services rendered prior to the effective date of the termination, provided such Covered Services are performed in accordance with this Agreement.

10.5 Termination for Material Breach. In the event of a material breach of this Agreement or any portion thereof by either Party, the non-breaching Party may serve on the breaching Party a written notice of intent to terminate this Agreement in whole or in relevant part, describing the grounds for termination. The breaching Party will have sixty (60) Days to cure the

breach from its receipt of the notice of intent to terminate. If the breaching Party fails to cure during that period, the non-breaching Party may terminate, effective immediately, this Agreement in its entirety or, subject to Section 10.9(d), the relevant SOW that gave rise to the material breach.

10.6 Mutual Agreement to Terminate. This Agreement or any SOW entered into hereunder may be terminated at any time upon the mutual written consent of the Parties, which writing will state the effective date of termination.

10.7 Termination for Exclusion. Notwithstanding any term of this Agreement to the contrary, this Agreement will terminate immediately if either DMG or Valleywise is excluded from participation in Medicare, AHCCCS, or any other federal or state health care program.

10.8 Cancellation of Agreement. This Agreement is subject to termination in accordance with the provisions of A.R.S. § 38-511.

10.9 Effect of Termination.

(a) Upon expiration or termination of this Agreement for any reason, all SOWs under this Agreement will automatically terminate as of the termination date.

(b) Notwithstanding the termination of this Agreement by either Party, DMG will cooperate with Valleywise in the transition of the Covered Services to such entity or entities as Valleywise designates, provided that Valleywise pays all compensation due and owing to DMG pursuant to Article III and the terms of any applicable SOWs.

(c) In the event of termination of this Agreement in whole or in part, Valleywise shall be liable for payment only for Covered Services rendered prior to the effective date of the termination, provided that such Covered Services were performed in accordance with the provisions of this Agreement. In addition, Valleywise has the right to the recoupment of monies or funds advanced to DMG consistent with Article VIII, above. Notwithstanding the above, upon termination of this Agreement for any reason, DMG agrees to provide Covered Services to any Valleywise Patient who, at the time of termination, is an inpatient at a Facility or at a hospital under contract with Valleywise for inpatient services, until such Valleywise Patient's orderly transition to another provider, and DMG will continue to be reimbursed for such Covered Services until the care and responsibility for such Valleywise Patients has been transferred.

(d) In the event any SOW is terminated or expires, this Agreement and all other SOWs will remain in effect unless otherwise terminated pursuant to the terms of this Article X; *provided, however*, that the Parties recognize that DMG has entered into this Agreement and the SOWs based upon the aggregate scope of work, and that if the scope of work is limited in any material respect, this may have the effect of reducing the quality of services which DMG may provide hereunder or may have other unintended consequences. Accordingly, despite anything else in this Agreement to the contrary, in the event that Valleywise seeks to terminate one or more SOWs (but not this entire Agreement and all SOWs) (as applicable, a "Terminated SOW"), the Parties shall meet and confer through the ELT at least ninety (90) Days in advance to negotiate in good faith potential modifications to this Agreement and the remaining SOWs to reach an equitable result.

(e) In the event of the expiration or termination of this Agreement, each Party will be solely responsible for ensuring that any required notices and/or other related documentation are provided to any Governmental Entity.

(f) The rights and remedies enumerated in this Article X shall be in addition to any other rights and remedies provided in this Agreement or provided for or permitted by Law.

10.10 Reductions in Service. Valleywise and DMG agree to give each other six (6) months' prior written notice in the event of the closure or termination of any department or service line for which DMG provides Covered Services pursuant to an active SOW. Notwithstanding the foregoing, Valleywise will give DMG one hundred twenty (120) Days' prior written notice in the event of closure of any Facility, termination of any Covered Service provided by DMG under this Agreement, or of any material decrease in the services Valleywise provides as of the Effective Date of this Agreement that would cause a material decrease in DMG's obligations under this Agreement (*i.e.*, a decrease of more than ten percent (10%) in the compensation payable by Valleywise to DMG); *provided, however*, that if the decrease is mandated by Law or a regulatory body, DMG hereby waives the notice period to the extent that timing of the Law or action of the regulatory body does not allow for such notice. Within ten (10) Days of DMG's receipt of the notice, the CEOs of both Valleywise and DMG shall meet to negotiate in good faith any modifications or amendments required to this Agreement or the applicable SOW.

10.11 Removal of Qualified Providers. Upon good cause and discussion in ELT, DMG, subject to compliance with the process set forth in this Section 10.11, will be required to remove any Qualified Provider who is not in compliance with the qualifications and standards for Qualified Providers or other terms set out in this Agreement from providing any Covered Services under this Agreement.

(a) To the extent the concerns of Valleywise regarding a Qualified Provider relate to the practice of medicine and the provision of clinical services under this Agreement, the CEO of Valleywise will refer the matter to the Valleywise Medical Staff to be addressed under the Valleywise Medical Staff Bylaws.

ARTICLE XI

INSURANCE AND INDEMNIFICATION

11.1 Insurance.

(a) DMG, its Qualified Providers, agents and employees shall maintain during the term of this Agreement insurance of the types and amounts set forth below. DMG shall provide Valleywise with a copy, upon request, of each policy that establishes the listed insurances below. In addition, DMG shall, where possible, notify Valleywise of any cancellation of the insurance or any material decrease in the amounts of coverage at least thirty (30) Days before such action occurs. In the event DMG does not purchase commercial insurance to fulfill all or a portion of its obligations under this Section 11.1, becomes self-insured for all or a portion of its obligations, or creates or enters any financial arrangement to fulfill its obligation hereunder, DMG will ensure, to

the satisfaction of Valleywise, that such non-commercial insurance arrangements are financially and actuarially sound. The insurance(s) required to be maintained are:

(i) Workers' compensation and employer's liability insurance with limits of $1,000,000 each accident, $1,000,000 each disease and $1,000,000 disease policy limits.

(ii) Automobile and General Liability Insurance:

A. General liability insurance at least as broad as ISO's CG0001 with a limit of $1,000,000 for each occurrence, a $2,000,000 Products/Completed Operations Aggregate, and $2,000,000 General Aggregate. The insurance shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual.

B. Automobile insurance for vehicles owned, hired and non-owned or leased by DMG with limits of $1,000,000 per occurrence.

C. Additional Insured: DMG will designate Valleywise as additional insured on DMG's general liability and vehicle liability insurance coverages.

(iii) Directors and Officers Liability coverage, with coverage limits at levels that are customary in the community for group medical practices.

(iv) Professional Liability:

A. Except as provided in Section 11.1(a)(iv)(B), below, DMG shall be solely responsible for procuring and maintaining professional liability coverage for any and all professional activities. Such professional liability coverage shall be maintained for the Term of this Agreement, and shall have annual policy period coverage minimum limits (i) of $5,000,000 per occurrence and $13,000,000 in the aggregate for Qualified Providers who are employees of DMG, and (ii) of $1,000,000 per occurrence and $3,000,000 in the aggregate for Qualified Providers who are DMG's independent contractors. Such professional liability insurance coverage requirements may be met through a combination of captive insurance and commercially purchased insurance policies. In the event that DMG's professional liability coverage obligation under this Agreement is maintained via a self-funded self-insurance program, through a wholly owned subsidiary or an affiliated program or entity, or through an entity whose directors are also employees or contractors of DMG, or via a captive insurance company, DMG represents and warrants that such entity is and will remain licensed to do business in Arizona subject to the jurisdiction of the Arizona Department of Insurance. DMG further represents and warrants that any such professional liability coverage program shall be reviewed for soundness by a qualified actuary, and DMG will provide Valleywise with documentation of such on an annual basis to the extent that such reports do not compromise DMG's position in any pending or future litigation claims.

B. Notwithstanding the above, Valleywise agrees to provide "Valleywise Medical Staff Activities" Liability Coverage as that term is defined below to DMG's Qualified Providers. "Valleywise Medical Staff Activities" Liability Coverage means that DMG's

Qualified Providers shall be deemed agents of Valleywise entitled, subject to the terms and conditions of the Valleywise Risk Management program, to defense and indemnity coverage for claims, suits, losses, or expenses arising out of "Valleywise Medical Staff Activities." "Valleywise Medical Staff Activities" means activities: (1) relating to non-clinical administrative duties of the Valleywise Medical Staff that are performed by any committee member or officer of the Valleywise Medical Staff, in their capacity as a committee member or officer; (2) relating to the training or education, employment, disciplinary, termination, non-renewal or related decisions affecting graduate medical personnel; (3) relating to the performance by a Qualified Provider in his or her capacity as a medical director for services provided under this Agreement; or (d) relating to the performance of non-clinical administrative duties at the request, and on behalf, of Valleywise and which directly relate to provisions of the Valleywise Medical Staff Bylaws. The coverage provided under this Section 11.1(a)(iv)(B) shall apply to all Valleywise Medical Staff Activities occurring during the Term of this Agreement and any extensions or renewals thereof.

The defense and indemnity and professional liability insurance provided under this Section 11.1(a)(iv)(B), including coverage limits and exclusions, shall be governed by the terms of the Valleywise Risk Management Insured and Self-Insurance Plan (Plan) and Risk Management program. Coverage, defense costs and indemnification for intentional and willful/wrongful acts, criminal acts, fines, assessments, penalties, or punitive damages are specifically excluded under this Section 11.1(a)(iv)(B). Valleywise shall provide DMG and its Qualified Providers with defense and legal representation in any matter involving Valleywise Medical Staff Activities subject to the terms and conditions of Valleywise's Plan and Risk Management Program.

Notwithstanding the above, in the event that DMG retains its own counsel for any purpose related to this Section 11.1(a)(iv)(B), DMG will be solely responsible for any and all expenses related to retention and representation by such counsel, but in doing so remains under the terms and conditions of Valleywise's Plan and Risk Management Program and does not preclude Valleywise from settling any claim or lawsuit.

Valleywise and its Risk Management Department in accordance with the terms of Valleywise's Plan or Risk Management program, including, but not limited to, purchased insurance or self-insurance, may defend or settle any claim for which Valleywise is providing Valleywise Medical Staff Activities Liability Coverage, or suit for monetary damages involving DMG or its Qualified Providers, and except where such settlement would require a payment of money by DMG, its Qualified Providers, or their respective professional liability insurance carriers, their consent to settlement is not required. However, Valleywise will make reasonable efforts to consult and coordinate with DMG and the affected Qualified Provider prior to making and/or implementing any settlement decision involving monetary damages. Settlements involving injunctive or other equitable relief or involving a restriction, suspension, or limitation upon the professional license of any Qualified Provider shall require the prior consent of the affected Qualified Provider but does not preclude Valleywise from settling or resolving any claim or lawsuit filed against Valleywise, its directors, or employees.

C. DMG agrees that in the event it or any of its Qualified Providers, agents, servants, and employees is named as a defendant in litigation, or identified in a written notice of claim, wherein professional misconduct or acts, mistakes, or omissions are

alleged for any activities under this Agreement, that DMG will promptly notify the Valleywise Director of Risk Management in writing. The duty to notify under this Section 11.1(a)(iv)(C) applies whether or not Valleywise, its directors, and employees are claimed to be involved, are named as a party to the matter, or could be potentially liable as a party.

(v) Primary Coverage. DMG's insurance, self-insurance, or captive insurance shall be the primary insurance under the terms of this Agreement for any acts, errors, or omissions of DMG. Valleywise and its Plan and Risk Management program, shall not contribute to DMG's indemnity, defense, or insurance or self-insurance obligations under this Agreement.

(b) Valleywise, on behalf of itself and its directors, officers, and employees, shall maintain during the Term of this Agreement the following categories of insurance coverage, whether through a policy of self-insurance or third-party coverage, in such amounts as are required by law or otherwise considered customary for Valleywise's business and operations:

(i) Workers' Compensation;
(ii) Property;
(iii) Automobile and General Liability;
(iv) Directors and Officers Liability; and
(v) Professional Liability.

11.2 Indemnification. Except as otherwise provided in this Section 11.2, and to the extent permitted by Law, each Party agrees to indemnify, defend, and hold harmless the other Party from and against any and all claims, losses, liability, costs, or expenses, including, but not limited to, those arising out of bodily injury to any person, including death, or property damage; *provided, however*, such indemnification shall exist only to the extent that such claims are solely caused by the negligence, misconduct, or other fault of the indemnitor, its agents, employees, or contractors.

(a) To the extent permitted by Law, when Valleywise engages in coding, billing, or collection activities in connection with Covered Services provided by DMG under the terms of this Agreement, Valleywise agrees to indemnify, defend, and hold harmless DMG from and against any and all claims, losses, liability, costs, or expenses arising out of Valleywise's actions or omissions which relate directly to such activities; *provided, however*, that such indemnification shall extend only to such claims, losses, liability, costs, or expenses that are caused solely by the negligence, misconduct, or other fault of Valleywise, its agents, employees, or other contractors. Nothing in this Section 11.2(a) shall relieve any Qualified Provider of the duty under this Agreement to maintain complete and accurate medical records with respect to all Covered Services furnished to Valleywise Patients. If any such claim, loss, liability, cost, or expense shall arise in part, but not in whole, out of either Party's negligence, misconduct, or other fault, then the Parties' rights shall be determined in accordance with applicable Arizona Law.

(b) To the extent permitted by Law, when DMG engages in coding, billing, or collection activities in connection with Covered Services provided on behalf of Valleywise under the terms of this Agreement, DMG agrees to indemnify, defend, and hold harmless Valleywise from and against any and all claims, losses, liability, costs, or expenses arising out of DMG's actions or omissions that relate, directly or indirectly, to such activities; *provided, however*, that such indemnification shall extend only to such claims, losses, liability, costs, or expenses that are

caused solely by the negligence, misconduct, or other fault of DMG, its agents, employees, or other contractors. If any such claim, loss, liability, cost, or expense shall arise in part, but not in whole, out of either Party's negligence, misconduct, or other fault, then the Parties' rights shall be determined in accordance with applicable Arizona Law.

11.3 Survival. The terms and conditions of this Article XI will survive termination of this Agreement indefinitely.

ARTICLE XII

GENERAL PROVISIONS

12.1 Independent Contractor. The Parties agree that, in providing Covered Services pursuant to this Agreement, DMG is and at all times will be an independent contractor in relation to Valleywise. Nothing contained in this Agreement is intended nor will be construed to create an employer/employee, joint venture, agency, or similar relationship between the Parties. Neither Party shall be liable in whole or in part for any purchases, contracts, loans, commitments, or other obligations proposed, tendered, or made by the other Party, unless expressly agreed to by the Party to be bound, in writing. Valleywise shall neither have nor exercise any control or direction over the methods by which the Qualified Providers perform their professional responsibilities, so long as these responsibilities are carried out in a competent, efficient, and satisfactory manner and in accordance with acceptable medical practices, community standards, this Agreement's terms, and the Valleywise Medical Staff Bylaws.

12.2 Personnel and Delegation. Each Party will be and remain the sole employer of its own employees, and nothing contained herein or in any SOW will be deemed to cause the employees of one Party to become the employees of the other Party. Except as otherwise expressly agreed in an SOW, each Party will retain sole authority over the hiring, supervision, evaluation, discipline, and termination of its own employees. While the Parties acknowledge that DMG may subcontract for performance of certain Covered Services under this Agreement, DMG's legal responsibility to Valleywise under this Agreement is to ensure that all of DMG's obligations are carried out; therefore, no subcontract shall alter DMG's ultimate responsibility under this Agreement. In the event that DMG subcontracts with other individuals or entities to furnish Covered Services under this Agreement, DMG shall cause such subcontractors to comply with the terms of this Agreement, including all exhibits and SOWs appended hereto.

12.3 Force Majeure. Neither Party will have any liability for any failure to perform under this Agreement if such failure arises out of unforeseeable causes beyond such Party's control. Such unforeseeable causes may include acts of civil or military authority, war, terrorism, accidents, explosions, sabotage, riots, strikes, lockouts or other labor disturbances, pandemics, or acts of God, including fires, floods, severe weather, earthquakes and natural disasters, or national emergency. Lack of funds and lack of personnel (except due to strikes or other items described in the prior sentence which are outside of DMG's control) will not be deemed to constitute a force majeure event, nor will a force majeure event include the non-performance or failure of any vendor or subcontractor (unless such non-performance or failure results from an unforeseen cause of the kind described in the preceding sentence). The Party experiencing the force majeure event will

give the other Party notice promptly following the occurrence of a force majeure event, and will use diligent efforts to re-commence performance as promptly as commercially practicable.

12.4 Amendment and Modification. This Agreement may be amended, modified, or supplemented only by a written amendment signed by each of the Parties. No course of dealing between the Parties, or any of their respective employees or contractors, will be deemed effective to modify or amend any part of this Agreement or any SOW, or any rights or obligations of any Party under or by reason of this Agreement or any SOW.

12.5 Waiver of Compliance; Consents. Any failure of DMG, on the one hand, or Valleywise, on the other hand, to comply with any obligation, covenant, agreement, or condition herein may be waived by Valleywise or DMG, respectively, only by a written instrument signed by the Party granting such waiver. Such waiver or failure to insist upon strict compliance with such obligation, covenant, agreement, or condition will not operate as a waiver of, or estoppel with respect to, any subsequent or other failure. Whenever this Agreement requires or permits consent by or on behalf of any Party, such consent will be given in writing in a manner consistent with the requirements for a waiver of compliance as set forth in this Section 12.5.

12.6 Access to Books and Records. Pursuant to Title 42 of the United States Code and applicable rules and regulations thereunder, until the expiration of four (4) years after this Agreement's termination or expiration, DMG will make available, upon appropriate written request by the Secretary of Health & Human Services or the Comptroller General of the Government Accountability Office, or any of their duly authorized representatives, a copy of this Agreement and such books, documents, and records as are necessary to certify the nature and extent of the costs of the Covered Services provided in connection with this Agreement. DMG further agrees that if it carries out any of its duties under this Agreement through a subcontract with a value or cost of Ten Thousand Dollars ($10,000) or more over a twelve (12)-month period, such subcontract will contain a clause to the effect that until the expiration of four (4) years after the furnishing of such services pursuant to such subcontract, the subcontractor will make available, upon appropriate written request by the Secretary of Health & Human Services or the Comptroller General of the Government Accountability Office, or any of their duly authorized representatives, a copy of such subcontract and such books, documents, and records of such organization as are necessary to verify the nature and extent of such costs.

12.7 Use of Party's Name. Each Party, with the prior consent of the other Party, may utilize the other Party's name and/or logotype (and where applicable, the name of its Qualified Providers) in its marketing literature.

12.8 Notices. All notices, requests, demands, claims, and other communications hereunder will be in writing. Any notice, request, demand, claim, or other communication hereunder will be deemed duly given: (a) when delivered personally to the recipient; (b) one (1) business day after being sent to the recipient by reputable overnight courier service (charges prepaid); (iii) one (1) business day after being sent to the recipient by electronic transmission with transmission or receipt electronically confirmed; or (iv) four (4) business days after being mailed to the recipient by certified or registered mail, return receipt requested and postage prepaid, and addressed to the intended recipient as set forth below:

If to Valleywise:	Valleywise Health Attention: Chief Executive Officer Conference and Administration Center 2601 East Roosevelt Phoenix, AZ 85008
cc:	Martin Demos, General Counsel Valleywise Health 2601 East Roosevelt Phoenix, AZ 85008
If to DMG:	District Medical Group, Inc. Attention: President 2929 East Thomas Road Phoenix, AZ 85016
cc:	Snell & Wilmer LLP Attention: Paul J. Giancola & Brad Martorana One Arizona Center 400 East Van Buren Phoenix, AZ 85004

Any Party may change the address to which notices, requests, demands, claims, and other communications hereunder are to be delivered by giving the other Party notice in the manner set forth herein.

12.9 Assignment.

(a) Notwithstanding any other provision in this Agreement to the contrary, on one hundred eighty (180) Days' written notice to DMG, Valleywise has a unilateral right to assign, transfer, subcontract, or sublicense this Agreement and/or all of its rights and obligations herein. Valleywise may not assign less than all of its rights and obligations under this Agreement without the written consent of DMG; *provided, however*, Valleywise may assign its rights as are required to obtain Federally Qualified Health Center status for Valleywise Facilities, as provided by federal law, upon sixty (60) Days' notice. Except as expressly provided in this Agreement, subsequent to the effective date of an assignment by Valleywise of this Agreement, Valleywise will no longer be legally obligated to perform any of the obligations imposed on Valleywise under this Agreement, except that Valleywise will be obligated to perform all of its obligations with respect to events occurring prior to the effective date of the assignment. Except as expressly provided in this Agreement, DMG understands and agrees that any such assignment by Valleywise to another legal entity exculpates Valleywise from any and all liability or responsibility under the terms of this Agreement to DMG.

(b) DMG may not assign its rights or obligations under this Agreement without providing Valleywise one hundred eighty (180) Days' written notice prior to such assignment and obtaining the prior written consent of Valleywise to the assignment. Valleywise shall have the right to withhold such consent in its reasonable discretion.

(c) For purposes of this Agreement, any Change in Control of DMG shall be considered an assignment of this Agreement within the meaning of and subject to the provisions of this Section 12.9. For purposes of this Section 12.9(c), a "Change in Control" shall mean: (i) a sale, transfer, or other disposition of all or substantially all of the assets of DMG to a third party; (ii) a transfer of a majority of the equity interests of DMG to a third party; or (iii) a transfer of the rights to control appointment or election of a majority of the members of the governing body of DMG to a third party.

12.10 Dispute Resolution. Any dispute or controversy arising out of or relating to this Agreement, including, but not limited to, disputes relating to the formation, performance, or alleged breach of this Agreement, shall be resolved in accordance with the procedures specified in this Section 12.10, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 12.10 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

(a) The Parties shall attempt in good faith to resolve any dispute arising out of or relating to this Agreement promptly by negotiation between the CEOs of Valleywise and DMG or their respective designees. Either Party may give the other Party written notice of any dispute not resolved in the normal course of business and such notice shall include: (i) a statement of the issue giving rise to the dispute; (ii) a statement of that Party's position and a summary of arguments supporting that position; and (iii) the name and title of the executive who will represent that Party and of any other person who will accompany the executive. Within fifteen (15) Days after delivery of the notice, the receiving Party shall submit to the other Party a written response which shall include: (i) a statement of that Party's position and a summary of arguments supporting that position; and (ii) the name and title of the executive who will represent that Party and of any other person who will accompany the executive. Within ten (10) Days after delivery of the response notice, the executives of both Parties shall meet at a mutually acceptable time and place, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute. All reasonable requests for information made by one Party to the other will be honored.

(b) If the Parties are unable to resolve their dispute pursuant to Section 12.10(a), above, the Parties thereafter agree to attempt to resolve such dispute via a mediation process sponsored by the Maricopa County Superior Court or other agreed upon mediation service.

(c) Any dispute arising out of or relating to this Agreement which has not been resolved pursuant to Sections 12.10(a) and (b), above, within sixty (60) Days, shall be finally resolved by arbitration pursuant to the rules of the American Health Lawyers Association Alternative Dispute Resolution Service; *provided, however*, that if one Party fails to participate in the negotiation as agreed herein, the other Party can commence arbitration prior to the expiration of the time periods set forth above.

(d) If the amount in controversy is less than One Million Dollars ($1,000,000), the dispute shall be resolved by a sole arbitrator. If the amount in controversy is equal to or greater than One Million Dollars ($1,000,000), the arbitration panel shall consist of three (3) arbitrators selected as follows. Each Party shall select one arbitrator, and the two Party-selected arbitrators shall select the third arbitrator who shall serve as Chair of the arbitration panel. Regardless of the number of arbitrators, each arbitrator shall have not less than ten (10) years' experience as a

hospital administrator or as a lawyer serving the health care industry with knowledge and experience in the legal regulation of hospitals and physicians, and each arbitrator must be neutral and independent of the Parties.

(e) The arbitration shall be governed by the Federal Arbitration Act (9 U.S.C. § 1 et seq.) and judgment upon the award rendered by the arbitrator may be entered by any court having jurisdiction thereof. The place of arbitration shall be Phoenix, Arizona.

12.11 Governing Law and Venue; Waiver of Jury Trial. This Agreement will be governed by and construed in accordance with the domestic laws of the State of Arizona without giving effect to any choice or conflict of law provision or rule (whether of the State of Arizona or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of Arizona. Any action to enforce the terms of this Agreement or any SOW entered into hereunder, including any arbitration award made pursuant to Section 12.10, will be brought in the competent federal or state court for Maricopa County, Arizona. EACH OF THE PARTIES HERETO HEREBY IRREVOCABLY WAIVES ANY AND ALL RIGHT TO TRIAL BY JURY IN ANY LEGAL PROCEEDING ARISING OUT OF OR RELATED TO THIS AGREEMENT.

12.12 Counterparts. This Agreement may be executed and delivered (including by facsimile transmission or by electronic mail with a .pdf scanned attachment) in one or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

12.13 Interpretation. The article and section headings contained in this Agreement are solely for the purpose of reference, are not part of the agreement of the Parties, and will not in any way affect the meaning or interpretation of this Agreement. The Parties are sophisticated, represented by counsel and jointly have participated in the negotiation and drafting of this Agreement and there will be no presumption or burden of proof favoring or disfavoring any Party by virtue of the authorship of any provision of this Agreement.

12.14 Entire Agreement; Further Assurance. This Agreement (including the exhibits and appendices hereto) embodies the entire agreement and understanding of the Parties in respect of the subject matter hereof and supersedes all prior agreements and understandings, both written and oral, among the Parties, including, but not limited to, that certain 2016 Amended and Restated Contract for Professional Services by and between the Parties. Notwithstanding the foregoing, the 2016 Amended and Restated Contract for Professional Services shall continue to apply with respect to any services provided under that agreement, and any collections received by either Party under that agreement for dates of service during the term of that agreement.

12.15 Third-Party Beneficiaries. This Agreement is not intended to, and does not, create any rights or benefits of any party other than the Parties (including without limitation any creditor of either Party).

12.16 Severability. Wherever possible, each provision of this Agreement will be interpreted in such manner as to be effective and valid under applicable Law, but in case any one or more of the provisions contained herein will, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability will not affect any

other provision of this Agreement, and this Agreement will be construed as if such invalid, illegal, or unenforceable provision or provisions had never been contained herein unless the deletion of such provision or provisions would result in such a material change as to cause completion of the transactions contemplated hereby to be unreasonable.

12.17 Construction. Unless the context of this Agreement otherwise requires: (i) words of any gender include each other gender; (ii) words using the singular or plural number also include the plural or singular number, respectively; (iii) the terms "hereof," "herein," "hereby," and derivative or similar words refer to this entire Agreement, including all exhibits and SOWs hereto; (iv) the terms "Article" or "Section" refer to the specified Article or Section of this Agreement; (v) the term "or" has, except where otherwise indicated, the inclusive meaning represented by the phrase "and/or"; (vi) the term "including" means "including without limitation"; and (vii) the term "foreign" is used with respect to the United States.

12.18 Conflicting Terms. Each SOW will be governed by the terms of this Agreement. In the event of any inconsistency between the terms of this Agreement and the terms set forth in a SOW, the terms of the SOW will prevail.

12.19 Survival. In addition to any other provisions that, by their nature, must be deemed to extend beyond the termination of this Agreement for its proper administration, the following provisions hereto will survive the termination of this Agreement: Sections 3.2, 3.3, 3.4, 5.1 and 5.7; Article VI; Section 7.1; Article VIII; Article IX; Section 10.9; Article XI; and Article XII.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the date first above written.

Maricopa County Special Health Care District d/b/a Valleywise Health	**District Medical Group, Inc.**
By: _____	By: _____
Name: _____	Name: _____
Its: _____	Its: _____

Exhibit A Valleywise Facilities

Exhibit B Business Associate Agreement

EXHIBIT A

Valleywise Facilities

Valleywise Health Medical Center
2601 E. Roosevelt Street
Phoenix, AZ 85008

Valleywise Emergency – Maryvale
5102 W. Campbell Avenue
Phoenix, AZ 85031

Valleywise Comprehensive Health Center – Phoenix
2525 E. Roosevelt Street
Phoenix, AZ 85008

Valleywise Comprehensive Health Center – Peoria
8088 W. Whitney Drive
Peoria, AZ 85345

Valleywise Community Health Center – West Maryvale
7808 W. Thomas Road
Phoenix, AZ 85033

Valleywise Community Health Center – South Phoenix/Laveen
5650 S. 35th Avenue
Phoenix, AZ 85041

Valleywise Community Health Center – South Central Phoenix
33 W. Tamarisk Street
Phoenix, AZ 85041

Valleywise Community Health Center – North Phoenix
2025 W. Northern Avenue
Phoenix, AZ 85021

Valleywise Community Health Center – Mesa
950 E. Main Street
Mesa, AZ 85203

Valleywise Community Health Center – McDowell
1101 N. Central Avenue, Suite 204
Phoenix, AZ 85004

Valleywise Community Health Center – Guadalupe
5825 E. Calle Guadalupe
Guadalupe, AZ 85283

Valleywise Community Health Center – Chandler
811 S. Hamilton Street
Chandler, AZ 85225

Valleywise Community Health Center – Avondale
950 E. Van Buren Street
Avondale, AZ 85323

Valleywise Behavioral Health Center – Phoenix
2619 E. Pierce Street
Phoenix, AZ 85008

Valleywise Behavioral Health Center – Mesa
570 W. Brown Road
Mesa, AZ 85201

Valleywise Behavioral Health Center – Maryvale
5102 W. Campbell Avenue
Phoenix, AZ 85031

EXHIBIT B

Business Associate Agreement

This Business Associate Agreement (this "Agreement") is entered into this 1st day of January, 2023, by and between Maricopa County Special Health Care District d/b/a Valleywise Health ("Covered Entity") and District Medical Group, Inc. ("Business Associate").

WHEREAS, Covered Entity is subject to the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated by the United States Department of Health and Human Services ("HHS") thereunder at 45 C.F.R. Part 160-164 ("HIPAA");

WHEREAS, Covered Entity and Business Associate are parties to that certain Master Services Agreement of even date herewith pursuant to which Business Associate provides certain administrative and other services to Covered Entity ("Services");

WHEREAS, Business Associate will have access to Protected Health Information of Covered Entity in connection with performing Services for or on behalf of Covered Entity; and

WHEREAS, Covered Entity and Business Associate wish to enter into this Agreement governing Business Associate's use and disclosure of Protected Health Information for the purpose of ensuring Covered Entity's compliance with HIPAA;

NOW, THEREFORE, in consideration of the foregoing recitals and the mutual promises herein made, the parties agree as follows:

1. Definitions. Any capitalized terms used in this Agreement but not otherwise defined herein shall have the meanings ascribed to them under HIPAA.

2. Permitted Uses and Disclosures by Business Associate. Business Associate may use or disclose Protected Health Information for the following purposes:

2.1 Business Associate may use or disclose Protected Health Information to carry out its obligations to perform Services for or on behalf of Covered Entity.

2.2 Business Associate may use or disclose Protected Health Information, if necessary, for Business Associate's proper management and administration or to fulfill any present or future legal responsibilities of Business Associate; provided, however, that if Business Associate discloses Protected Health Information to a third party for such purpose, Business Associate shall (i) obtain reasonable assurances from the person to whom the Protected Health Information is disclosed that it will be held confidentially and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to such person and (ii) obligate such person to notify Business Associate of any instances of which it is aware in which the confidentiality of the Protected Health Information has been breached.

2.3 Business Associate may use or disclose Protected Health Information as Required By Law.

2.4 Business Associate may de-identify Protected Health Information in accordance with 45 C.F.R. § 164.514(b) and use such de-identified data for any purpose consistent with applicable law. Business Associate also may use Protected Health Information to perform data aggregation services as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

3. Limitations on Use and Disclosure. Business Associate shall not use or disclose Protected Health Information received from or created on behalf of Covered Entity in a manner that would violate HIPAA (including the minimum necessary requirements thereof) if done by Covered Entity.

4. Safeguards. Business Associate shall employ administrative, physical, and technical safeguards, consistent with the size and complexity of Business Associate's operations, to ensure that Protected Health Information is used and disclosed in accordance with the terms of this Agreement. Business Associate shall comply with the security standards set forth at 45 C.F.R. § 164.308, 164.310, 164.312, and 164.316. With respect to Protected Health Information maintained or transmitted by Business Associate in an electronic form, in addition to complying with the other terms of this Agreement, Business Associate shall: (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of such information; (ii) ensure that any agent, including a subcontractor that creates, receives, maintains, or transmits Protected Health Information on behalf of Business Associate, agrees to implement reasonable and appropriate safeguards to protect such information; and (iii) report to Covered Entity promptly in writing any Security Incident of which Business Associate becomes aware, including incidents that may constitute Breaches of Unsecured Protected Health Information. Business Associate also will report the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy electronic Protected Health Information or interfere with system operations in an information system containing electronic Protected Health Information, of which Business Associate becomes aware, provided that: (i) such reports will be provided only as frequently as the parties mutually agree, but in no event more than once per calendar quarter; and (ii) if the definition of "Security Incident" under the Security Rule is amended to remove the requirement for reporting unsuccessful attempts to use, disclose, modify, or destroy electronic Protected Health Information, the portion of this Section 4 addressing the reporting of unsuccessful, unauthorized attempts will no longer apply as of the effective date of such amendment.

5. Disclosure to Agents. In the event Business Associate discloses to any agent, including a subcontractor, Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, Business Associate shall obtain from each such agent an agreement in writing to be bound by the same restrictions and conditions regarding the use and disclosure of Protected Health Information as are applicable to Business Associate under this Agreement.

6. Reporting and Mitigation of Improper Disclosures and Breaches.

6.1 Business Associate shall promptly report to Covered Entity any use or disclosure of Protected Health Information not provided for by, or in violation of, this Agreement of which Business Associate becomes aware. Business Associate shall reasonably cooperate with Covered Entity and make best efforts to mitigate, to the extent practicable, any harmful effects of

any improper use or disclosure of Protected Health Information of which Business Associate becomes aware.

6.2 Business Associate shall notify Covered Entity of any Breach of Unsecured Protected Health Information of which it becomes aware without unreasonable delay but in no event more than five (5) business days after Business Associate's discovery of the Breach. Business Associate shall provide the following additional information to Covered Entity as soon as reasonably practicable following the initial notification: (i) the identification of each individual whose Unsecured Protected Health Information was, or is reasonably believed to have been, affected by the Breach; (ii) a description of what happened, including the date and time of the Breach of Unsecured Protected Health Information and the date of its discovery; (iii) description of the types of Protected Health Information involved; (iv) identity of who made or caused the Breach of Unsecured Protected Health Information and who received the Protected Health Information; (v) names of systems, programs, or networks involved or affected by the Breach of Unsecured Protected Health Information; (vi) description of Business Associate's investigation and responses; (vii) actions taken by Business Associate to mitigate any deleterious effect of the Breach of Unsecured Protected Health Information; and (viii) additional information as requested by Covered Entity.

7. Individual Rights.

7.1 Within five (5) business days of a request by Covered Entity, Business Associate shall provide to Covered Entity all Protected Health Information in Business Associate's possession necessary for Covered Entity to provide Individuals or their representatives with access to or copies thereof in accordance with 45 C.F.R. § 164.524. If an Individual makes a request for access directly to Business Associate, Business Associate will within five (5) business days forward such request in writing to Covered Entity. Covered Entity will be responsible for making all determinations regarding the grant or denial of an Individual's request for Protected Health Information and Business Associate will make no such determination. Only Covered Entity will release Protected Health Information to an Individual pursuant to such a request, unless Covered Entity directs Business Associate to do so.

7.2 Within five (5) business days of a request by Covered Entity, Business Associate shall provide to Covered Entity all information and records in Business Associate's possession necessary for Covered Entity to provide Individuals or their representatives with an accounting of disclosures thereof in accordance with 45 C.F.R. § 164.528. Business Associate shall track and record all such disclosures to ensure compliance with this section, and shall maintain a record of all such disclosures for six (6) years from the date of the disclosure.

7.3 Within five (5) business days of a request by Covered Entity, Business Associate shall provide to Covered Entity all Protected Health Information in Business Associate's possession necessary for Covered Entity to respond to a request by an Individual to amend such Protected Health Information in accordance with 45 C.F.R. § 164.526. In the event that Covered Entity amends any Protected Health Information in its possession, a copy of which is also retained by Business Associate, upon notice from Covered Entity, Business Associate shall promptly incorporate any amendments to Protected Health Information made by Covered Entity into the information maintained by Business Associate. If an Individual makes a request for amendment

directly to Business Associate, Business Associate will within five (5) business days forward such request in writing to Covered Entity. Covered Entity will be responsible for making all determinations regarding amendments to Protected Health Information, and Business Associate will make no such determinations unless Covered Entity directs Business Associate to do so.

7.4 Business Associate shall promptly comply with any restrictions on the uses of Protected Health Information agreed to by Covered Entity in accordance with HIPAA upon written notification by Covered Entity.

8. Access by HHS and Covered Entity. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity, available to HHS in accordance with HIPAA and available to Covered Entity upon request.

9. Return of Protected Health Information. Upon termination of this Agreement, Business Associate shall, if feasible, return or destroy (as determined by Business Associate) all Protected Health Information received from, or created or received by Business Associate or any of its agents or subcontractors on behalf of, Covered Entity that Business Associate or any of its agents and subcontractors still maintains in any form, and Business Associate and its agents and subcontractors shall retain no copies of such information. If such return or destruction is not feasible, Business Associate shall provide notice to Covered Entity of the conditions that make such return or destruction infeasible and Business Associate shall extend the protections of this Agreement to such information and limit further uses and disclosures to those purposes that make the return or destruction of the Protected Health Information infeasible. This provision shall apply to Protected Health Information that is in the possession of agents or subcontractors of Business Associate. Covered Entity acknowledges and agrees that it shall be deemed infeasible for Business Associate to return or destroy Protected Health Information if: (i) Protected Health Information has been archived in a manner that impedes deletion; or (ii) the Protected Health Information cannot be destroyed due to Business Associate's reasonable need to maintain such information for audit defense, litigation, or other valid business purposes.

10. Obligations of Covered Entity.

10.1 Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices that may affect Business Associate's use or disclosure of Protected Health Information.

10.2 Covered Entity shall notify Business Associate of any restriction on the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

10.3 Covered Entity shall be responsible for obtaining any legally required consents or authorizations from Individuals for the disclosure of their Protected Health Information to, or use of their Protected Health Information by, Business Associate in the course of performing Services for or on behalf of Covered Entity.

11. Term and Termination

11.1 Unless otherwise terminated in accordance with Section 11.2, the term of this Agreement shall be from the date hereof until termination of the Master Services Agreement.

11.2 Either party may terminate this Agreement in the event of a material breach of the other party's obligations under this Agreement that is not cured by the other party within thirty (30) days of receipt of written notice of the breach from the non-breaching party.

12. Miscellaneous

12.1 Amendment; Construction. If HIPAA is amended in any manner that renders this Agreement inconsistent therewith, the parties shall negotiate in good faith to amend this Agreement to the extent necessary to comply with such amendments. Notwithstanding the foregoing, the parties acknowledge and agree that the terms of this Agreement will be construed in light of any applicable interpretation or guidance on the Privacy Rule, the Security Rule, or the Breach Notification Rule that may be issued by HHS from time to time.

12.2 Survival. Business Associate's obligations under Sections 6, 8, and 9 shall survive the termination of this Agreement for any reason.

12.3 Full Authority. Each party hereto represents and warrants to the other party that it has the legal power and authority to enter into and perform its obligations under this Agreement without violating the rights or obtaining the consent of any third party.

12.4 Fees, Expenses. Each of the parties hereto shall pay its own fees and expenses incurred in connection with the Agreement and the consummation of the transactions contemplated hereby.

12.5 Independent Contractors. The relationship between the parties is solely that of independent contractors and this Agreement shall not create an agency, partnership, joint venture, or employer/employee relationship. Nothing herein shall be deemed to authorize either party to act, represent, or bind the other party except as expressly provided by this Agreement.

12.6 Successors and Assigns. All covenants and agreements contained in this Agreement by or on behalf of any of the parties hereto shall bind and inure to the benefit of the respective successors and assigns of the parties hereto.

12.7 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, and all of which together shall be deemed to be one and the same instrument.

12.8 Assignment. Neither party shall assign this Agreement without the prior written consent of the other party.

12.9 No Third Party Beneficiaries. None of the provisions of this Agreement is or shall be construed as for the benefit of or enforceable by any person or entity not a party to this Agreement.

12.10 Notice. All requests, reports, approvals, and notices required or permitted to be given under this Agreement shall be in writing and, unless specifically provided otherwise in this Agreement, shall be deemed to have been given when sent if personally delivered, faxed (with receipt confirmed) or mailed by registered or certified air mail, return receipt requested, or by overnight mail with receipt confirmed, postage prepaid, to the party concerned, at its address or addresses as set forth below or as designated from time to time by notice in writing.

If to Covered Entity:

Valleywise Health
Attention: Chief Executive Officer
Conference and Administration Center
2601 East Roosevelt
Phoenix, AZ 85008

cc: Martin Demos, General Counsel
Valleywise Health
2601 East Roosevelt
Phoenix, AZ 85008

If to Business Associate:

District Medical Group, Inc.
Attention: President
2929 East Thomas Road
Phoenix, AZ 85016

cc: Snell & Wilmer LLP
Attention: Paul J. Giancola & Brad Martorana
One Arizona Center
400 East Van Buren
Phoenix, AZ 85004

12.11 Severability. If any portion of this Agreement is construed to be illegal, invalid, or unenforceable, such portion shall be deemed stricken and deleted from this Agreement to the same extent and effect as if it were never incorporated herein, but all other portions shall continue in full force and effect; provided that such resulting construction of the Agreement does not frustrate a material purpose of the Agreement.

12.12 Governing Law. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Arizona (without regard to the principles of conflicts of law embodied therein) applicable to contracts executed and performable in such state. Each party submits to the jurisdiction of the State and Federal Courts located in the State of Arizona for any action or proceeding relating to this Agreement, and expressly waives any objection it may have to such jurisdiction or the convenience of such forum.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date first above written.

COVERED ENTITY

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

By: _____

Print Name: _____

Title: _____

BUSINESS ASSOCIATE

District Medical Group, Inc.

By: _____

Print Name: _____

Title: _____

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.b.i.

Contracts

90-23-177-1

Statement of Work #2-FQHC Services

Statement of Work #2
FQHC Services

This STATEMENT OF WORK (this "SOW"), dated effective as of January 1, 2023 (the "SOW Effective Date"), is made pursuant to the Master Services Agreement (the "MSA") dated effective as of January 1, 2023 between Maricopa County Special Health Care District d/b/a Valleywise Health ("Valleywise") and District Medical Group, Inc. ("DMG"). Any capitalized terms used herein but not defined shall have the respective meanings given in the MSA.

Services

Engagement of DMG: Subject to and upon the terms and conditions set forth in the MSA and this SOW, Valleywise hereby engages DMG to provide physician and advanced clinical practitioner services ("FQHC Services") to patients at Valleywise's federally qualified health centers in the medical specialties ("Specialties") determined as necessary to staff each FQHC Location (defined below). The Specialties as of the SOW Effective Date are as listed in Table 2.2.

The FQHC Services shall be "Covered Services" as that term is defined in the MSA. All FQHC Services will be furnished by DMG through Qualified Providers who meet the qualifications and standards set forth in the MSA, and who deliver services consistent with the standards of the applicable specialty, the terms of the Valleywise Medical Staff Bylaws, rules, regulations, applicable licensure requirements, accreditation and certification standards, and the regulations and policies established by Medicare, AHCCCS, and other payors. DMG shall be the sole and exclusive provider of FQHC Services during the Term, unless otherwise agreed by DMG. For the purposes of this SOW:

> "FQHC Locations" refers to each of Valleywise's locations which are classified as, or receive payment for any services as, a federally qualified health center. The FQHC Locations as of the SOW Effective Date are listed on Table 2.1.
>
> "Session" refers to a continuous four-hour block of time, or portion thereof, for which a Qualified Provider in a designated Specialty is to be available for the provision of patient care services at a FQHC Location. Sessions may be designated in whole sessions or in portions of a Session (e.g., 1.0 Session represents 4 hours; and 1.25 Sessions represents 5 hours).

DMG or a Qualified Provider may initiate blocks on a Qualified Provider's schedule for the purpose of providing time for the Qualified Provider to complete medical record documentation and administrative tasks ("Administrative Time"), provided that such Administrative Time blocks for each Qualified Provider (as determined on a provider-by-provider basis) shall not exceed twenty percent (20%) of the time which the Qualified Provider is scheduled for Sessions during any given calendar week. In light of the fact that patients are scheduled in 20-minute increments, it is acknowledged that the twenty percent (20%) Administrative Time allowance will be measured based on 20-minute patient slots. If DMG or a Qualified Provider blocks time in excess of such twenty percent (20%) Administrative Time limitation in a calendar week, DMG shall not be entitled to bill for the time blocked that is in excess of twenty percent (20%). Notwithstanding the foregoing, the Parties acknowledge and agree that the schedule of Administrative Time blocks must be mutually agreed upon at least ninety (90) Days in advance and may not be modified by DMG or any Qualified Provider without reasonable written notice to Valleywise.

Example: *Suppose that a Qualified Provider is scheduled for 10 Sessions in a week, or 120 patient slots (10 Sessions * 4 hours/Session * 3 patients/hour). The Qualified Provider may block off up to 24 patient slots (120 patient slots * 20% = 24 patient slots) for medical record documentation and administrative tasks, which need not be allocated equally among all Sessions. Thus, for example, the*

Qualified Provider may block 2 hours (6 patient slots) out of a 4 hour Session that is scheduled on a Thursday afternoon, so long as the 20% limitation is not exceeded on an aggregate basis for the week.

Session Scheduling: Based upon the agreed-upon hours of operation and the needs of Valleywise patients, the ELT (defined below) shall determine the number of Sessions to be scheduled each week or month at the FQHC Locations for each Specialty. DMG, in consultation with Valleywise, shall have the responsibility for contracting with Qualified Providers in order to provide staffing for the Sessions, and such responsibility includes the ability to determine the mix of physicians and advanced clinical practitioners. DMG shall further have the responsibility and discretion for hiring Qualified Providers on a full-time or part-time basis; and/or engaging Qualified Providers as independent contractors. In the event that Valleywise has comments regarding the staffing mix, such comments shall be presented through the ELT and resolved by the ELT. Valleywise and DMG shall use their commercially reasonable efforts to avoid canceling any scheduled Session. If Valleywise or DMG determines that a Session must be cancelled, then it shall promptly notify the other Party (which notice may be provided via electronic transmission and need not constitute a signed writing).

Patient Scheduling: Valleywise shall be responsible for scheduling patients for each Session. Valleywise shall ensure that the number of patients scheduled for each Session shall be commensurate with the 50th percentile of the specialty-specific clinical benchmarks published in the prior year's survey by the Medical Group Management Association ("MGMA") for either physicians or advanced clinical practitioners, as applicable (depending on whether a Session will be staffed by a physician or advanced clinical practitioner), taking into account the anticipated no-show rate. Any specific restrictions that a Qualified Provider wishes to place on the categories of patients that may be scheduled for his or her Sessions whose medical conditions are otherwise within the Qualified Provider's scope of practice must be reviewed and approved in advance by the ELT.

Operational Changes: Valleywise and DMG acknowledge and agree that Valleywise may wish to change and update, from time to time: the Specialties; the hours of operation of the FQHC Locations; the number of FQHC Sessions to be scheduled at each FQHC Location; and/or the allocation of Sessions among various Specialties. Any such changes and updates requested by Valleywise shall be subject to the review and discussion of the Enterprise Leadership Team ("ELT"). Unless otherwise stipulated by the ELT, any such changes and updates approved by the ELT shall be effective one hundred eighty (180) Days after such approval.

Any unplanned reduction in FQHC Services, or changes which would have the effect of decreasing DMG's Base Compensation (defined below) by more than ten percent (10%), or due to changes in health plan contracts, or due to Valleywise labor shortages or financial difficulties, shall be discussed and resolved by DMG and Valleywise at least one hundred twenty (120) Days in advance of any such reduction. Any changes that cannot be resolved by mutual agreement will be eligible for Dispute Resolution in accordance with the provisions of the MSA.

Access to Personnel, Facilities & Records: Valleywise shall provide access to its premises, facilities, personnel, equipment, software, books, records, and other personal property as reasonably necessary and appropriate for DMG to provide, and to ensure accurate invoicing of Valleywise for, the FQHC Services. This shall include Valleywise's provision of support consistent with the 50th percentile clinical productivity benchmarks published by the MGMA, as applicable, including with respect to medical assistant to provider ratios, room to provider ratios, and throughput. Valleywise shall ensure that all equipment utilized by DMG in the performance of the FQHC Services is in good working order and suitable for the purposes for which it is used, and conforms to all relevant industry standards and requirements. DMG shall not cause or permit any intentional or unreasonable damage to Valleywise's facilities or equipment, ordinary wear and tear excepted. Valleywise shall respond promptly to any DMG request to

provide direction, information, equipment, approvals, authorizations, or decisions that are reasonably necessary for DMG to perform the FQHC Services in accordance with the requirements of this SOW.

Compensation

Valleywise shall pay DMG for the FQHC Services an amount equal to: (i) the Base Compensation (which shall be based on the number of Sessions, as described below), plus (ii) if earned, Productivity Compensation, plus (iii) the Benefits Load.

Base Compensation

Base Compensation: As base compensation for making Qualified Providers available for performance of the FQHC Services each month (the "Base Compensation"), Valleywise shall pay to DMG an amount equal to: (i) the number of Sessions performed by Qualified Providers in the month, plus Sessions that were cancelled by Valleywise without thirty (30) Days' advance notice; *multiplied by* (ii) the applicable Compensation Rate for each respective Session (which Compensation Rate, as described below, shall be Specialty-specific, and shall depend on the type (e.g., physician or advanced clinical practitioner) of Qualified Provider performing the Session). The Base Compensation shall be determined on a per-Session basis, meaning that the Base Compensation shall be due and payable regardless of the number of patients that are actually scheduled for a Session or the number of patients that actually present for treatment at a Session. Compensation shall be due to DMG for all Sessions that are scheduled to be provided, provided that Valleywise may, as needed, cancel a Session by providing thirty (30) Days' prior written notice to DMG (in which case DMG shall not be entitled to bill for the timely-cancelled Session and shall exclude the Session from the invoice presented to Valleywise for payment).

Compensation Rate: The per-Session compensation rate for each Specialty for FQHC Services ("Compensation Rate") shall be an amount equal to (i) the 50th percentile (median) rate taken from the MGMA Provider Compensation & Production Survey (Total Compensation) for each Specialty (the "MGMA Total Compensation"), *divided by* (ii) 440. The Compensation Rate for each Specialty as of the SOW Effective Date is set forth in Table 2.2.

Productivity Compensation

In addition to the Base Compensation, Valleywise shall pay DMG a productivity bonus (the "Productivity Compensation") for the FQHC Services, if earned. The Productivity Compensation shall be determined for each Contract Year on a Specialty-by-Specialty basis, as the excess of:

(i) the Encounter-Based Compensation for the Specialty; *over*
(ii) the Session-Based Compensation for that Specialty.

For clarity, because the Productivity Compensation is calculated by Specialty, the Productivity Compensation may be achieved for some Specialties but not other Specialties. In no event shall the Productivity Compensation for any Specialty be a negative amount.

The "Encounter-Based Compensation" for each Specialty shall be equal to (A) the number of billed patient encounters performed during the Contract Year for the respective Specialty, *multiplied by* (b) Compensation Per Encounter for that Specialty.

The "Compensation Per Encounter" shall be determined, on a Specialty-by-Specialty basis, as (i) the MGMA median compensation per work relative value unit ("wRVU"), *multiplied by* (ii) the MGMA median wRVUs per encounter, taking into account normalization of the market data to reflect a solely

clinic-based setting for OB/GYN and MFM. The Compensation Per Encounter shall be determined for each Contract Year in advance of such Contract Year and shall be documented in Table 2.2.

The "Session-Based Compensation" for a Specialty shall be the aggregate Base Compensation earned for the Contract Year, but solely to the extent payable with respect to Sessions that were actually performed and not cancelled. The Session-Based Compensation shall not take into account or be calculated in any way with reference to the Benefits Load.

Benefits Load

"Benefits Load" means (i) 24.56%, multiplied by the Base Compensation; *plus* (ii) 24.56%, multiplied by the Productivity Compensation. The Benefits Load shall be payable in addition to the Base Compensation and the Productivity Compensation.

Specialty Services That are Not FQHC Services: If Valleywise receives payments for services at a given location as a FQHC and also receives payments for services outside of the FQHC fee schedule, then the location shall be considered an FQHC Location only to the extent that FQHC Services are reimbursable under the FQHC Fee Schedule. For the avoidance of doubt, any services provided by Qualified Providers within a particular Specialty (e.g., cardiology) that are not considered to be FQHC Services, but which are performed for patients at the FQHC Locations, will be performed under Statement of Work #1, and DMG will be compensated for those services pursuant to Statement of Work #1. Further, services which would otherwise be payable as FQHC Services under this SOW, but which are performed by Department Chairs, will be compensated pursuant to Statement of Work #4 and will not be compensated under this SOW.

Adjustments to Compensation Rate: The MGMA benchmarks used for the purposes of determining the compensation payable hereunder (Table 2.2), shall be updated effective at the beginning of each Contract Year (starting with the Contract Year which commences July 1, 2024), based upon the following applicable MGMA surveys:

Contract Year	**MGMA Survey**
July 1, 2024 – June 30, 2025	2023 (reflecting compensation paid in 2022)
July 1, 2025 – June 30, 2026	2024 (reflecting compensation paid in 2023)
July 1, 2026 – June 30, 2027	2025 (reflecting compensation paid in 2024)
July 1, 2027 – June 30, 2028	2026 (reflecting compensation paid in 2025)

Based on the foregoing MGMA surveys, the per-Session Compensation Rate shall be calculated by the ELT, and the Compensation per Encounter shall be calculated as described above by the ELT. Table 2.2 shall be updated by the ELT in advance of each Contract Year to reflect the updated per-Session Compensation Rate and Compensation Per Encounter. For the avoidance of doubt, because such updates to Table 2.2 are ministerial in nature and shall not result in a change in the methodology or formula used to calculate the Compensation Rate, such updates shall not constitute, and shall not require, an amendment to the MSA or to this SOW.

The ELT shall also review in advance of a Contract Year any adjustments proposed by an ELT member to the Survey used or the percentile compensation applied.

Billing for FQHC Services: Valleywise shall bill for the FQHC Services in a prompt and reasonable manner, and for clarity shall bill for all encounters regardless of whether Valleywise anticipates

receiving payments for the FQHC Services, provided that the medical record documentation has been completed within the standards outlined in the Medical Staff Bylaws.

Invoicing and Payment

Billing and Payment (Base Compensation): DMG shall invoice Valleywise monthly for the Base Compensation and the Benefits Load applicable to the Base Compensation for that month, within fifteen (15) Days following the end of each calendar month. The invoice shall include a list of Sessions performed and a list of Sessions which were not performed but are chargeable because they were not cancelled by Valleywise with at least thirty (30) Days' prior written notice. Valleywise shall pay the Base Compensation and the accompanying Benefits Load, to the extent not reasonably disputed, to DMG by wire transfer, ACH or direct deposit to an account designated in writing by DMG, by the thirtieth (30^{th}) Day following the receipt by Valleywise of each invoice. Any reasonably disputed items by Valleywise with respect to the invoices shall be identified to DMG in writing prior to the date on which the invoice payment is due. If the Parties cannot resolve the dispute within ninety (90) Days, then the dispute shall be eligible for Dispute Resolution in accordance with the provisions of the MSA.

Billing and Payment (Productivity Compensation): DMG shall deliver to Valleywise an invoice setting forth the Productivity Compensation, and the corresponding Benefits Load, due and payable by Valleywise with respect to each Contract Year within sixty (60) Days of the end of that Contract Year. Valleywise shall pay the Productivity Compensation and accompanying Benefits Load, to the extent not reasonably disputed, to DMG by wire transfer, ACH or direct deposit to an account designated in writing by DMG, by the thirtieth (30^{th}) Day following the receipt by Valleywise of the invoice. Any reasonably disputed items by Valleywise with respect to the invoices shall be identified to DMG in writing prior to the date on which the invoice payment is due. If the Parties cannot resolve the dispute within ninety (90) Days, then the dispute shall be eligible for Dispute Resolution in accordance with the provisions of the MSA.

Miscellaneous

Review / Reconciliation: Valleywise shall have the right to request a review, audit, and/or reconciliation of any invoice submitted pursuant to this SOW for a period of six (6) months following the date of payment on the invoice. Any such review, audit, and/or reconciliation after that time shall be waived, except as otherwise permitted by the MSA.

Term; Termination: The term of this SOW shall be coterminous with the Term as defined in the MSA, unless earlier terminated in accordance with the MSA.

Effect of Termination: Upon expiration or termination of this SOW, neither Party shall have any further obligation hereunder except for (1) obligations due and owing which arose prior to the date of termination, and (2) obligations which expressly extend beyond the term of this SOW, including payment obligations for any FQHC Services provided hereunder.

General Provisions: Sections 12.11 through Section 12.19 of the MSA are hereby incorporated into this SOW by reference as if set forth in full herein.

Enterprise Leadership Team: All decisions by the ELT shall include the approval of the Valleywise Chief Executive Officer and at least one (1) DMG representative to the ELT.

Initial Contract Year: The Parties acknowledge that the initial "Contract Year" as defined in the MSA is a period that comprises 18 months (i.e., January 1, 2023 – June 30, 2024), rather than a 12-month period. Accordingly, the term "Contract Year" as used herein shall refer to an 18-month period for the first "Contract Year" and to a 12-month period for each subsequent Contract Year.

[Signature Page Follows]

IN WITNESS WHEREOF, the Parties hereto have executed this Statement of Work #2 effective as of the date first above written.

Maricopa County Special Health Care District d/b/a Valleywise Health	**District Medical Group, Inc.**
By: _____	By: _____
Name: _____	Name: _____
Its: _____	Its: _____

TABLE 2.1

FQHC Locations
(Effective January 1, 2023)

Valleywise Community Health Center – West Maryvale
7808 W. Thomas Road
Phoenix, AZ 85033

Valleywise Community Health Center – South Phoenix/Laveen
5650 S. 35th Avenue
Phoenix, AZ 85041

Valleywise Community Health Center – South Central Phoenix
33 W. Tamarisk Street
Phoenix, AZ 85041

Valleywise Community Health Center – North Phoenix
2025 W. Northern Avenue
Phoenix, AZ 85021

Valleywise Community Health Center – Mesa
950 E. Main Street
Mesa, AZ 85203

Valleywise Community Health Center – McDowell
1101 N. Central Avenue, Suite 204
Phoenix, AZ 85004

Valleywise Community Health Center – Guadalupe
5825 E. Calle Guadalupe
Guadalupe, AZ 85283

Valleywise Community Health Center – Chandler
811 S. Hamilton Street
Chandler, AZ 85225

Valleywise Community Health Center – Avondale
950 E. Van Buren Street
Avondale, AZ 85323

Valleywise Comprehensive Health Center – Phoenix
2525 E. Roosevelt Street
Phoenix, AZ 85008

Valleywise Comprehensive Health Center – Peoria
8088 W. Whitney Drive
Peoria, AZ 85345

TABLE 2.2

FQHC Services
(Effective as of January 1, 2023)

Specialties

Family Medicine
Internal Medicine
Pediatrics: Internal Medicine
OB/GYN
Maternal-Fetal Medicine
Pediatrics
Integrated Behavioral Health Psychiatry (including McDowell clinics)
Primary Care APPs
OB/GYN APPs

Compensation Rate per Session and Compensation per Encounter
(January 1, 2023 – June 30, 2024)

Specialty	Base Rate per Session	$/Encounter > Threshold	Encounters per Session
Family Medicine	$ 611	$ 81.81	7.47
Internal Medicine	$ 638	$ 89.05	7.20
Peds/IM	$ 575	$ 87.32	6.58
OB/GYN	$ 833	$ 83.40	9.99
Maternal-Fetal Medicine	$ 1,161	$ 132.77	8.74
Pediatric	$ 538	$ 77.25	6.96
Primary Care APP	$ 265	$ 43.67	6.07
OB/GYN APP	$ 279	$ 78.02	3.58
Psychiatry (75th %ile)	$ 697	$ 144.87	4.81

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.b.ii.

Contracts
MCO-20-045-MSA

Melanie Talbot

From: Compliance 360 <msgsystem@usmail.compliance360.com>
Sent: Wednesday, November 8, 2023 5:51 PM
To: Melanie Talbot
Subject: Contract Approval Request: Envolve Dental Master Agreement Envolve Dental Inc.

Message Information

From Purves, Steve
To Talbot, Melanie;
Subject Contract Approval Request: Envolve Dental Master Agreement Envolve Dental Inc.
Additional Information Indicate whether you approve or reject by clicking the Approve or Reject button below.

Approve/Reject Contract

Click here to approve or reject the Contract.

Attachments

Name	Description	Type	Current File / URL

Contract Information

Division Contracts Division
Folder Contracts \ Managed Care/Revenue
Status Pending Approval
Title Envolve Dental Master Agreement
Contract Identifier Board - New Contract
Contract Number MCO-20-045-MSA
Primary Responsible Party Orozco, Stephanie A.
Departments
Product/Service Description Dental
Action/Background Approve a new agreement (MCO-20-045-MSA) between Envolve Dental, Inc. and Maricopa County Special Health Care District dba Valleywise Health, for the provision of comprehensive dental services.
Evaluation Process This is a new agreement MCO-20-045-MSA between Envolve Dental, Inc. and Maricopa County Special Health Care District dba Valleywise Health. This

	document is a repaper to supersede Contract #90-15-194-1 and will allow members to receive comprehensive dental services through Valleywise Health dental providers. This agreement excludes retail pharmacy and medical which is covered through a relationship with a separate entity.
Category	Other
Effective Date	12/1/2023
Term End Date	11/30/2024
Annual Value	$0.00
Expense/Revenue	Revenue
Budgeted Travel Type	N/A
Procurement Number	
Primary Vendor	Envolve Dental Inc.

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

December 6, 2023

Item 1.c.i.

Governance

Appointment of Governing Council Member - Essen Otu

Valleywise Community Health Centers Governing Council Application

Full Legal Name: Essen Ubong Otu
(As it appears on your Arizona Driver's License, Federal, State, or Locally Issued Identification Card, or U.S. Passport)

Chosen Name: Essen What are your pronouns? He/Him/His

Home Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Home Telephone: _____ Cell: [redacted]

E-mail Address: [redacted]

Employer: [redacted]

Work Address: [redacted]

City: [redacted] State: [redacted] Zip: [redacted]

Do you or any immediate family members (spouse, child, parent, or sibling, by blood, adoption, or marriage) work for the Maricopa County Special Health Care District dba Valleywise Health, or any other hospital or health care institution, as defined in A.R.S. § 36-401, that provides similar services to Valleywise Health? YES ○ NO ◉

Health care industry is defined as hospitals, other health care institutions, nurses, doctors, dentist, and other licensed healthcare professionals whose primary responsibility is providing primary preventative and therapeutic healthcare services. Do you receive more than 10% of your annual income from the health care industry? YES ○ NO ◉

Were you referred by someone? YES ◉ NO ○

If yes, please list his/her name: Scott Jacobson

Valleywise Health

Valleywise Community Health Centers Governing Council Application

1. Have you personally or a dependent child received care at a Valleywise Health Community Health Center (dental care included) or at one of the Federally Qualified Health Center Clinics located within Valleywise Comprehensive Health Center-Phoenix or Peoria? YES NO

If yes, please list the Clinic utilized, and approximate month/year of last visit

N/A	N/A
Name of Clinic	Date of Visit

2. Why would you like to be a member of the Valleywise Community Health Centers Governing Council?

Having served in leadership for over 10 years at Mountain Park Health Center in roles overseeing DEIB, community and public affairs and as a longtime board member and Chairman of the Vitalyst Health Center Board of Trustees, I understand the important impact of FQHCs and SDOH. My " why" comes down to a desire to help apply my professional and lived experiences to governance in a way that maintains and increase access to and quality of care while addressing health disparities through an SDOH lens.

3. As a community member, what do you feel are the greatest health care concerns in Maricopa County?

My frame of reference as a long-time Phoenix and Maricopa County resident on the greatest health concerns in County go back to an understanding and direct experiences with the broader SDOH framework. I understand that health goes far beyond access to care and outcomes-based approaches but is largely dependent on many other factors. I feel the greatest health care concerns stem with barriers to accessing high quality and low-cost healthcare. Nonetheless, I know health conditions like diabetes and hypertension to larger concerns around heat are significant health issues that need widespread awareness, advocacy and innovation to impact on a systems-level

4. What special interests or experiences do you have that would benefit the Council?

Having grown up in what I would describe as an underserved community, Maryvale, working directly for and in FQHC' s and having sat on numerous health and non-health related boards and councils provides me with experience I believe would add value to the Council. My experience in health philanthropy is also something I believe will benefit the Council. I have seen the local, statewide and national impact of collective systems change approaches and my direct experience with Vitalyst Systems Change grants Legacy Foundation, and Educare Foundations on both school-based and YMCA-based health center projects give me a unique perspective about innovation and access to care.

Valleywise Health

Valleywise Community Health Centers Governing Council Application

5. Council members are appointed to a three (3) year term. The Council meets one evening a month for approximately two hours. In addition to meetings, a member should allow time for other duties such as reading meeting material in order to prepare for meetings. Furthermore, members are required to sit on at least one standing committee. Standing committee meetings generally occur once a month during the daytime for approximately two hours. Do you have at least eight hours per month to devote to the Valleywise Community Health Centers Governing Council?
YES (●) NO ( )

6. Have you served or are you currently serving on any other boards or committees? If so, please list the board/committees and dates of service.

I am currently serving on the board of the Arizona Community Foundation and have previously served on the following boards or councils:

- Board Member, Nominating & Gov Committee: Arizona Community Foundation (2018-present),
- Board of Trustees, Former Board Chair and Emeritus Trustee: Vitalyst Health Foundation (2010-2022)
- Board Member: Diversity Leadership Alliance (DLA) (2013-2022)
- Black Philanthropy Initiative Task Force Member: Arizona Community Foundation (ACF) (2008-2017)
- Founder: Real Engagement through Active Philanthropy (REAP) Giving Circle: (2014)
- Founding Member: Greater Phoenix Urban League Young Professionals: (2005-2007)

7. Health Resources and Services Administration (HRSA), the government agency that provides funding for our Federally Qualified Health Center Clinics, requires information on Council members including members' areas of expertise, race/ethnicity, and gender.

Area of expertise ***(select no more than two)***:

Healthcare ☐	Finance ☐	Legal ☐
Community Affairs ☐	Trade Unions ☐	Government ☒ EO
Social Services ☒		

Valleywise Health

Valleywise Community Health Centers Governing Council Application

Ethnicity:

Hispanic or Latino ○ Non-Hispanic or Latino ◉ Prefer not to answer ○

Race:

Asian ○ Native Hawaiian ○ Other Pacific Islander ○

Black/African American ◉ American Indian/Alaska Native ○

White ○ More than one race ○ Prefer not to answer ○

Gender: Male ◉ Female ○ Prefer not to answer ○

Please share anything about yourself that you think would add to the diversity and/or advocacy of the Council.

Throughout the course of my career, I have honed my ability to establish reciprocal and tangible value to diverse stakeholders and partners in the spirit of driving sustainable impact. I pride myself in both leading and contributing to effective teams, boards and groups I engage with.
In my previous roles, I leveraged collaboration to cultivate and sustain relationships with diverse stakeholder groups to contribute to organizational improvements through a

8. All members of the Valleywise Community Health Centers Governing Council must comply with the Maricopa County Special Health Care District Code of Conduct and Ethics and Conflicts of Interest and Gift policy. One of the Principles of Standards of Conduct included in the Code is for Valleywise Health to complete a background check on existing and potential Governing Council members.

Would you consent and authorize Valleywise Health to procure background checks?
YES ◉ NO ○

Signature [redacted] Date 9/27/23

is considered a public record

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 1.d.i.

Medical Staff Credentials

Recommended by Credentials Committee: October 3, 2023
Recommended by Medical Executive Committee: October 10, 2023
Submitted to MSHCDB: October 25, 2023

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**
Anita Mary Chacko, D.O.	Courtesy	Internal Medicine	11/01/2023 to 10/31/2025	
Trevor Wayne Smith, M.D.	Courtesy	Pediatrics	11/01/2023 to 10/31/2025	
Kimberly P. Walters, D.M.D.	Active	Dentistry	11/01/2023 to 10/31/2025	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
NAME	**SPECIALTY/PRIVILEGES**	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Jeffrey M. Curtis, M.D.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for In-Patient Core Adult Cognitive and Adult Procedural Privileges.
Jomarys Demorizi Guzman, M.D.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Ambulatory Pediatrics, Adolescent and Adult Core Privileges.
Michelle Do Huynh, D.O.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Ambulatory Pediatrics, Adolescent and Adult Core privileges and Subdermal Contraceptive Capsule (Insertion/Removal) Privileges.
Douglas R. Jones, M.D.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for In-Patient Core Adult Cognitive and Adult Procedural Privileges.
Roberta I. H. Matern, M.D.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Ambulatory Pediatrics, Adolescent and Adult Core Privileges and In-Patient Core Adult Cognitive and Adult Procedural Privileges.
Marie Elizabeth Oberst, D.O.	Family & Community Medicine	FPPE successfully completed	FPPE reviewer has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Ambulatory Pediatrics, Adolescent and Adult Core Privileges and In-Patient Core Adult Cognitive and Adult Procedural Privileges.

Recommended by Credentials Committee: October 3, 2023
Recommended by Medical Executive Committee: October 10, 2023
Submitted to MSHCDB: October 25, 2023

REAPPOINTMENTS/ONGOING PROFESSIONAL PRACTICE EVALUATION				
NAME	**CATEGORY**	**SPECIALTY/PRIVILEGES**	**APPOINTMENT DATES**	**COMMENTS**
William D. Dachman, M.D.	Active	Internal Medicine	11/01/2023 to 10/31/2025	
Marie Elizabeth Oberst, D.O.	Active	Family & Community Medicine	11/01/2023 to 10/31/2025	
Bidisha Ray, M.D.	Active	Obstetrics & Gynecology	11/01/2023 to 10/31/2025	
Srilakshmi Settipalli, M.D.	Active	Family & Community Medicine	11/01/2023 to 10/31/2025	

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT/SPECIALTY**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Marie Elizabeth Oberst, D.O.	Family & Community Medicine	Addition: Subdermal Contraceptive Capsule (Insertion/Removal)	FPPE

STAFF STATUS CHANGE			
NAME	**DEPARTMENT**	**CHANGE FROM/TO**	**COMMENTS**
Patricia A. Graham, M.D.	Obstetrics & Gynecology	Courtesy to Emeritus	Resigned effective September 30, 2023. Physician is recognized for outstanding or noteworthy contributions to the medical sciences and/or has a record of previous long-standing service to the Hospital and has resigned in good standing from the active practice of medicine at Valleywise Health.

RESIGNATIONS *Information Only*			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Anh Hong Bui, M.D.	Family & Community Medicine	Courtesy to Inactive	Resigned effective July 1, 2023
Clayton William Long, M.D.	Pediatrics	Courtesy to Inactive	Resigned effective July 1, 2023
Rachel Frances Lusk, M.D.	Pediatrics	Active to Inactive	Resigned effective August 15, 2023

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: October 3, 2023
Recommended by Medical Executive Committee: October 10, 2023
Submitted to MSHCDB: October 25, 2023

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

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

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – INITIAL APPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Kristin Lee Coolidge, F.N.P.	Family & Community Medicine	Practice Prerogatives on file	11/01/2023 to 10/31/2025	
Giovanna Marie Love, F.N.P.	Obstetrics & Gynecology	Practice Prerogatives on file	11/01/2023 to 10/31/2025	

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
	DEPARTMENT/SPECIALTY	**RECOMMENDATION EXTEND or PROPOSED STATUS**	**COMMENTS**
Samantha Ari Bianchi, P.A.-C.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine P.A. Core & Minor Surgery Privileges.
Jacqueline Rhea Blanch, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Nurse Practitioner Core Privileges.
Misty E. Cox, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Nurse Practitioner Core Privileges and Women's Health Privileges.
Jennifer Faluade, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Nurse Practitioner Core Privileges.
Michelle Harbottle, P.A.-C	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Minor Surgery Privileges.
Corinne Christine Hinkle, P.A.-C.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine P.A. Core & Minor Surgery Privileges.
Rachel Ann Power, P.A.-C.	Internal Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Physician Assistant Core Privileges.
Amanda Marie Swingle, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Nurse Practitioner Core Privileges.

Recommended by Credentials Committee: October 3, 2023
Recommended by Medical Executive Committee: October 10, 2023
Submitted to MSHCDB: October 25, 2023

INITIAL/FOCUSED PROFESSIONAL PRACTICE EVALUATION			
Oghenetega E. Vance, F.N.P.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Nurse Practitioner Core Privileges.
Katie Elizabeth Wenzel, P.A.-C.	Family & Community Medicine	FPPE successfully completed	Chair has submitted documentation demonstrating practitioner has successfully completed FPPE requirement for Family & Community Medicine Physician Assistant Core Privileges.

ADVANCED PRACTICE CLINICIAN / ALLIED HEALTH PROFESSIONAL – REAPPOINTMENTS				
NAME	**DEPARTMENT**	**PRACTICE PRIVILEGES/ SCOPE OF SERVICE**	**APPOINTMENT DATES**	**COMMENTS**
Nicole Marcella Davis, F.N.P.	Internal Medicine	Practice Prerogatives on file	11/01/2023 to 10/31/2025	
Deanna Cruz Gem, A.N.P.	Internal Medicine	Practice Prerogatives on file	11/01/2023 to 10/31/2025	
Corinne Christine Hinkle, P.A.-C.	Family & Community Medicine	Practice Prerogatives on file	11/01/2023 to 10/31/2025	
Mary Ellen Kenworthey, W.H.N.P.	Obstetrics & Gynecology	Practice Prerogatives on file	11/01/2023 to 10/31/2025	
Stacey Elizabeth Klein, A.C.N.P.	Internal Medicine	Practice Prerogatives on file	11/01/2023 to 10/31/2025	

CHANGE IN PRIVILEGES			
NAME	**DEPARTMENT**	**ADDITION / REDUCTION / WITHDRAWAL**	**COMMENTS**
Corinne Christine Hinkle, P.A.-C.	Family & Community Medicine	Withdrawal: Subdermal Contraceptive Capsule (Insertion/Removal) Privileges, Therapeutic Procedures including Arthrocentesis and injection of joints, tendons, bursa to trigger points	Voluntary Relinquishment of Privileges due to non-utilization of privileges

RESIGNATION (Information Only)			
NAME	**DEPARTMENT/SPECIALTY**	**STATUS**	**REASON**
Jismi Theeyattuveli, A.G.A.C.N.P.	Internal Medicine	Allied Health Professional to Inactive	Resigned effective August 23, 2023
Oghenetega E. Vance, F.N.P.	Family & Community Medicine	Allied Health Professional to Inactive	Resigned effective October 31, 2023
Tijana Zelenovic, F.N.P.	Family & Community Medicine	Allied Health Professional to Inactive	Resigned effective June 30, 2023

General Definitions:

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

Recommended by Credentials Committee: October 3, 2023
Recommended by Medical Executive Committee: October 10, 2023
Submitted to MSHCDB: October 25, 2023

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

December 6, 2023

Item 2.

FQHC QI/QA Plan for CY 2024 Redline

Maricopa County Special Health Care District
Federally Qualified Health Center (FQHC)
Valleywise Health
Quality Improvement and Quality Assurance Plan
CY 2023~~3~~4

Introduction

Maricopa County Special Health Care District, aka Valleywise Health FQHC serves as the healthcare safety net for Maricopa County in Arizona. It is the only public teaching hospital and health care system in Arizona providing primary and specialty care services predominantly to underserved, low-income and ethnically diverse populations. The Valleywise Health service area has high rates of poor health indictors with high rates of obesity, diabetes, cardiovascular disease and respiratory illness. With many individuals living within medically underserved areas, access to care can frequently be a challenge for underserved residents. To combat these challenges, Valleywise Health is dedicated to addressing the social determinants of health for all patients.

Valleywise Health Federally Qualified Health Centers includes 9 Community Health Centers including Valleywise Community Health Center- McDowell serving persons living with HIV/AIDS, Valleywise Comprehensive Health Center – Peoria (PEC) and the Valleywise Comprehensive Health Center - Phoenix (PXC) which includes Internal Medicine, Pediatrics, Women's Care, Dental, Antepartum Testing and Diabetes Education.

The FQHCs are certified as NCQA Medical Home, providing patient-centered and comprehensive care. A robust care coordination program, embedded into all FQHCs, helps to ensure children and families receive access to medical care and social services. Strong community partnerships include providing early literacy programs at some of FQHC sites, supplying free lunches in collaboration with a local food bank, and a monthly food distribution program, which help patients and families address both their medical and social needs.

Mission, Vision and Values

Mission

To provide exceptional care, without exception, every patient, every time

Vision

To be nationally recognized for transforming care to improve community health

Values

Accountability

We hold ourselves and each other accountable by accepting personal responsibility for all that we do and stewardship of the resources we deploy on behalf of our community.

Compassion

We demonstrate sensitivity to our patients and each other by offering emotional, spiritual, cultural, and physical support.

Excellence

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

Safety

We ensure a safe environment for all and a highly reliable, effective care experience.

FQHCs will employ a comprehensive approach to continual excellence of healthcare, clinical training and population health research. This Quality Improvement and Quality Assurance (QI/QA) Plan serves as the foundation of the health center's commitment to continuously improve and ensure the safety and quality of the services provided to all patients by:

- Providing convenient, affordable quality care where and when people need it most.
- Integrating healthcare seamlessly into the lives of patients and consumers.
- Engaging individuals in their own care.
- Casting a stronger net of programs and services to keep all members of our community well.
- Improve Processes by prioritizing key problems, utilizes hypotheses about the nature of these problems, and develops targeted interventions.
- Conducting Patient Satisfaction Surveys are on an ongoing basis to be reported and reviewed quarterly.

Purpose

The purpose of the FQHC QI/QA Plan is to establish a written description of the specific structure, process, scope and role of the quality improvement program. The FQHC Quality Improvement Program exists to improve the overall performance in the areas of access, clinical care, integrating care, and consumer satisfaction. The FQHCs QI Plan will be evaluated at least annually and updated whenever necessary. The QI Plan is the responsibility of the Quality Department and FQHC Leadership and is to be reviewed and approved by Valleywise Health Community Health Center Governing Council Chair, Federally Qualified Health Center CEO, ~~Compliance and Quality Committee Chair~~, and FQHC Medical Director.

The Purpose of the FQHC Quality Improvement Program is to:

- Continually evaluate and enhance quality management processes, program outcomes, and administrative efficiencies.
- Monitor and evaluate the systems and processes related to the quality of services that can be expected to affect the health status, quality of life, and satisfaction of persons served by FQHC.
- Identify and assign priority to opportunities for performance improvement, as identified by stakeholders (e.g., staff, consumers, providers).
- Continuously monitor and analyze data related to program outcomes and consumer satisfaction to identify opportunities for improvement.

Structure: Responsibility, Accountability and Communication

Valleywise Health Centers Governing Council –
Responsibility for quality begins with Valleywise Community Health Center Governing Council who regularly assesses processes, systems and outcomes produced by the QI/QA Plan

integral to quality performance. The review of quality indicators, including benchmarks and baseline, is completed on a regular basis. Continuous Quality Improvement (CQI) involves taking action as needed based on the results of data analysis and the opportunities for performance improvement. The Governng Council also fulfills the following responsibilities:

- Authorizes resources to support quality initiatives.
- Assigns responsibility for quality programming to the Chief Executive Officer of the FQHC~~, and to its Compliance and Quality Committee~~.
- Maintain leadership oversight for all designated FQHC primary care clinics
- Ensures the organization is community-based and responsive to the needs of the population it serves

~~***Valleywise Helath Centers Governing Council - Compliance and Quality Committee***~~

~~The Valleywise Health Community Health Center – Compliance and Quality Committee includes personnel from throughout the organization and meets quarterly. Formal minutes are maintained and contain the date, time and place of meetings, attendees with their title, matters discussed with specifics on data for the clinical measures, action plans to address problems/deficiencies, and responsible individuals for follow-up.~~

~~The Compliance and Quality Committee includes representatives from administration, medical, and quality departments. Having representatives from across the organizational structure ensures system wide accountability and communication.~~

~~The Compliance and Quality Committee has leadership responsibility for this plan and is responsible for:~~

- ~~Prioritizing current quality initiatives and activities~~
- ~~Ensuring a process is in place to complete a written needs assessment~~
- ~~Reviewing patient satisfaction survey results~~
- ~~Reviewing risk activities to ensure providers are providing quality care~~
- ~~Patient Safety activities including process improvements related to occurrence report trends~~
- ~~Consistent monitoring of the Uniform Data System (UDS) clinical measures~~
- ~~Quality assessment, planning and annual program /QI/QA evaluation~~

~~Certain tasks and activities will be carried out by the Ambulatory Quality Initiative Workgroup who must report findings of reviews and analyses to the CEO of the FQHC clinics and the Quality Medical Director Committee. Outcomes and recommendations will be provided to the Compliance and Quality Committee. Summary reports are delivered by the Compliance and Quality Committee to the Valleywise Community Health Center Governing Council for their review, feedback, and input.~~

Quality Medical Director Committee

The Valleywise Medical Director Committee is led by the CEO of the FQHC clinics and meets at least 4 times a year. Formal minutes are maintained.

The Quality Medical Director Committee has leadership responsibility for the following:

- Prioritizing current quality initiatives and activities
- Consistent monitoring of the Uniform Data System (UDS) clinical measures

Valleywise Health Ambulatory Quality Initiative Workgroup

The Director of Nursing for Ambulatory Services designated by the CEO and Ambulatory Medical Director oversees the QI Workgroup and is responsible for monitoring improvement quality activities service areas such as Medical, Dental and Integrated Behavioral Health. This workgroup will develop, manage and implement activities in the QI/QA plan that:

- Incorporates advice and direction from the Quality Medical Directors Committee and ~~the Compliance and Quality Committee~~ and Valleywise Community Health Centers Governing Council.
- Identifies the most important aspects of care.
- Determines goals, sets objectives, and projects outcomes for all Plan, Do, Study, Act (PDSA) activities.
- Identifies data to be collected, frequency of data collected, and persons responsible to collect the data.
- Encourages involvement of staff in the QI process.
- Collaborates with the QA analyst to implement Valleywise Community Health Center Governing Council QI Goals.
- Compiles/utilizes outcome measurement data for analysis.
- Communicates QI goals, activities, and results to staff.
- ~~Incorporates advice and direction of the Compliance and Quality Committee~~
- ~~and~~ Valleywise Community Health Center Governing Council in the activities.

Performance Improvement, Patient Safety and Quality Standards

The Performance Improvement Program includes:

- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that falls below standards

Performance Improvement

Monitoring and evaluating expected performance on key Clinical and Financial performance measures required by the Health Resources and Services Administration (HRSA) the efforts and resources of Valleywise Community Health Centers can be redirected to obtain the desired outcomes through establishing performance indicator for the following:

- Quality of Care: access to prenatal care, childhood immunization, cervical cancer screening, colorectal cancer screening, depression screening and follow up, oral health, children and adolescent weight screening and follow up, adult weight screening and follow up, tobacco use screening and cessation, breast cancer screening, cholesterol treatment (lipid therapy for coronary artery disease), HIV linkage to care.

- Health Outcomes: improve outcomes for patients with diabetes, hypertension, and birthweight of patients born to Health Center patients.
- Integrated Behavioral Health
- Value of Care: reduce the total cost per patient, medical cost per patient.

By using performance indicators, the variation between the target desired and current status of the item(s) being measured can be identified. Data reports from the Electronic Health Record and other systems are reviewed regularly for trends, achievement of objectives and comparisons. Clinic productivity is reviewed to determine progress in reaching documented targets for units of service. Random chart reviews are conducted by each service area Team to determine if they contain all required recording and documentation and show evidence of sound clinical practice.

Performance indicator results are used to guide management decision making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Process improvements
- Staff training
- Marketing and outreach activities
- Other activities identified by consumers and/or other stakeholders

Patient Safety

Patient and family engagement in primary care helps to forge trusting relationships that promote safety. Valleywise Community Health Centers uses evidence-based strategies to improve patient safety by engaging patients and families through our Patient Centered Medical Home (PCMH) delivery model. Valleywise Community Health Centers are committed to providing safe, high-quality care through clinical decision-support tools, shared decision-making, performance measurement, and population health management.

Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. Valleywise Community Health Governing Council identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of stakeholders for both clinical services and administrative functions
- Accreditation standards
- Practice Guidelines
- Clinical pathway protocols and other authorization criteria
- Government requirements, regulations, and rules

Utilization of Appropriate Information System

The Valleywise Health Community Health Center Governing Council ~~Compliance and Quality Committee~~ will review Electronic Health Record (EHR) reports:

- To verify all Quality Indicators are being captured and performance measures are being met.
- Provide data integrity audits to verify that information in electronic records and databases correspond with required and expected information.
- To track diagnostic tests and other services provided to health center patients.

Confidentiality

Every patient is entered into our electronic health record (EHR) system and is assigned a unique patient number.

Patient records are kept confidential and private in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations. Intake paperwork given to new patients in the waiting room include the Summary Notice of Privacy Practices (HIPAA) and the HIPAA Consent and Acknowledgement Form to sign. The signed HIPAA Consent and Acknowledgement Form is part of the patient record.

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Patient medical records are not viewed or shared with any external provider or person(s) if the patient has not signed a Valleywise Health Authorization for Release of Information form (even if the other provider has their own consent form signed by the patient). Signed Authorization for Release of Information forms are scanned into patient chart.

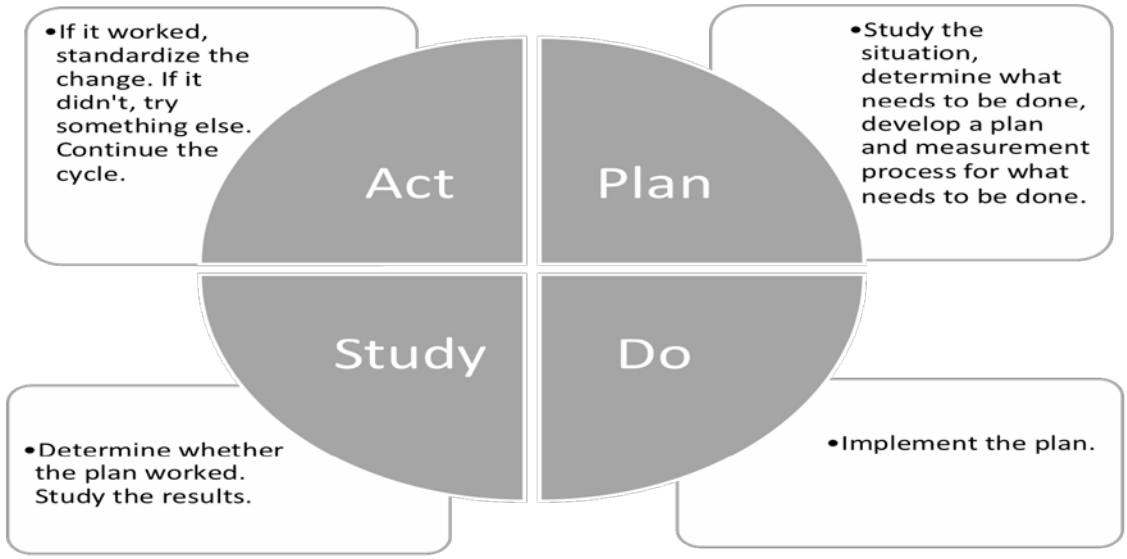
Staff profiles and navigation schemes in the EHR system are set up in accordance to their level of security clearance consent with their ability to view client charts.

Accreditation/Licensure

The Valleywise Health Human Resources, Regulatory and Compliance Departments are responsible for making sure all accreditations, licenses, certifications, and scheduled maintenances are up to date.

Quality Improvement/ Quality Assurance

The Valleywise Community Health Centers Quality Assurance program utilizes the Plan-Do-Study-Act (PDSA) methodology for testing and implementing quality improvement; and continuously monitoring, evaluating, and improving processes. The plan is a patient-driven philosophy and process that focuses on preventing problems and maximizing quality of care.



1. Plan: Design (or revise) a process to improve results.
2. Do: Implement the plan and measure its performance.
3. Check: Measure and evaluate the results to determine if the results met the desired goals.
4. Act: Decide if changes are needed to improve the process. If so, begin the PDCA process again

Goals

Goal #1	Reasoning	Actions	Target Date
Preventive Care and Screening: Screening for Depression and Follow-up Plan	Increase compliance to meet ~~2021~~ 2022 UDS National	Workgroup developing specific actions to address noncompliance	End of ~~CY2023~~CY2024
Goal #2	Reasoning	Actions	Target Date

Controlling High Blood Pressure	Increase compliance to meet ~~2021~~ 2022 UDS National Average	Workgroup developing specific action to address. Ensure protocol is being followed in the FQHCs.	End of ~~CY2023~~CY2024
Goal #3	Reasoning	Actions	Target Date
Diabetes: Hemoglobin A 1 c Poor Control	Continue compliance to meet 202~~1~~2 UDS National Average	Workgroup developing specific actions to address. Continue with Care Coordination involvement and Social determinants of Health	End of ~~CY2023~~CY2024
Goal #4	Reasoning	Actions	Target Date
Screening for ~~Clinical Depression and Follow up Plan if Positive Screen~~Colorectal Cancer	Increase compliance to meet 2022 UDS National Average	Workgroup developing specific actions to address.	End of CY2024

Improvement Strategies

Establishing and successfully carrying out strategies to incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used will vary according to the situation and the kind of improvement that is desired. Valleywise Community Health Centers will develop improvement strategies based on performance reviews, and stakeholder input.

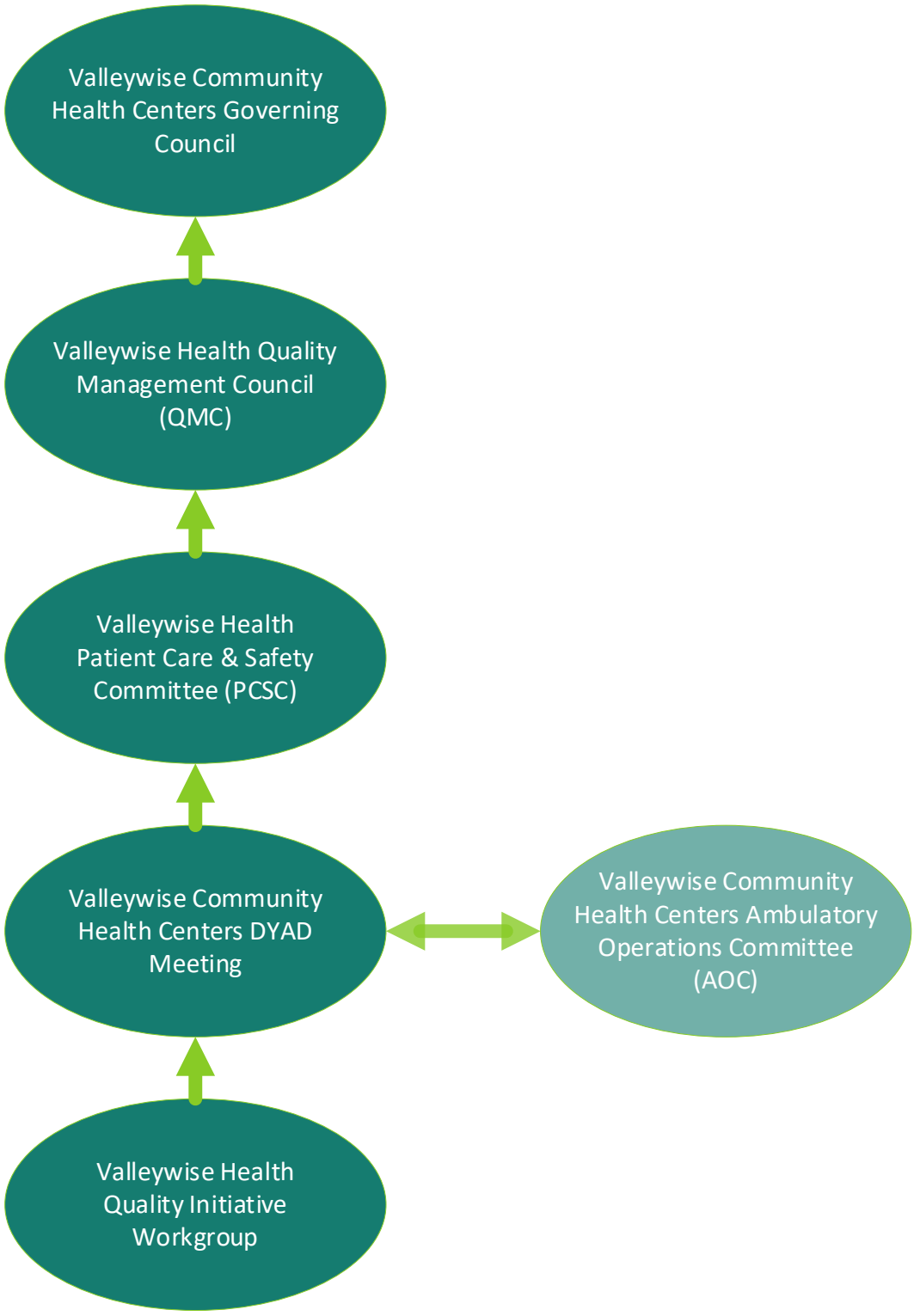
QI Reporting Structure

Quality Improvement

&

Quality Assurance

Process Plan


Valleywise Community Health Centers Governing Council
Valleywise Health Quality Management Council (QMC)
Valleywise Health Patient Care & Safety Committee (PCSC)
Valleywise Community Health Centers DYAD Meeting
Valleywise Community Health Centers Ambulatory Operations Committee (AOC)
Valleywise Health Quality Initiative Workgroup

Effective Date: 2005

Revised: June 2007, July 2008; September 2009; June 2011; June 2012; March 2014; October 2015; August 2018; June 2019; June 2020; January 2021, November 2021, November 2022, ~~November~~December 2023

Approved:	
~~Dr. Michelle Barker~~Scott Jacobson **Valleywise Community Health Centers Governing Council Chair**	**DATE**
~~Barbara Harding~~Michelle Barker **SVP Ambulatory Services & CEO FQHC Clinic**	**DATE**
~~Eileen Sullivan~~ **~~Valleywise Community Health Centers Governing Council's Compliance and Quality Committee Chair~~**	**~~DATE~~**
Christina Smarik-Snyder, MD **FQHC Medical Director**	**DATE**

Review and Approvals

The Valleywise Community Health Centers Governing Council (VCHCGC) has reviewed and approved this Quality Improvement and Quality Assurance (QI/QA) Plan~~, as reviewed and approved by the Compliance and Quality Committee~~ and affirms the Council's commitment to quality improvement to better meet the mission of the Valleywise Health.

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 2.

FQHC QI/QA Plan for CY 2024

Maricopa County Special Health Care District
Federally Qualified Health Center (FQHC)
Valleywise Health
Quality Improvement and Quality Assurance Plan
CY 2024

Introduction

Maricopa County Special Health Care District, aka Valleywise Health FQHC serves as the healthcare safety net for Maricopa County in Arizona. It is the only public teaching hospital and health care system in Arizona providing primary and specialty care services predominantly to underserved, low-income and ethnically diverse populations. The Valleywise Health service area has high rates of poor health indictors with high rates of obesity, diabetes, cardiovascular disease and respiratory illness. With many individuals living within medically underserved areas, access to care can frequently be a challenge for underserved residents. To combat these challenges, Valleywise Health is dedicated to addressing the social determinants of health for all patients.

Valleywise Health Federally Qualified Health Centers includes 9 Community Health Centers including Valleywise Community Health Center- McDowell serving persons living with HIV/AIDS, Valleywise Comprehensive Health Center – Peoria (PEC) and the Valleywise Comprehensive Health Center - Phoenix (PXC) which includes Internal Medicine, Pediatrics, Women's Care, Dental, Antepartum Testing and Diabetes Education.

The FQHCs are certified as NCQA Medical Home, providing patient-centered and comprehensive care. A robust care coordination program, embedded into all FQHCs, helps to ensure children and families receive access to medical care and social services. Strong community partnerships include providing early literacy programs at some of FQHC sites, supplying free lunches in collaboration with a local food bank, and a monthly food distribution program, which help patients and families address both their medical and social needs.

Mission, Vision and Values

Mission

To provide exceptional care, without exception, every patient, every time

Vision

To be nationally recognized for transforming care to improve community health

Values

Accountability

We hold ourselves and each other accountable by accepting personal responsibility for all that we do and stewardship of the resources we deploy on behalf of our community.

Compassion

We demonstrate sensitivity to our patients and each other by offering emotional, spiritual, cultural, and physical support.

Excellence

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

Safety

We ensure a safe environment for all and a highly reliable, effective care experience.

FQHCs will employ a comprehensive approach to continual excellence of healthcare, clinical training and population health research. This Quality Improvement and Quality Assurance (QI/QA) Plan serves as the foundation of the health center's commitment to continuously improve and ensure the safety and quality of the services provided to all patients by:

- Providing convenient, affordable quality care where and when people need it most.
- Integrating healthcare seamlessly into the lives of patients and consumers.
- Engaging individuals in their own care.
- Casting a stronger net of programs and services to keep all members of our community well.
- Improve Processes by prioritizing key problems, utilizes hypotheses about the nature of these problems, and develops targeted interventions.
- Conducting Patient Satisfaction Surveys are on an ongoing basis to be reported and reviewed quarterly.

Purpose

The purpose of the FQHC QI/QA Plan is to establish a written description of the specific structure, process, scope and role of the quality improvement program. The FQHC Quality Improvement Program exists to improve the overall performance in the areas of access, clinical care, integrating care, and consumer satisfaction. The FQHCs QI Plan will be evaluated at least annually and updated whenever necessary. The QI Plan is the responsibility of the Quality Department and FQHC Leadership and is to be reviewed and approved by Valleywise Health Community Health Center Governing Council Chair, Federally Qualified Health Center CEO, , and FQHC Medical Director.

The Purpose of the FQHC Quality Improvement Program is to:

- Continually evaluate and enhance quality management processes, program outcomes, and administrative efficiencies.
- Monitor and evaluate the systems and processes related to the quality of services that can be expected to affect the health status, quality of life, and satisfaction of persons served by FQHC.
- Identify and assign priority to opportunities for performance improvement, as identified by stakeholders (e.g., staff, consumers, providers).
- Continuously monitor and analyze data related to program outcomes and consumer satisfaction to identify opportunities for improvement.

Structure: Responsibility, Accountability and Communication

Valleywise Health Centers Governing Council –
Responsibility for quality begins with Valleywise Community Health Center Governing Council who regularly assesses processes, systems and outcomes produced by the QI/QA Plan

integral to quality performance. The review of quality indicators, including benchmarks and baseline, is completed on a regular basis. Continuous Quality Improvement (CQI) involves taking action as needed based on the results of data analysis and the opportunities for performance improvement. The Governng Council also fulfills the following responsibilities:

- Authorizes resources to support quality initiatives.
- Assigns responsibility for quality programming to the Chief Executive Officer of the FQHC.
- Maintain leadership oversight for all designated FQHC primary care clinics
- Ensures the organization is community-based and responsive to the needs of the population it serves

Quality Medical Director Committee

The Valleywise Medical Director Committee is led by the CEO of the FQHC clinics and meets at least 4 times a year. Formal minutes are maintained.

The Quality Medical Director Committee has leadership responsibility for the following:

- Prioritizing current quality initiatives and activities
- Consistent monitoring of the Uniform Data System (UDS) clinical measures

Valleywise Health Ambulatory Quality Initiative Workgroup

The Director of Nursing for Ambulatory Services designated by the CEO and Ambulatory Medical Director oversees the QI Workgroup and is responsible for monitoring improvement quality activities service areas such as Medical, Dental and Integrated Behavioral Health. This workgroup will develop, manage and implement activities in the QI/QA plan that:

- Incorporates advice and direction from the Quality Medical Directors Committee and and Valleywise Community Health Centers Governing Council.
- Identifies the most important aspects of care.
- Determines goals, sets objectives, and projects outcomes for all Plan, Do, Study, Act (PDSA) activities.
- Identifies data to be collected, frequency of data collected, and persons responsible to collect the data.
- Encourages involvement of staff in the QI process.
- Collaborates with the QA analyst to implement Valleywise Community Health Center Governing Council QI Goals.
- Compiles/utilizes outcome measurement data for analysis.
- Communicates QI goals, activities, and results to staff.
- Incorporates advice and direction of the Valleywise Community Health Center Governing Council in the activities.

Performance Improvement, Patient Safety and Quality Standards

The Performance Improvement Program includes:

- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that falls below standards

Performance Improvement

Monitoring and evaluating expected performance on key Clinical and Financial performance measures required by the Health Resources and Services Administration (HRSA) the efforts and resources of Valleywise Community Health Centers can be redirected to obtain the desired outcomes through establishing performance indicator for the following:

- Quality of Care: access to prenatal care, childhood immunization, cervical cancer screening, colorectal cancer screening, depression screening and follow up, oral health, children and adolescent weight screening and follow up, adult weight screening and follow up, tobacco use screening and cessation, breast cancer screening, cholesterol treatment (lipid therapy for coronary artery disease), HIV linkage to care.
- Health Outcomes: improve outcomes for patients with diabetes, hypertension, and birthweight of patients born to Health Center patients.
- Integrated Behavioral Health
- Value of Care: reduce the total cost per patient, medical cost per patient.

By using performance indicators, the variation between the target desired and current status of the item(s) being measured can be identified. Data reports from the Electronic Health Record and other systems are reviewed regularly for trends, achievement of objectives and comparisons. Clinic productivity is reviewed to determine progress in reaching documented targets for units of service. Random chart reviews are conducted by each service area Team to determine if they contain all required recording and documentation and show evidence of sound clinical practice.

Performance indicator results are used to guide management decision making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Process improvements
- Staff training
- Marketing and outreach activities
- Other activities identified by consumers and/or other stakeholders

Patient Safety

Patient and family engagement in primary care helps to forge trusting relationships that promote safety. Valleywise Community Health Centers uses evidence-based strategies to improve patient safety by engaging patients and families through our Patient Centered Medical

Home (PCMH) delivery model. Valleywise Community Health Centers are committed to providing safe, high-quality care through clinical decision-support tools, shared decision-making, performance measurement, and population health management.

Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. Valleywise Community Health Governing Council identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of stakeholders for both clinical services and administrative functions
- Accreditation standards
- Practice Guidelines
- Clinical pathway protocols and other authorization criteria
- Government requirements, regulations, and rules

Utilization of Appropriate Information System

The Valleywise Health Community Health Center Governing Council will review Electronic Health Record (EHR) reports:

- To verify all Quality Indicators are being captured and performance measures are being met.
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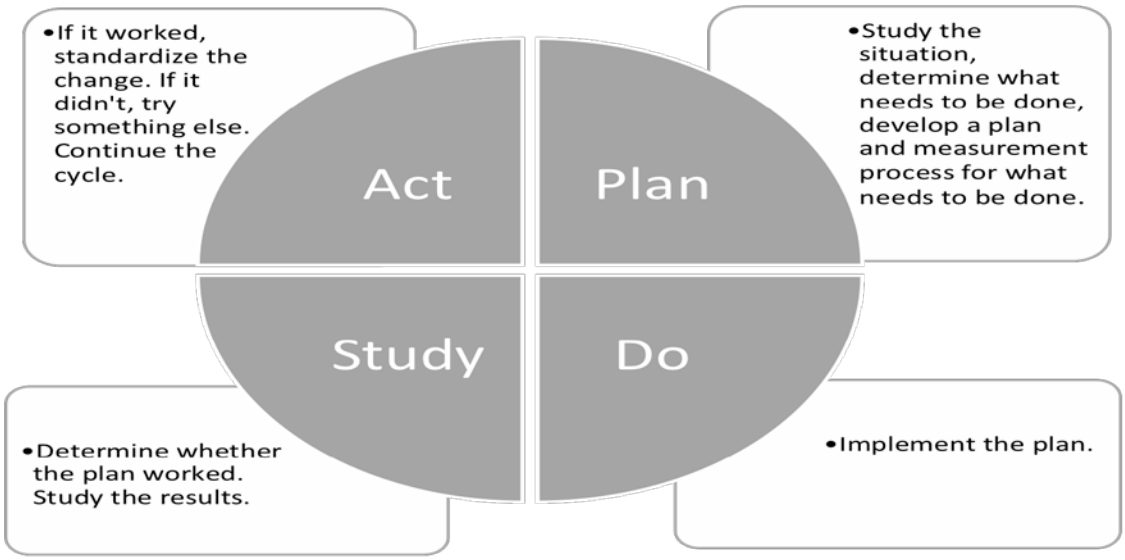

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Goals

Goal #1	Reasoning	Actions	Target Date
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Goal #3	Reasoning	Actions	Target Date
Diabetes: Hemoglobin A 1 c Poor Control	Continue compliance to meet 2022 UDS National Average	Workgroup developing specific actions to address. Continue with Care Coordination involvement and Social determinants of Health	End of CY2024
Goal #4	Reasoning	Actions	Target Date
Screening for Colorectal Cancer	Increase compliance to meet 2022 UDS National Average	Workgroup developing specific actions to address.	End of CY2024

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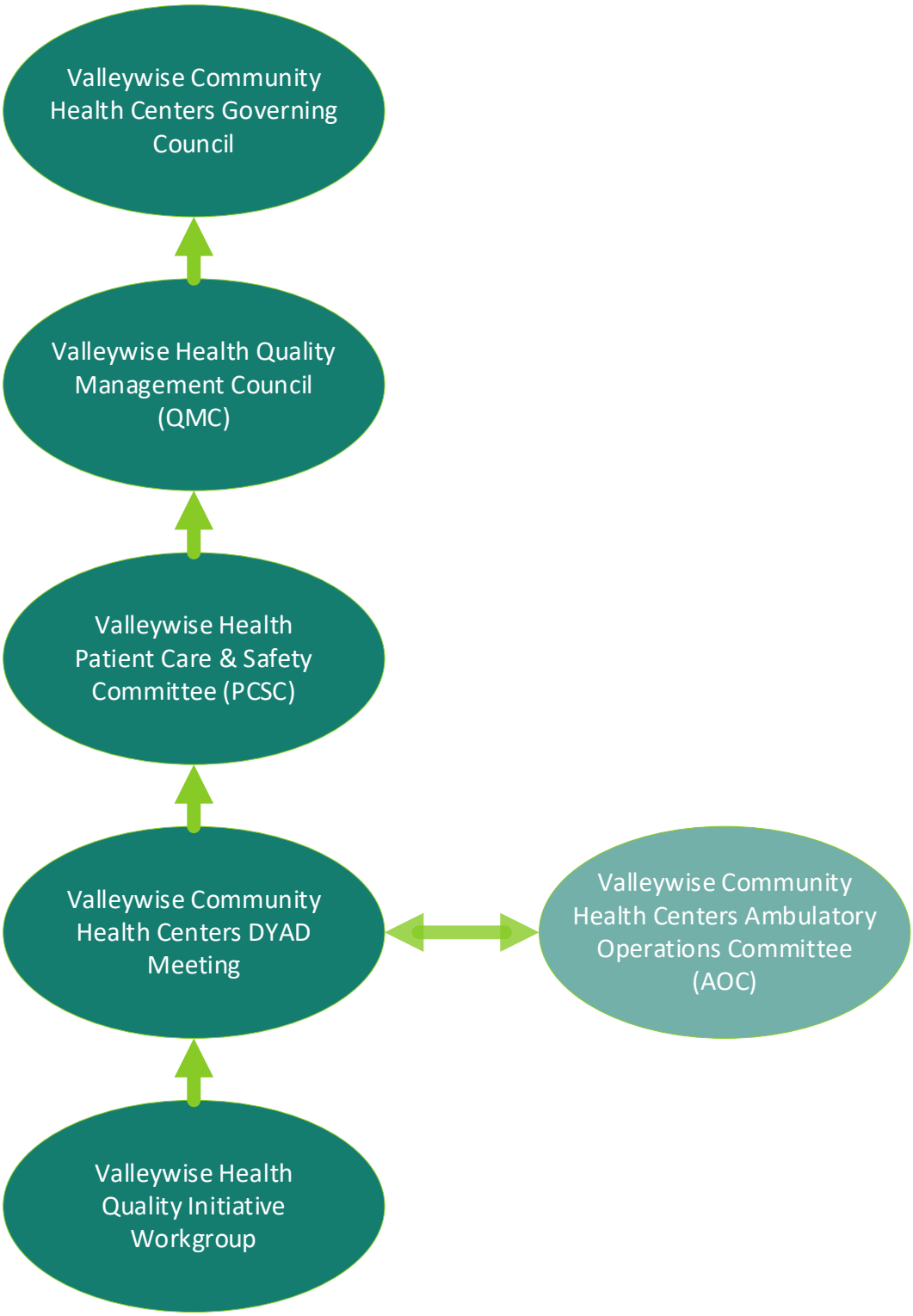
QI Reporting Structure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Approved:	
Scott Jacobson **Valleywise Community Health Centers Governing Council Chair**	**DATE**
Michelle Barker **SVP Ambulatory Services & CEO FQHC Clinic**	**DATE**
Christina Smarik-Snyder, MD **FQHC Medical Director**	**DATE**

Review and Approvals

The Valleywise Community Health Centers Governing Council (VCHCGC) has reviewed and approved this Quality Improvement and Quality Assurance (QI/QA) Plan and affirms the Council's commitment to quality improvement to better meet the mission of the Valleywise Health.

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 3.

Change in Scope - Add Site HRSA Form 5B

DATE: December 6th, 2023

TO: Valleywise Community Health Centers Governing Council

FROM: Michelle Barker, DHSc, Senior Vice President of Ambulatory Services and Federally Qualified Health Centers Chief Executive Officer

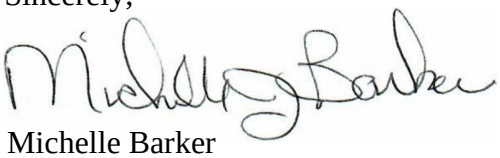
SUBJECT: Valleywise Community Health Centers Governing Council Approval to the HRSA Change in Scope of Service for the Mobile Health Unit

---

In May 12, 2021 the Governing Council authorized the purchase of a Mobile Health Unit (MHU) with funds provided under the CARES act. The MHU has been built to Valleywise Health specification and was delivered to our Peoria Clinic over the summer. Staff are in the process of preparing the MHU for service to our community. Part of the process includes installation of equipment, hiring staff, licensing by the Arizona Department of Health Services, and submitting a change in scope of service to HRSA for approval of FQHC status.

Valleywise Health is asking the Governing Council's approval to submit a change in scope of service to HRSA adding the Mobile Health Unit (MHU) to the form 5B (service site locations) as an FQHC.

Sincerely,



Michelle Barker
Senior Vice President of Ambulatory Services & CEO of FQHC Clinics

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 4.

Valleywise Health Mobile Health Unit

December 6th, 2023

Mobile Health Clinic

Summary Report

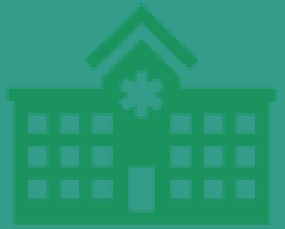
Salvador Avina, Project Manager

Valleywise Health

Objectives

Increasing patient access to health care services improving health care outcomes.

Objectives



Providing community outreach and identifying SDOH and needed resources.

Objectives

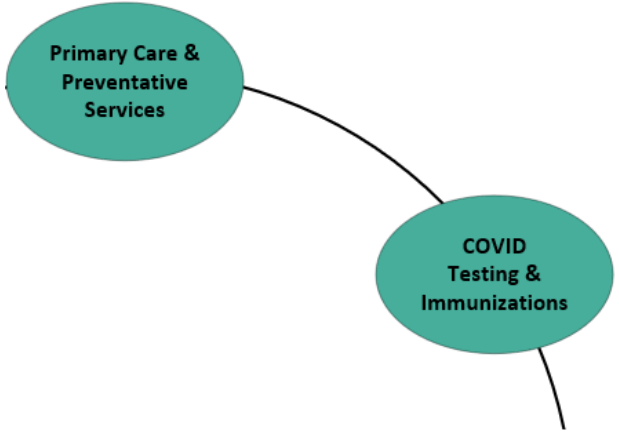
Planning, implementation, and development of mobile health unit program

Objectives

Determining sustainability by tracking, analyzing, and measuring productivity and volume.

Scope

Scope



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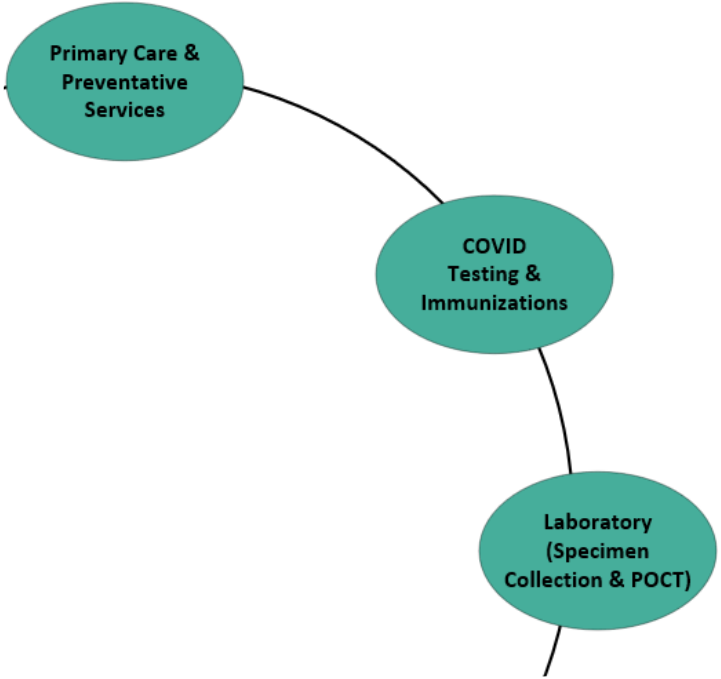

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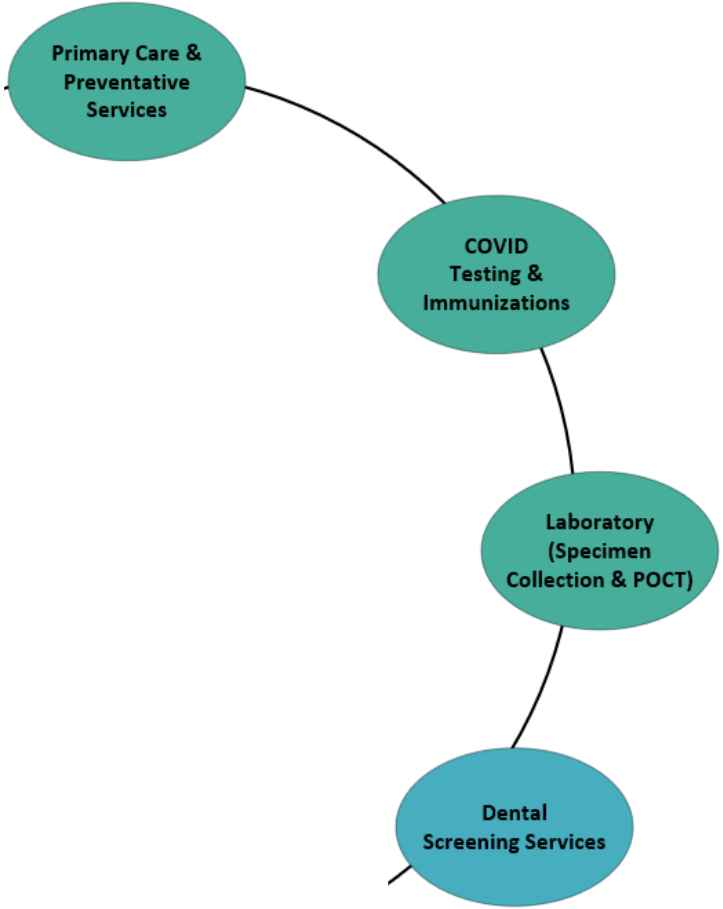

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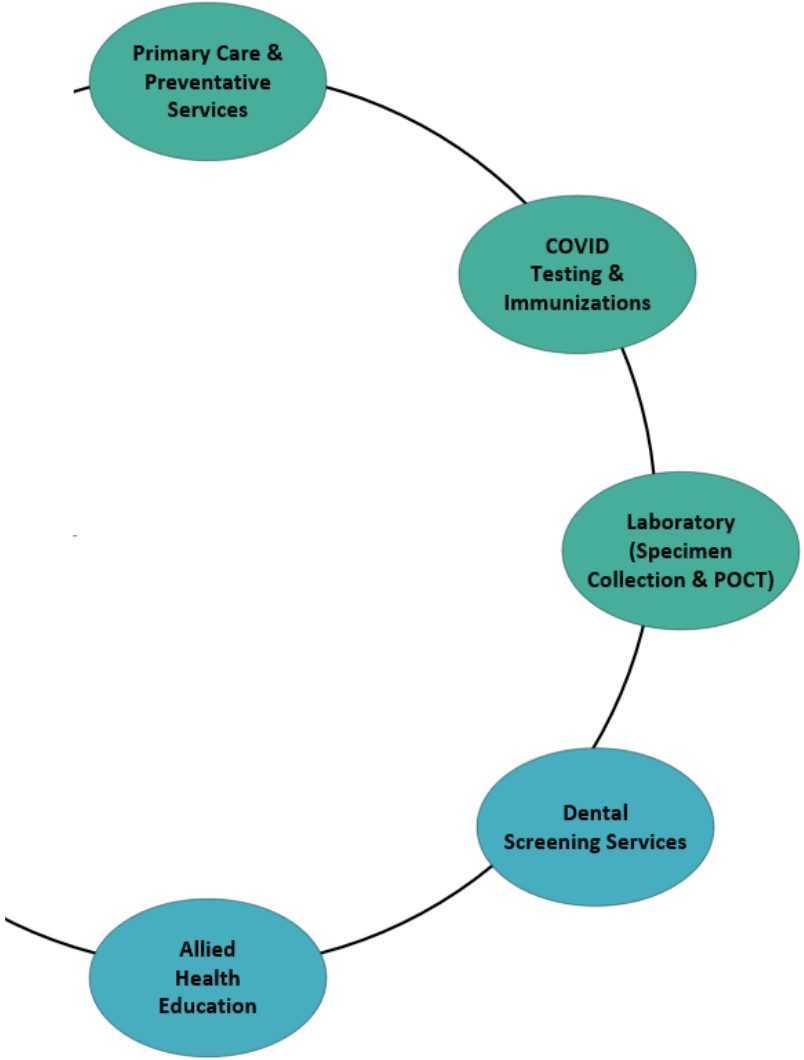

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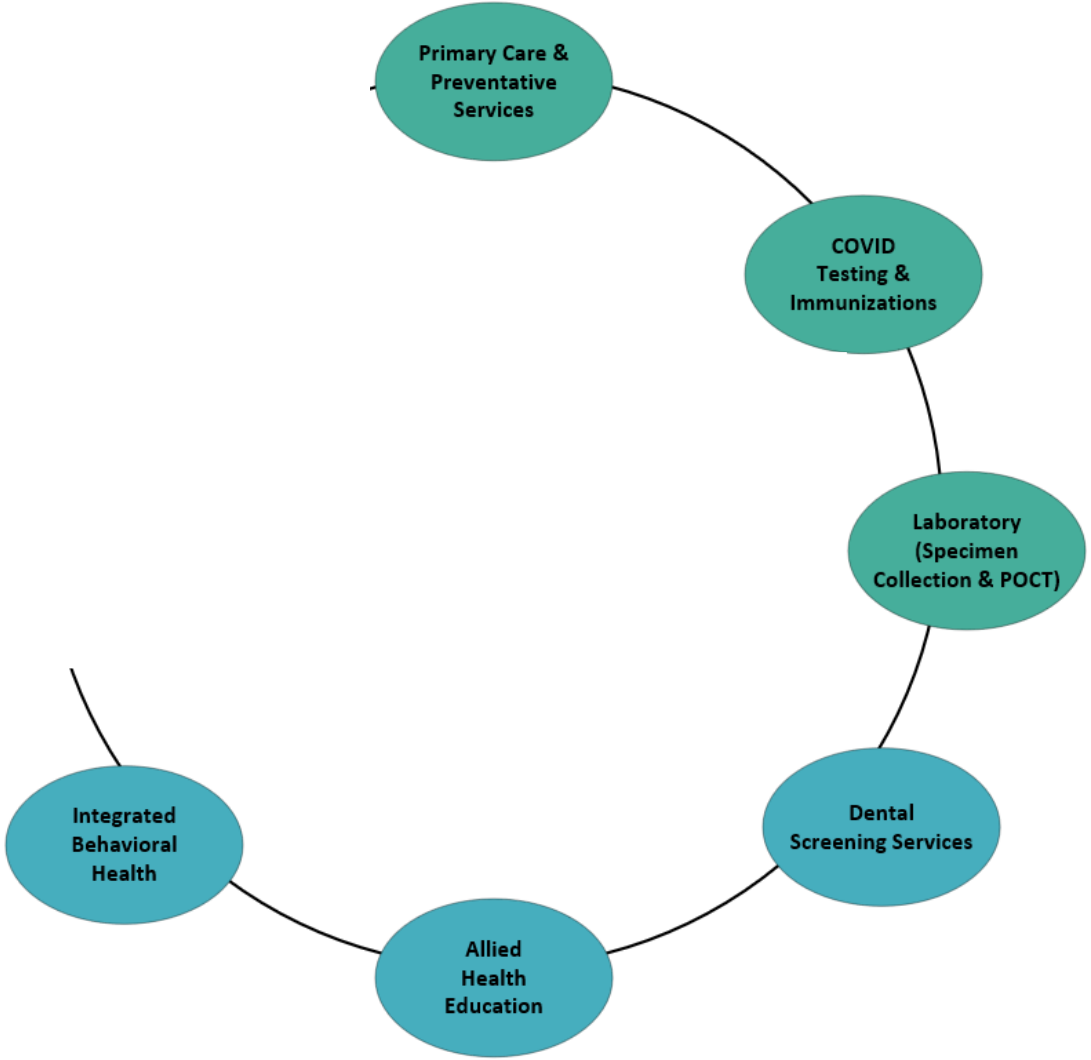

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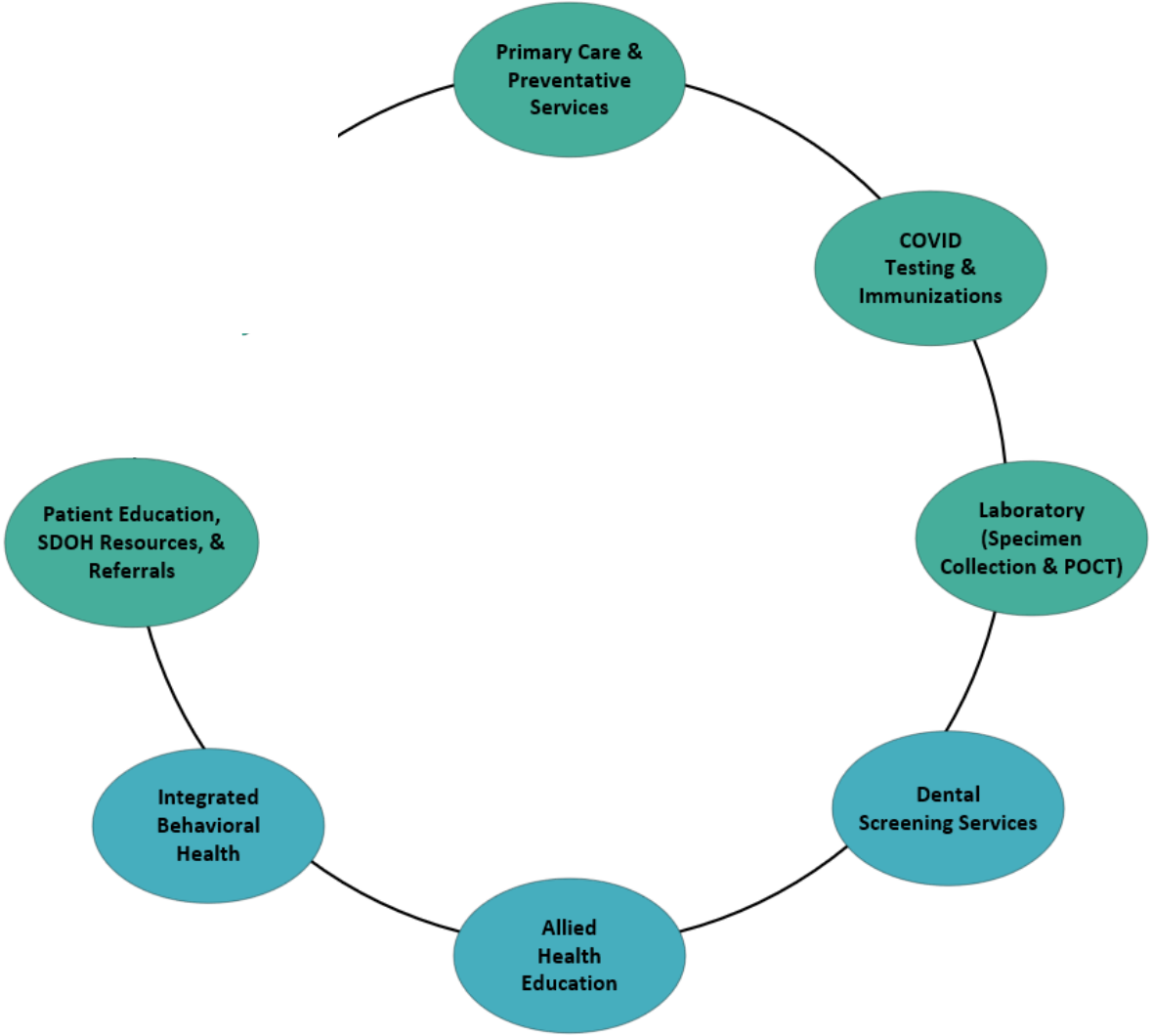
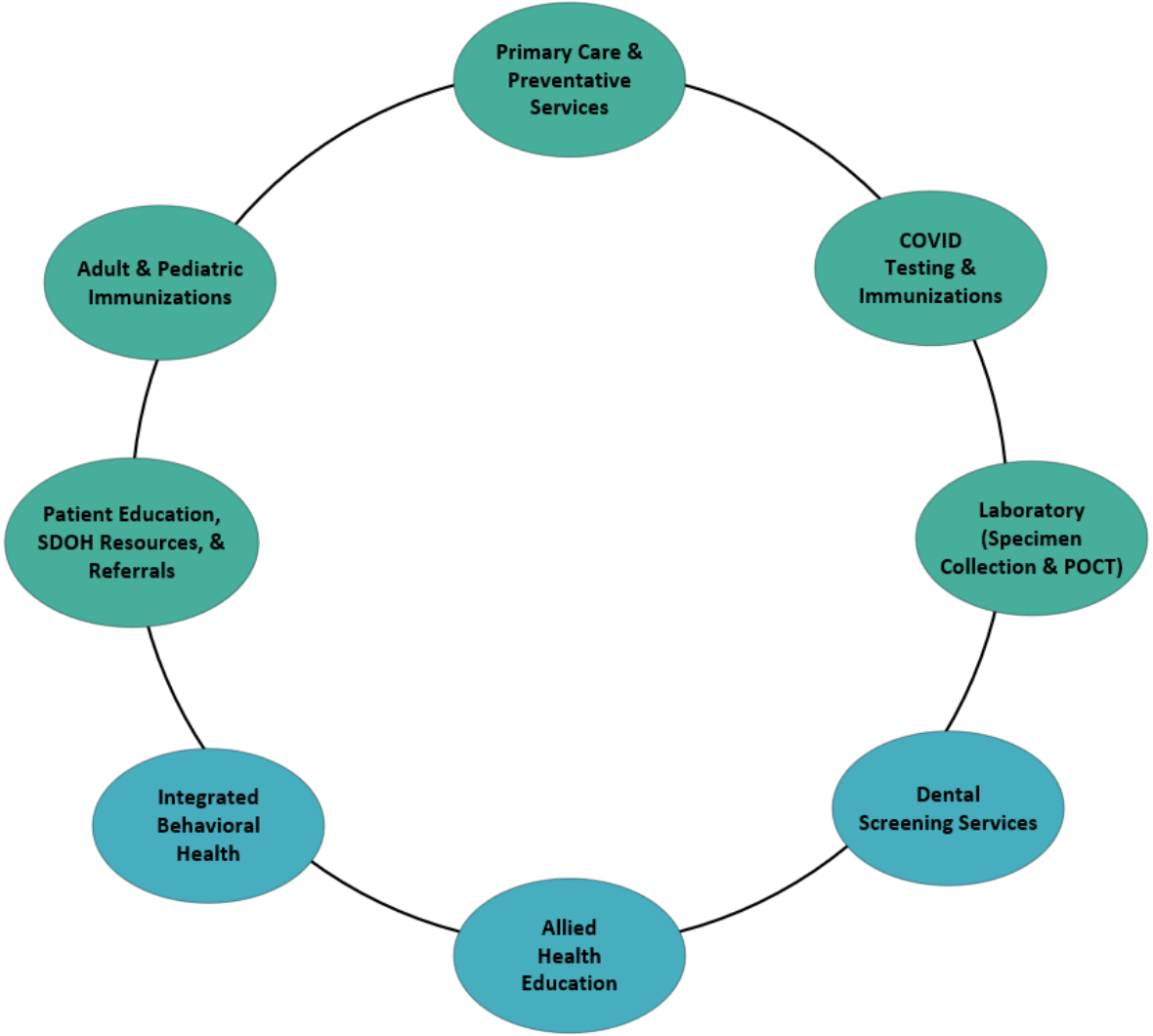
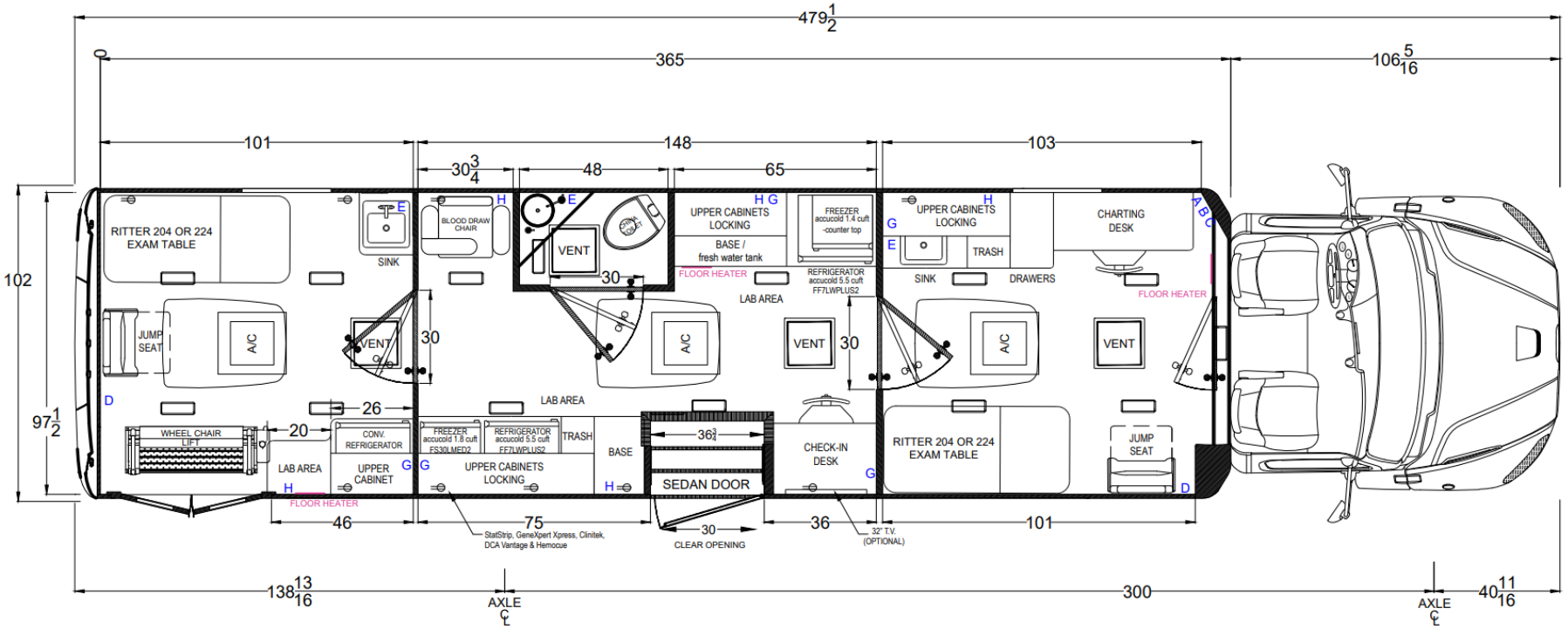


Scope



Layout



Project Timeline

- Mobile Health Clinic delivered June 28th and stationed at PEC
- Staffing: Recruiting Family Nurse Practitioner
- Security: Upgrading security system by installing a new camera
- Marketing: Community presentation with ribbon cutting ceremony, planning community event for hospital grand opening in April 2024, and roadshows across FQHCs
- Community Outreach: Developing partnerships with external organizations to increase awareness of future launch
- Exploring additional grant funding opportunities
- Deployment by 2024

Mobile Health Unit Photos

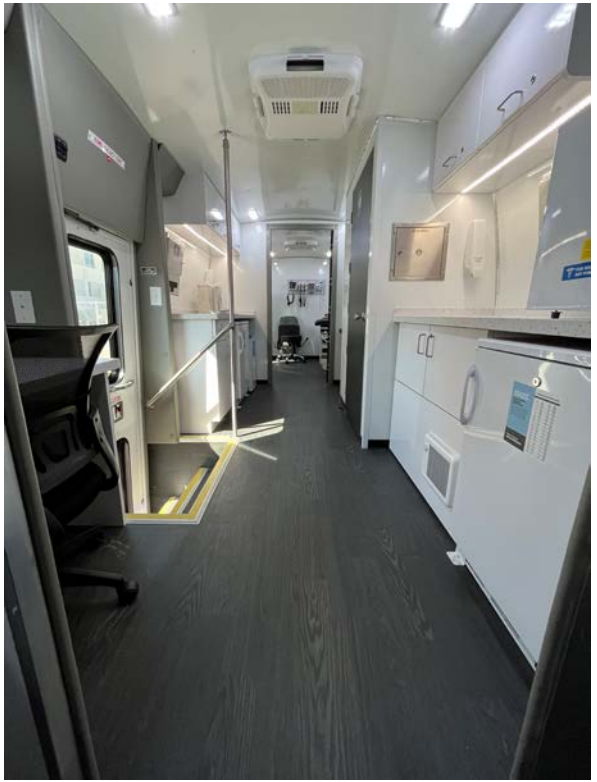
Outside of Mobile Health Clinic (Driver Side)

Outside of Mobile Health Clinic (Passenger Side)

Outside of Mobile Health Clinic (Front Door Open)

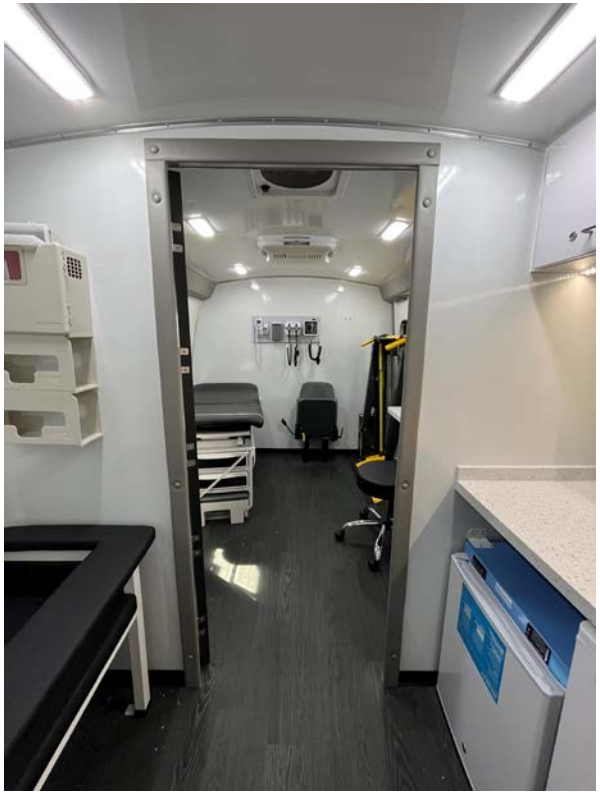
Outside of Mobile Health Clinic (Wheelchair Lift)

Inside Mobile Health Clinic (Front Exam Room)



Inside of Mobile Health Clinic (Middle Lab and Phlebotomy Area)

Inside of Mobile Health Clinic (Back Exam Room)

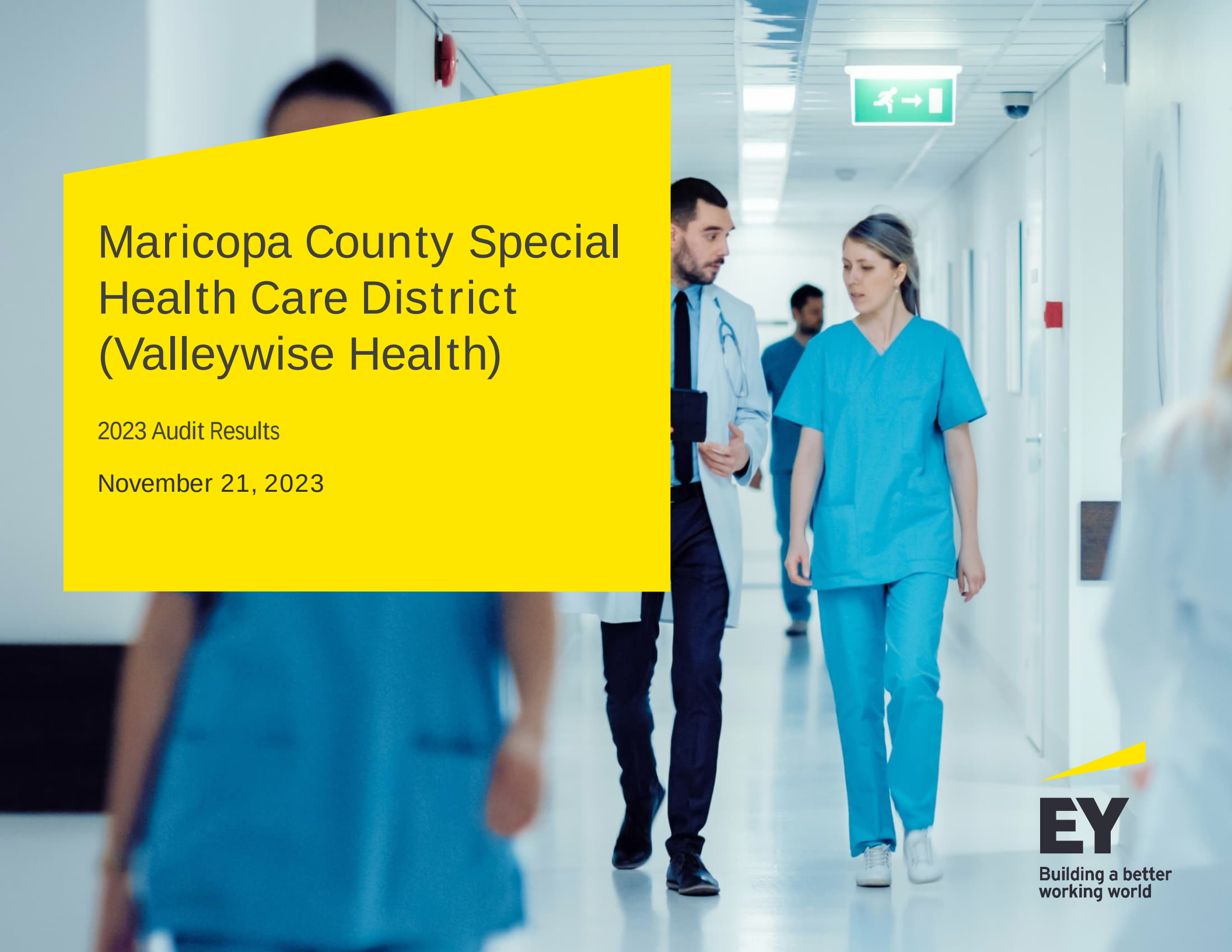


Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 5.

Annual Audit for
FYE June 30, 2023



Maricopa County Special Health Care District (Valleywise Health)

2023 Audit Results

November 21, 2023

Building a better working world

Executive summary

2023 Audit Results

We have completed our audit procedures on the 2023 Valleywise Health financial statements and will issue an unmodified opinion.

- No material corrected or uncorrected audit differences were identified.
- No material weaknesses were identified.

Digital Audit Delivery

We incorporated the following digital tools within our audit process:

- Health Revenue Analyzer
- General Ledger Analyzer
- Enhanced use of EY's Canvas Client Portal to facilitate transmission and tracking of support

Areas of Audit Emphasis

We identified the following areas of emphasis, which we considered in performing the 2023 audit:

- Patient service revenue and accounts receivable
- Proposition 480 bond funds and capital expenditures
- Self-insured accruals, including professional, general and workers' compensation liabilities
- Pension plan liabilities
- Risk of management override of controls

Looking Forward

Uniform Guidance audit for the 2023 Schedule of Expenditures of Federal Awards:

- Due by March 31, 2024

Required communications

Building a better working world

Required communications

Area	Comments
• Auditor's responsibility under generally accepted auditing standards, including our discussion of the type of auditor's report we are issuing	Our responsibilities are included in our audit engagement agreement. A copy of such agreement can be provided upon request. We will issue an unmodified opinion on Valleywise's financial statements as of and for the year ended June 30, 2023.
• Changes to the audit strategy, timing of the audit and significant risks identified	Our audit strategy is consistent with the plan communicated during the April 2023 FAC committee meeting.
• Matters relevant to our evaluation of the entity's ability to continue as a going concern	We did not identify any events or conditions that led us to believe there was substantial doubt about Valleywise's ability to continue as a going concern.

Required communications

Area	Comments
Our views about the qualitative aspects of the entity's significant accounting practices, including: • Accounting policies • Accounting estimates	Management has not selected or changed any significant policies or changed the application of those policies in the current year.
• Related party relationships and transactions*	We noted no significant matters regarding Valleywise's relationships and transactions with related parties.
• Changes to the terms of the audit with no reasonable justification for the change	None.
• Significant unusual transactions**	We are not aware of any significant unusual transactions executed by Valleywise.
• Difficult or contentious matters subject to consultation outside of the audit team	None.

Required communications

Area	Comments
• Material corrected misstatements related to accounts and disclosures • Uncorrected misstatements related to accounts and disclosures, considered by management to be immaterial	There are no material corrected or uncorrected misstatements.
• Significant deficiencies and material weaknesses in internal control over financial reporting*	No material weaknesses have been identified.
• Our responsibility, procedures performed, the results of those procedures and any reporting to be included in our auditor's report relating to other information included in the annual report	We have reviewed Valleywise's Supplementary Information and did not identify anything requiring communication.
• Fraud and noncompliance with laws and regulations (illegal acts)**	We are not aware of any matters that require communication.
• Obtain information relevant to the audit	Inquiries regarding matters relevant to the audit are to be performed at this meeting.
• Independence matters*	We are not aware of any matters that in our professional judgment would impair our independence.

Required communications

Area	Comments
• New accounting pronouncements	No issues have been identified regarding management's planned application of new accounting pronouncements.
• Significant issues discussed with management in connection with the auditor's initial appointment or recurring retention** • Disagreements with management and significant difficulties encountered in dealing with management when performing the audit** • Management's consultations with other accountants**	None.
• Other material written communications with management	There are no other findings or issues arising from the audit that are, in our judgment, significant and relevant to those charged with governance regarding the oversight of the financial reporting process.
• Other matters**	There are no other matters arising from the audit that are significant and relevant to those charged with governance regarding the oversight of the financial reporting process.

Required communications

Area	Comments
• AICPA ethics ruling regarding third-party service providers	From time to time, and depending on the circumstances, (1) we may subcontract portions of the Audit Services to other EY firms, who may deal with the Company or its affiliates directly, although EY alone will remain responsible to you for the Audit Services and (2) personnel (including non-certified public accountants) from an affiliate of EY or another EY firm or any of their respective affiliates, or from independent third-party service providers (including independent contractors), may participate in providing the Audit Services. In addition, third-party service providers may perform services for EY in connection with the Audit Services.
• Representations we are requesting from management	The letter of representations signed by management and related to the audit can be provided upon request.

As required, provided above is a summary of required communications between the audit team and those charged with governance, as required by AICPA Clarified US Auditing Standard (AU-C) 260, *The Auditor's Communication With Those Charged With Governance,* and other applicable auditing standards. This communication is intended solely for the information and use of the audit committee and, if appropriate, management, and is not intended to be, and should not be, used by anyone other than these specified parties.

All communications are to be made annually unless marked otherwise.

* Communicate at least annually or when event occurs.

** Communicate when event occurs, and consider need for separate communications within the presentation.

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Our assurance services help our clients meet their reporting requirements by providing an objective and independent examination of the financial statements that are provided to investors and other stakeholders. Throughout the audit process, our teams provide a timely and constructive challenge to management on accounting and reporting matters and a robust and clear perspective to audit committees charged with oversight.

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FINANCIAL STATEMENTS AND REQUIRED SUPPLEMENTARY INFORMATION

Maricopa County Special Health Care District
d/b/a Valleywise Health
Years Ended June 30, 2023 and 2022
With Reports of Independent Auditors

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

Financial Statements and Required Supplementary Information

Years Ended June 30, 2023 and 2022

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 Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of Maricopa County Special Health Care District d/b/a Valleywise Health (the District), as of and for the years ended June 30, 2023 and 2022, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the District at June 30, 2023 and 2022, and the respective changes in financial position, and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States (Government Auditing Standards). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for 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.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free of material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

- Obtain an understanding of internal control relevant to the audit 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 District's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that Management's Discussion and Analysis, the Schedule of District's Proportionate Share of the Net Pension Liability, the Schedule of District's 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 financial statements. Such information is the responsibility of management and, although not a part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, 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 financial statements, and other knowledge we obtained during our audit of the 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.

Other Information

Management is responsible for the other information included in the annual report. The other information comprises the introductory and statistical sections but does not include the financial statements and our auditor's report thereon. Our opinions on the financial statements do not cover the other information, and we do not express an opinion or any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and consider whether a material inconsistency exists between the other information and the financial statements, or the other information otherwise appears to be materially misstated. If, based on the work performed, we conclude that an uncorrected material misstatement of the other information exists, we are required to describe it in our report.

Other Reporting Required by *Government Auditing Standards*

In accordance with Government Auditing Standards, we have also issued our report dated November __, 2023 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.

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

Management's Discussion and Analysis

Years Ended June 30, 2023 and 2022

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) provides an overview of the financial position and activities for the years ended June 30, 2023 and 2022. 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. The financial statements discussed in this section offer short-term and long-term financial information about the District's activities, including:

Statements of Net Position: This statement includes all of the District's assets, deferred outflows of resources, liabilities, deferred inflows of resources, and net position and provides information about the nature and amounts of investments in resources (assets) and the obligations of the District to creditors (liabilities). It also provides the basis for evaluating the capital structure, and assessing the liquidity and financial flexibility of the District.

Statements of Revenues, Expenses and Changes in Net Position: This statement accounts for all of the current year's revenues and expenses, measures changes in operations over the past two years, and can be used to determine whether the District has been able to recover all of its costs through several revenue sources.

Statements of Cash Flows: The primary purpose of this statement is to answer questions such as where cash came from, what cash was used for, and what was the change in the cash balance during the reporting period.

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, an unrelated not-for-profit entity, the District provides care throughout Maricopa County.

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.

Licensed for 758 beds, the District provides a full range of inpatient acute and intensive care, inpatient and outpatient behavioral health, and a full complement of ancillary, support, and ambulatory services. The facilities that are housed on the District's main campus include:

- Valleywise Health Medical Center
- Valleywise Health – Arizona Burn Center
- Valleywise Comprehensive Health Center – Phoenix
- Valleywise Behavioral Health Center – Phoenix

The facilities that are located external to the main campus include:

- Valleywise Behavioral Health Center – Maryvale
- Valleywise Behavioral Health Center – Mesa
- Valleywise Comprehensive Health Center – Peoria

Ambulatory care is also provided at nine Community Health Centers located throughout Maricopa County. In addition to ambulatory services, many of these locations offer outpatient behavioral health and dental services.

Care Reimagined

On November 4, 2014, the voters of Maricopa County approved Proposition 480. Proposition 480 allows the District to issue up to $935,000,000 in general obligation bonds to be repaid in 30 years to fund outpatient health facilities, including improvement or replacement of existing outpatient health centers, a behavioral health hospital, and the construction of a new acute medical center

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, 2023, $817,790,916 of the bond proceeds have been expended. During fiscal year 2023, the majority of project funds were expended on the main campus for the construction of the new hospital scheduled to be complete in April 2024. The Comprehensive Health Center-Peoria (Peoria), project has been completed and opened on January 2021. Peoria includes an outpatient surgery center, endoscopy suites, dialysis services, primary and specialty clinics, and a family learning center. Two new Community Health Centers, in Mesa and West Maryvale, opened during fiscal year 2022, replacing old clinics at Mesa and Maryvale locations.

The District was authorized to issue $935,000,000, in aggregate, principal amount toward the project. At June 30, 2023, all of the District's authorized amount has been issued.

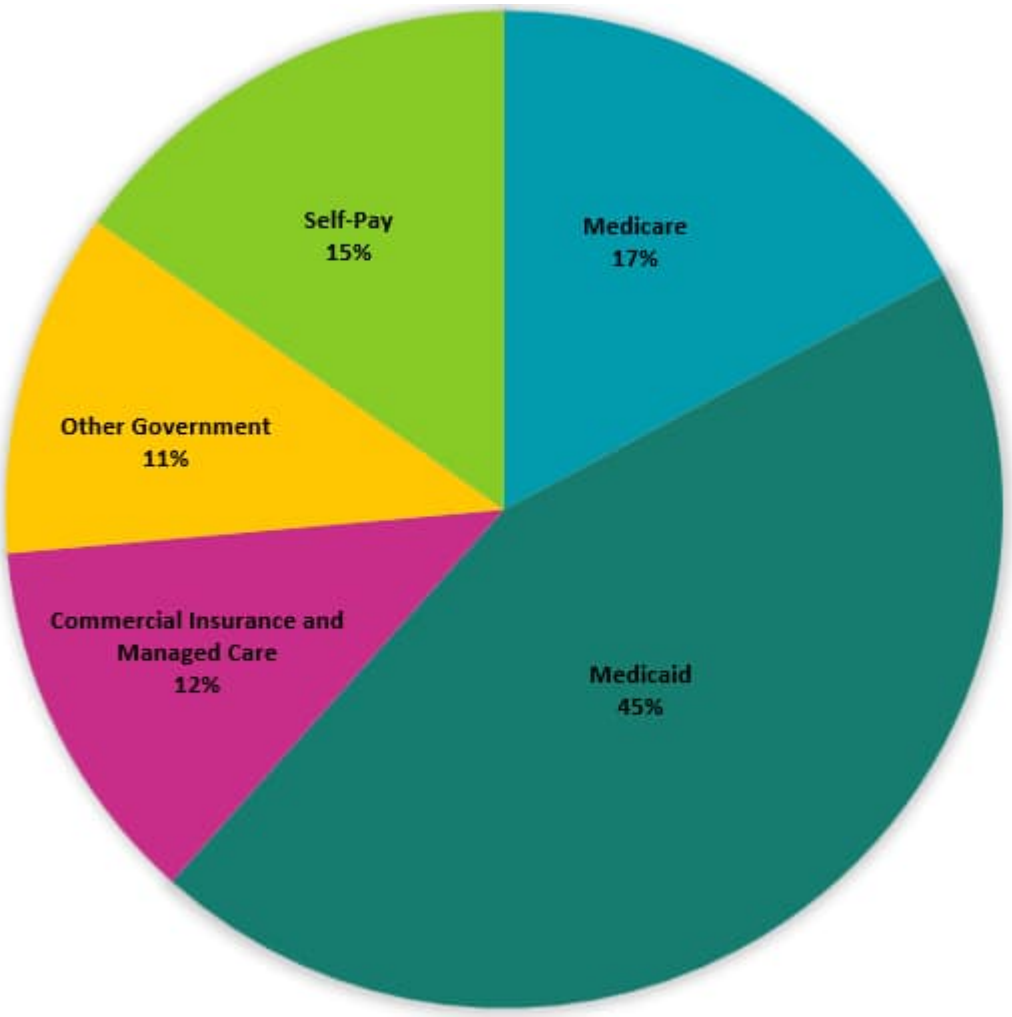
Financial Highlights

Year Ended June 30, 2023, Compared to Year Ended June 30, 2022	Year Ended June 30, 2022, Compared to Year Ended June 30, 2021
Net patient services revenue increased by $14.7 million or 3.0% from the prior year 2022. Other operating revenue increased $56.0 million, largely due to an increase in the new Arizona Health Care Cost Containment System (AHCCCS) program, HEALTHII, GME, 340B and retail pharmacy sales, and grant program related revenues.	Net patient services revenue increased by $5.4 million or 1.1% from the prior year 2021. Other operating revenue increased $3.1 million, largely due to an increase in the new Arizona Health Care Cost Containment System (AHCCCS) program, HEALTHII, and grant program related revenues.
Operating expense increased from $815.3 million in 2022 to $878.5 million in 2023, a $63.2 million or 7.8% increase from the prior year. These are largely due to the increase in salaries and outside contract labor usage due to staffing shortage and increase usage of supplies as part of higher cost of treating patients and related illnesses.	Operating expense increased from $755.1 million in 2021 to $815.2 million in 2022, a $60.2 million or 8.0% increase from the prior year. These are largely due to the increase in salaries and outside contract labor usage due to staffing shortage and increase usage of supplies as part of higher cost of treating patients with COVID-19 and related illnesses.

Gross charges by major payor financial class for fiscal years 2023, 2022, and 2021 are as follows:

	Year Ended June 30		
	2023	**2022**	**2021**
Medicare	17.2%	18.4%	18.5%
Medicaid	44.4	42.2	44.4
Commercial insurance and managed care	12.0	13.0	12.2
Other government	11.2	11.9	12.8
Self-pay	15.2	14.5	12.1
Total	100.0%	100.0%	100.0%

The District's payor mix has stayed relatively stable over the past two years prior to 2023. During fiscal year 2023, the District experience an increase number of self pay/uninsured patients and significant decrease of Medicare patients.

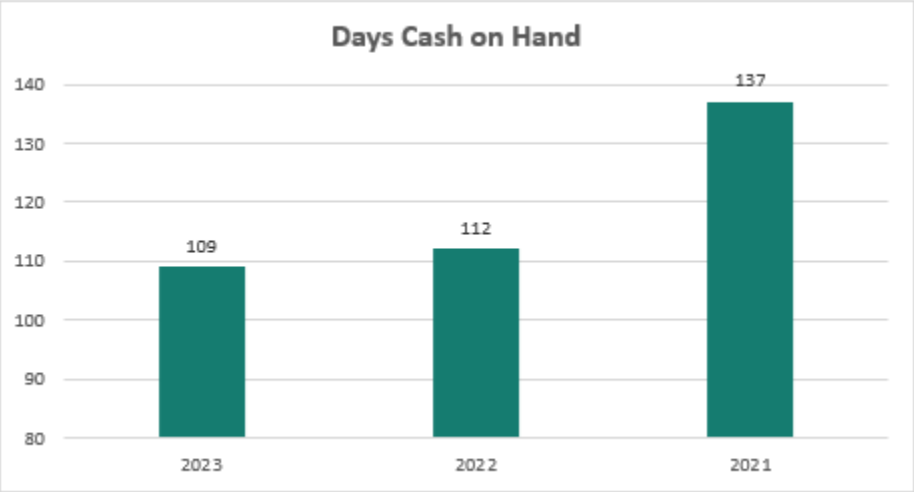

Self-Pay
15%
Medicare
17%
Other Government
11%
Commercial Insurance and
Managed Care
12%
Medicaid
45%

Condensed Statements of Net Position

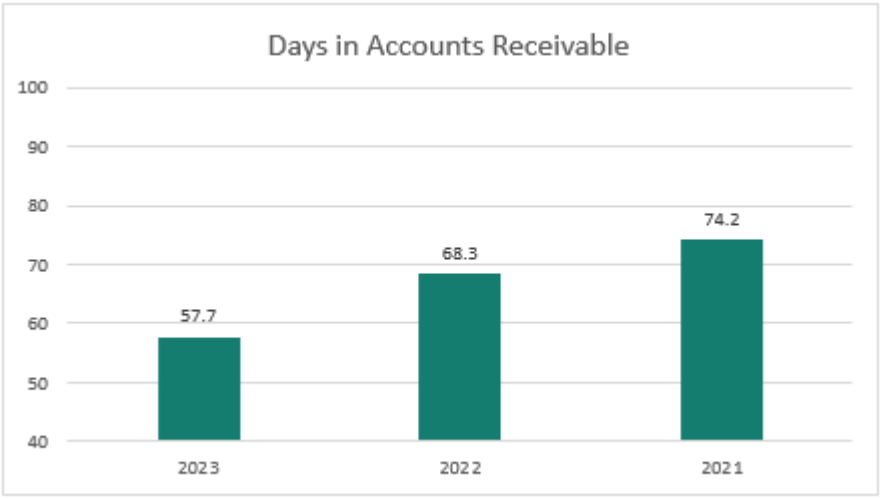
	Year Ended June 30		
	2023	2022	2021
Assets			
Current assets	$ 471,654,649	$ 517,466,741	$ 526,969,313
Other assets	125,536,461	236,513,174	409,633,599
Capital assets	796,596,154	723,183,812	594,155,126
Total assets	1,393,787,264	1,477,163,727	1,530,758,038
Deferred outflows of resources	56,462,313	84,873,429	89,357,989
Liabilities			
Current liabilities	232,589,943	236,666,466	206,915,919
Risk claims payable, less current portion	13,784,858	12,512,090	9,283,822
Net pension and OPEB liability	356,444,643	287,090,884	394,175,117
Long-term debt	645,751,295	682,637,421	736,509,938
Total liabilities	1,248,570,739	1,218,906,861	1,346,884,796
Deferred inflows of resources	18,778,412	104,660,022	3,972,294
Net position			
Unrestricted deficit	(300,286,787)	(394,856,298)	(510,048,594)
Net investment in capital assets	274,132,348	296,238,100	298,100,940
Restricted for bonds	166,504,192	306,922,948	477,027,521
Restricted for grants	42,550,673	30,165,523	4,179,070
Total net position	$ 182,900,426	$ 238,470,273	$ 269,258,937

Cash and Cash Equivalents

Unrestricted cash and cash equivalents for fiscal year 2023 were approximately $241.2 million, an increase of approximately $7.8 million from the $233.4 million in fiscal year 2022. Days cash on hand decreased 2.5 days to 109.2 days in fiscal year 2023 from the fiscal year 2022 days of 111.7. This decrease in cash is due to increase in operating expenses specifically in salaries, wages, benefits, and purchased services. Unrestricted cash and cash equivalents for fiscal year 2022 were approximately $233.4 million, a decrease of approximately $28.8 million from fiscal year 2021. Days cash on hand decreased 25.8 days to 111.7 days in fiscal year 2022 from the fiscal year 2021 days of 137.5.



While net accounts receivable decreased by approximately $6.9 million, net days in accounts receivable decreased from the prior year by approximately 15.5%, from 68.3 to 57.7 days. Net account receivable in fiscal year 2022 decreased by $6.8 million from fiscal year 2021 and net days also decreased by 7.9% from 74.2 to 68.3 days. Increased cash collections contributed to the decrease in account receivable and number of days.



Capital Assets

As of June 30, 2023, 2022, and 2021 the District had $796.6 million , $723.2 million, and $594.2 million, respectively, and invested in capital assets, net of accumulated depreciation. For the years ended June 30, 2023, 2022 and 2021, the District purchased capital assets amounting to $129.3 million, $181.3 million, and $151.3 million, respectively. The organization has made significant investments in new facilities through the Care Reimagined project and plans to continue this investment within the coming years. These investments include:

- Valleywise Comprehensive Health Center – Peoria, which opened in January 2021 providing ambulatory care and outpatient surgery.
- New Community Health Centers providing ambulatory care in different cities of Maricopa County.
- New acute care hospital (Valleywise Health Medical Center), currently under construction and planned to be completed in April 2024.

Debt

As of June 30, 2023, 2022, and 2021, the District had bonds payable of $666.9 million $718.3 million, and $763.0 million, 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, $36.0 million, was used to reimburse the District's general fund for prior capital asset purchases. For the years ended June 30, 2023 and 2022, and 2021, the District had no outstanding capital lease and other long-term obligations.

The following table summarizes net operating revenues, operating expenses, and non-operating revenues (expenses) for the fiscal years ended June 30, 2023, 2022, and 2021.

	Year Ended June 30		
	2023	2022	2021
Operating revenues:			
Net patient service revenue	$ 509,398,504	$ 494,650,061	$ 489,209,495
AHCCCS medical education revenue	50,659,492	47,113,700	51,866,779
Other revenue	126,703,335	74,234,388	66,022,660
Total operating revenues	686,761,331	615,998,149	607,098,934
Operating expenses			
Salaries and wages	296,737,796	287,796,627	278,443,621
Employee benefits	99,974,978	82,744,342	105,599,319
Purchased services	258,558,270	209,273,236	144,360,745
Medical claims and other expenses	68,529,325	81,838,190	72,572,408
Supplies	98,744,775	101,359,687	95,262,465
Depreciation	55,921,558	52,241,569	58,845,414
Total operating expenses	878,466,702	815,253,651	755,083,972
Operating loss	(191,705,371)	(199,255,502)	(147,985,038)
Nonoperating revenues (expenses)			
Property tax receipts	138,392,868	147,491,236	139,606,198
Noncapital grants	9,263,795	5,930,243	5,890,625
Noncapital subsidies from State	3,547,896	3,547,896	3,547,896
Other nonoperating (expenses) revenues, net	(4,246,685)	27,834,946	3,212,369
Interest income	7,601,696	3,731,217	2,031,886
Interest expense	(18,424,046)	(20,068,700)	(15,027,454)
Total nonoperating revenues, net	136,135,524	168,466,838	139,261,520
Decrease in net position	(55,569,847)	(30,788,664)	(8,723,518)
Net position, beginning of year	238,470,273	269,258,937	277,982,455
Net position, end of year	$ 182,900,426	$ 238,470,273	$ 269,258,937

Revenues

Net Patient Services Revenue

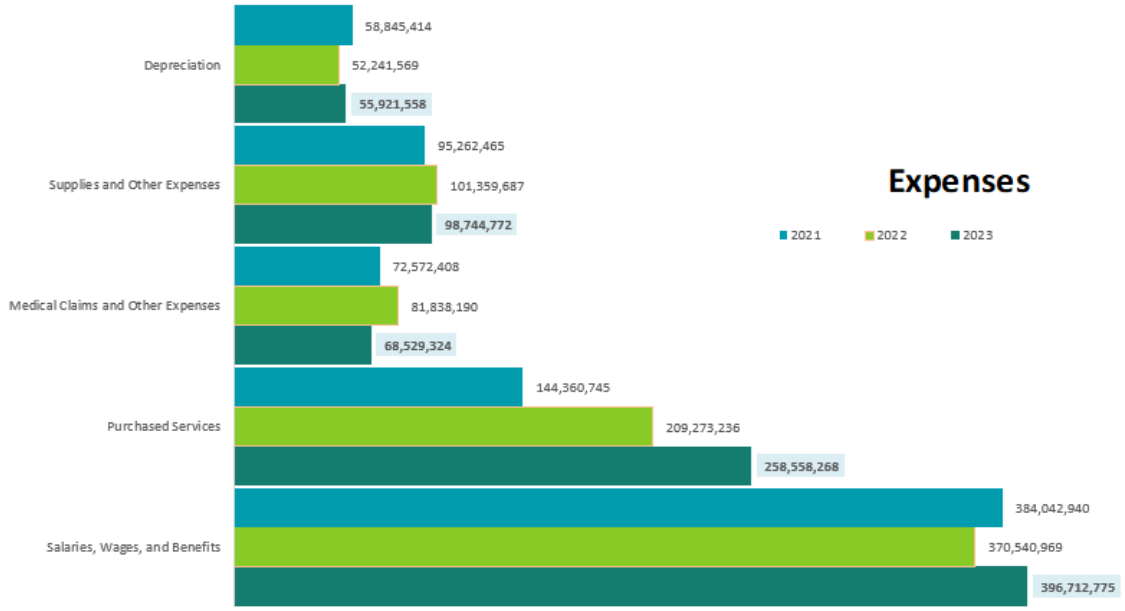
Net patient service revenue is derived from inpatient, outpatient, ambulatory, and emergency services provided to patients. Net patient service revenue for the year ended June 30, 2023, was $509.4 million, an increase from the prior year net patient service revenue of $494.7 million. Net patient service revenue increased $14.7 million or 3.0% in the year ended June 30, 2023, mainly due to changes in payor mix and volume increases in the ambulatory areas. Net patient service revenue for the year ended June 30, 2022, was $494.7 million, an increase from the prior year net patient service revenue of $489.2 million. Net patient service revenue increased $5.5 million or 1.1% in the year ended June 30, 2022, due to changes in payor mix.

	Year Ended June 30		
	2023	2022	Increase (Decrease)
Gross charges	$2,617,939,822	$2,562,415,380	2.2%
Contractual deductions	1,873,553,660	1,728,490,890	8.4%
As a percentage of gross charges	**(71.6%)**	**(67.5%)**	
Charity care	209,374,248	312,132,097	(32.9%)
As a percentage of gross charges	**(8.0%)**	**(12.2%)**	
Bad debt	25,613,410	27,142,332	(-14.4%)
As a percentage of gross charges	**(1.0%)**	**(1.1%)**	
Net patient service revenue	$ 509,398,504	$ 494,560,061	3.0%
As a percentage of gross charges	**19.5%**	**19.3%**	

Total operating revenues in fiscal year 2023 were $686.8 million in comparison with the prior year of $616.0 million, due in great part to the quality of gross revenue and improved payor mix as noted above and increased other revenues, mainly in the new AHCCCS program, HEALTHII and increased grant programs related revenues.

Operating Expenses

Total operating expenses in fiscal year 2023 were $878.5 million, which is an increase of $63.2 million (7.8%) over the prior year operating expenses of $815.3 million. Total operating expenses in fiscal year 2022 were $815.3 million, which is an increase of $60.2 million (8.0%) over fiscal year 2021 operating expenses of $755.1 million.



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 $100.7 million, $37.7 million, and $0.4 million, respectively, for the year ended June 30, 2023, $89.5 million, $58.0 million, and $43.9 million respectively, for the year ended June 30, 2022, and $84.2 million, $55.4 million, and $18.2 million, respectively, for the year ended June 30, 2021. Also included in nonoperating revenues are noncapital grants and noncapital subsidies from the state. These amounts were $9.3 million and $3.5 million, respectively, for the year ended June 30,

2023, $5.9 million and $3.5 million, respectively, for the year ended June 30, 2022, and $5.9 million and $3.5 million, respectively, for the year ended June 30, 2021. Other nonoperating revenues and expenses consisted primarily of other nonoperating revenues (expenses), interest income, and interest expense. These amounts were ($4.2) million, $7.6 million and ($18.4) million, respectively, for the year ended June 30, 2023, $27.8 million, $3.7 million and ($20.1) million, respectively, for the year ended June 30, 2022, and $3.2 million, $2.0 million and ($15.0) million, respectively, for the year ended June 30, 2021.

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

	Year Ended June 30 2023	2022
Assets		
Current assets:		
Cash and cash equivalents	**$ 241,214,127**	$ 233,412,109
Restricted cash – bond	**48,489,150**	77,286,783
Patient accounts receivable, net of allowances	**85,709,368**	92,605,989
Receivable from AHCCCS for medical education, net	**49,894,607**	46,875,590
Other receivables	**17,263,119**	39,377,126
Due from related parties	**3,376,279**	1,721,769
Supplies	**12,217,206**	11,730,777
Prepaid expenses	**13,490,793**	14,456,598
Total current assets	**471,654,649**	517,466,741
Other assets:		
Restricted cash – bond	**118,015,042**	229,636,165
Right-of-use assets	**7,521,419**	6,877,009
Total other assets	**125,536,461**	236,513,174
Capital assets:		
Land	**35,325,278**	35,615,279
Depreciable capital assets, net of accumulated depreciation	**761,270,876**	687,568,533
Total capital assets, net of accumulated depreciation	**796,596,154**	723,183,812
Total assets	**1,393,787,264**	1,477,163,727
Deferred outflows of resources		
Employer contributions made after measurement date	**34,467,520**	34,248,240
Difference between expected and actual experience	**3,256,622**	4,677,652
Changes in assumptions	**18,643,716**	39,477,696
Change in proportion and differences between employer contributions and proportionate share of contributions	**94,455**	6,469,841
Total deferred outflows of resources	**$ 56,462,313**	$ 84,873,429

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

Statements of Net Position (continued)

	Year Ended June 30 2023	2022
Liabilities and net position		
Current liabilities:		
Current maturities of long-term debt	**$ 26,130,000**	$ 40,351,007
Current portion of lease liabilities	**2,516,402**	2,177,940
Accounts payable	**79,974,978**	56,365,202
Accrued payroll and expenses	**28,158,703**	38,205,132
Risk claims payable, current portion	**513,856**	553,457
Overpayments from third-party payors	**10,506,859**	29,549,513
Other current liabilities	**84,789,145**	69,464,215
Total current liabilities	**232,589,943**	236,666,466
Risk claims payable, less current portion	**13,784,858**	12,512,090
Net pension and OPEB liability	**356,444,643**	287,090,884
Long-term lease liabilities	**5,005,017**	4,699,069
Long-term debt	**640,746,278**	677,938,352
Total liabilities	**1,248,570,739**	1,218,906,861
Deferred inflows of resources		
Difference between expected and actual experience	**6,758,096**	3,937,296
Change in assumptions	**874,912**	1,052,464
Difference between projected and actual investment earnings	**10,161,450**	98,870,631
Change in proportion and differences between employer contributions and proportionate share of contributions	**983,954**	799,631
Total deferred inflows of resources	**18,778,412**	104,660,022
Net position		
Unrestricted deficit	**(300,286,787)**	(394,856,298)
Net investment in capital assets	**274,132,348**	296,238,100
Restricted for bonds	**166,504,192**	306,922,948
Restricted for grants	**42,550,673**	30,165,523
Total net position	**$ 182,900,426**	$ 238,470,273

See accompanying notes.

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

Statements of Revenues, Expenses and Changes in Net Position

	Year Ended June 30	
	2023	**2022**
Operating revenues		
Net patient service revenue	**$ 509,398,504**	$ 494,650,061
AHCCCS medical education revenue	**50,659,492**	47,113,700
Other revenue	**126,703,335**	74,234,388
Total operating revenues	**686,761,331**	615,998,149
Operating expenses		
Salaries and wages	**296,737,796**	287,796,627
Employee benefits	**99,974,978**	82,744,342
Purchased services	**258,558,270**	209,273,236
Medical claims and other expenses	**68,529,325**	81,838,190
Supplies	**98,744,775**	101,359,687
Depreciation	**55,921,558**	52,241,569
Total operating expenses	**878,466,702**	815,253,651
Operating loss	**(191,705,371)**	(199,255,502)
Nonoperating revenues (expenses)		
Property tax receipts	**138,392,868**	147,491,236
Noncapital grants	**9,263,795**	5,930,243
Noncapital subsidies from State	**3,547,896**	3,547,896
Other nonoperating (expenses) revenues, net	**(4,246,685)**	27,834,946
Interest income	**7,601,696**	3,731,216
Interest expense	**(18,424,046)**	(20,068,700)
Total nonoperating revenues, net	**136,135,524**	168,466,838
Decrease in net position	**(55,569,847)**	(30,788,664)
Net position, beginning of year	**238,470,273**	269,258,937
Net position, end of year	**$ 182,900,426**	$ 238,470,273

See accompanying notes.

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

Statements of Cash Flows

	Year Ended June 30 2023	2022
Operating activities		
Receipts from and on behalf of patients	**$ 516,295,125**	$ 501,458,115
Payments to suppliers and contractors	**(385,185,121)**	(388,718,427)
Payments to employees	**(394,875,938)**	(478,790,701)
Other operating receipts	**194,803,307**	237,497,910
Other operating payments	**(19,042,654)**	(12,895,861)
Net cash used in operating activities	**(88,005,281)**	(141,448,964)
Noncapital financing activities		
Property tax receipts supporting operations	**100,676,385**	89,530,796
Noncapital contributions and grants received	**9,263,795**	5,930,243
Noncapital subsidies and other nonoperating receipts	**(698,789)**	31,382,842
Net cash provided by noncapital financing activities	**109,241,391**	126,843,881
Capital and related financing activities		
Property tax receipts for debt service	**37,716,483**	57,960,440
Principal payments on long-term debt and capital leases	**(51,413,081)**	(44,678,125)
Purchase of capital assets	**(129,333,900)**	(181,270,255)
Interest paid on long-term debt	**(18,424,046)**	(20,068,700)
Net cash used in capital and related financing activities	**(161,454,544)**	(188,056,640)
Investing activities		
Interest from investments	**7,601,696**	3,731,217
Net cash provided by investing activities	**7,601,696**	3,731,217
Decrease in cash and cash equivalents	**(132,616,738)**	(198,930,506)
Cash and cash equivalents, beginning of year	**540,335,057**	739,265,563
Cash and cash equivalents, end of year	**$ 407,718,319**	$ 540,335,057

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

Statements of Cash Flows (continued)

	Year Ended June 30 2023	2022
Reconciliation of operating loss to net cash used in operating activities		
Operating loss	**$ (191,705,371)**	$ (199,255,502)
Depreciation	**55,921,558**	52,241,569
Changes in operating assets and liabilities:		
Patient and other accounts receivable, and other assets	**54,402,727**	(15,415,921)
Due from related parties	**(1,654,510)**	44,696
Supplies and prepaid expenses	**479,376**	(2,803,266)
Overayments from third-party payors	**(19,042,654)**	(12,895,861)
Risk claims payable	**1,233,167**	2,033,963
Accounts payable and accrued expenses	**12,360,426**	34,601,358
Net cash used in operating activities	**$ (88,005,281)**	$ (141,448,964)

See accompanying notes.

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

Notes to Financial Statements

June 30, 2023

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) 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, three 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 the 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.

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

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.

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.

Use of Estimates

The preparation of these basic financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the basic financial statements and accompanying notes. Actual results could differ from those estimates.

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, 2023 and 2022, the District had approximately $407,718,000 and $540,335,000, respectively, of cash and cash equivalents and restricted cash. Restricted cash includes cash and cash equivalents that are restricted for use and includes approximately $48,489,000 and $77,287,000 as of June 30, 2023 and 2022, respectively, of tax proceeds restricted

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

for debt service on the general obligation bonds and approximately $118,015,000 and $229,636,000 as of June 30, 2023 and 2022, 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.

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 net realizable value, determined using the first-in, first-out method.

Capital Assets

Capital assets are recorded at cost at the date of purchase, 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 positions consist 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 Arizona Health Care Cost Containment System (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 the process of reconciling with AHCCCS and various health plans regarding the federal fiscal year 2022 ARRD report.

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 $56,068,000 and $84,878,000 for the years ended June 30, 2023 and 2022, 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 $10,161,000 and $8,697,000 for the years ended June 30, 2023 and 2022, 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 9).

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.

2. 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. 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, 2018.

- 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.

2. Net Patient Service Revenue (continued)

- 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.

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, 2023 and 2022, 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. Deposits, Pooled Funds, and Investment Income

Deposits

Custodial credit risk is the risk that in the event of a bank failure, an entity's deposits may not be returned to it. The District's deposit policy for custodial credit risk requires compliance with the provisions of state law.

The District's deposits are held by Maricopa County (the County) in conjunction with other County funds and are reported as cash and cash equivalents. The County has represented to the District that there is sufficient collateral to cover all of the County's deposits, including the District's deposits. The County issues a Comprehensive Annual Financial Report. Further information regarding County deposits and investments are contained within the basic financial statement notes to the Comprehensive Annual Financial Report. The most recent report can be obtained by writing to Maricopa County Department of Finance, 301 W. Jefferson, Suite 960, Phoenix, Arizona 85003, or at www.maricopa.gov.

3. Deposits, Pooled Funds, and Investment Income (continued)

Pooled Funds

By state statute, the County is required to ensure that all County funds are either insured by the Federal Deposit Insurance Corporation, collateralized by securities held by the cognizant Federal Reserve Bank, or invested in U.S. government obligations. The District's cash held by the County is pooled with the funds of other county agencies and then, in accordance with statutory limitations, placed in banks or invested as the County may determine. The District's pooled funds are reported as part of cash and cash equivalents, and restricted cash - bond and were approximately $380,036,000 as of June 30, 2023.

4. 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 $57,580,000 and $54,585,000 for the years ended June 30, 2023 and 2022, respectively.

5. Receivables From AHCCCS for Medical Education

During the years ended June 30, 2023 and 2022, the District entered into intergovernmental agreements with AHCCCS such that AHCCCS provided available medical education funds from CMS. At June 30, 2023 and 2022, available funds from CMS for medical education totaled approximately $66,022,000 and $61,508,000, respectively. At June 30, 2023 and 2022, the amount due to the District is approximately $49,895,000, which is net of the $16,127,000 matching funds to be provided by the District, and $46,876,000, which is net of the $14,632,000 matching funds provided by the District, respectively.

6. Other Receivables

At June 30, 2023 and 2022, significant components of other receivables included amounts due from third party payors, such as:

	2023	2022
Retail pharmacy accounts receivable	**$ 2,263,000**	$ 1,763,000
340B program	**1,407,000**	786,000
Home Assist Health	**700,000**	806,000
Grants receivable	**5,739,000**	2,546,000
CARES Act – Provider Relief Funds	**–**	27,083,000
Other	**7,154,000**	6,393,000
Total other receivables	**$ 17,263,000**	$ 39,377,000

7. Capital Assets

Capital assets activity for the year ended June 30, 2023, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Adjustments	Ending Balance
Capital assets not being depreciated:						
Construction-in-progress	**$ 369,061,921**	**$ 129,623,900**	**$ –**	**$ (54,248,424)**	**$ –**	**$ 444,437,397**
Capitalized software-in-progress	**330,119**	**–**	**–**	**–**	**–**	**330,119**
Land	**35,615,278**	**–**	**(290,000)**	**–**	**–**	**35,325,278**
Capital assets being depreciated:						
Buildings and leasehold improvements	**419,366,459**	**–**	**–**	**42,557,433**	**–**	**461,923,892**
Capitalized software	**49,516,241**	**–**	**–**	**–**	**–**	**49,516,241**
Equipment	**238,294,027**	**–**	**–**	**11,690,991**	**–**	**249,985,018**
Total capital assets	**1,112,184,045**	**129,623,900**	**(290,000)**	**–**	**–**	**1,241,517,945**
Accumulated depreciation	**389,000,233**	**55,921,558**	**–**	**–**	**–**	**444,921,791**
Capital assets, net	**$ 723,183,812**	**$ 73,702,342**	**$ (290,000)**	**$ –**	**$ –**	**$ 796,596,154**

7. Capital Assets (continued)

Capital assets activity for the year ended June 30, 2022, was as follows:

	Beginning Balance	Additions	Disposals	Transfers	Adjustments	Ending Balance
Capital assets not being depreciated:						
Construction-in-progress	$ 238,432,510	$ 182,475,787	$ –	$ (51,846,376)	$ –	$ 369,061,921
Capitalized software-in-progress	330,119	–	–	–	–	330,119
Land	26,342,487	–	(380,000)	9,652,791	–	35,615,278
Capital assets being depreciated:						
Buildings and leasehold improvements	393,737,421	–	(7,903,574)	33,532,612	–	419,366,459
Capitalized software	49,516,241	–	–	–	–	49,516,241
Equipment	229,935,513	–	(302,459)	8,660,973	–	238,294,027
Total capital assets	938,294,291	182,475,787	(8,586,033)	–	–	1,112,184,045
Accumulated depreciation	344,139,165	52,241,569	(7,380,501)	–	–	389,000,233
Capital assets, net	$ 594,155,126	$ 130,234,218	$ (1,205,532)	$ –	$ –	$ 723,183,812

During the years ended June 30, 2023 and 2022, the District recognized $10,484,000 and $10,484,000, respectively, in accelerated depreciation expenses due to the anticipated decommissioning of the current medical center building.

8. 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 actuary determined claims payable is approximately $14,299,000 and $13,066,000, of which $514,000 and $553,000 has been recorded as a current liability and approximately $13,785,000 and $12,513,000 has been recorded as a noncurrent liability on the accompanying statements of net position as of June 30, 2023 and 2022, respectively. Risk claims payable are undiscounted.

8. Risk Claims Payable (continued)

As of June 30, 2023, the District maintained commercial insurance as follows:

Insurance	Limits	Self-Insured Retention/Deductible
Workers' compensation	Statutory	$500,000 each claim
Medical malpractice	$15,000,000 each incident – first layer Additional $15,000,000 – second excess layer Additional $20,000,000 – third excess layer	$2,000,000 each incident Additional $2,000,000 one claim layer buffer

The insurance policies listed above became effective December 1, 2012, and remain current through June 30, 2023.

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

	2023	2022	2021
Beginning balance	**$ 13,065,547**	$ 11,031,584	$ 12,145,246
Total incurred	**6,926,933**	6,191,156	2,949,206
Total paid	**(5,693,766)**	(4,157,193)	(4,062,868)
Ending balance	**$ 14,298,714**	$ 13,065,547	$ 11,031,584

9. Other Current Liabilities

At June 30, 2023 and 2022, significant components of other current liabilities included amounts such as:

	2023	2022
Interest payable	**$ 14,570,000**	$ 15,579,000
Deferred revenue – Grants & Research	**21,829,000**	19,364,000
Deferred revenue - Foundation	**21,873,000**	10,802,000
Other current liabilities	**26,517,000**	23,719,000
Total other current liabilities	**$ 84,789,000**	$ 69,464,000

10. Long-Term Debt

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
2023					
General obligation bonds, series C	**$ 422,188,095**	**$ –**	**$ (19,134,289)**	**$ 403,053,806**	**$ 16,130,000**
General obligation bonds, series D	**296,101,264**	**–**	**(32,278,792)**	**263,822,472**	**10,000,000**
Direct placement general obligation bonds	**–**	**–**	**–**	**–**	**–**
Total long-term debt	**$ 718,289,359**	**$ –**	**$ (51,413,081)**	**$ 666,876,278**	**$ 26,130,000**
2022					
General obligation bonds, series C	$ 440,953,718	$ –	$ (18,765,623)	$ 422,188,095	$ 15,351,007
General obligation bonds, series D	305,008,663	–	(8,907,399)	296,101,264	25,000,000
Direct placement general obligation bonds	17,000,000	–	(17,000,000)	–	–
Total long-term debt	$ 762,962,381	$ –	$ (44,664,028)	$ 718,289,359	$ 40,351,007

10. Long-Term Debt (continued)

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 Valleywise Health Medical Center and its Level One Trauma Center and Arizona Burn Center, on the existing campus. As of June 30, 2023, the District has issued $935,000,000 in general obligation bonds.

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 1.61% 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 bonds were 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.

On June 10, 2021, the District closed on its fourth offering of general obligation bonds in the amount of $244,070,000 in order to continue the various improvement projects. The bonds were issued at a premium of $60,939,000. The bonds bear coupon interest at the rate of 5.00% through maturity in fiscal year 2035. Financing for the District's fourth offering were public placements.

Proposition 480 allows the County to levy 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, 2023.

10. Long-Term Debt (continued)

Credit Facility, Maricopa County

On June 25, 2020, the County agreed to extend the District a $30,000,000 line of credit through its credit facility in response to the COVID-19 pandemic crisis. The District did not have any outstanding borrowings on the line of credit at June 30, 2023 and 2022.

Scheduled maturities of long-term debt, excluding a net premium of $77,603,000, for the years ending June 30 are as follows:

	General Obligation Bonds		Direct Placement General Obligation Bonds	
	Principal	Interest	Principal	Interest
2024	$ 26,130,000	$ 28,487,350	$ –	$ –
2025	30,070,000	27,082,350	–	–
2026	31,575,000	25,541,225	–	–
2027	33,150,000	23,923,100	–	–
2028	34,810,000	22,224,100	–	–
2029–2033	201,975,000	82,507,125	–	–
2034–2038	209,410,000	28,420,800	–	–
2039–2041	33,215,000	664,300	–	–
	$ 600,335,000	$ 238,850,350	$ –	$ –

11. Restricted Net Position

Restricted net position at June 30, 2023 and 2022, consists of grant funds received for specific purposes that are expected to be expended as defined on the agreement, in the amount of approximately $42,551,000 and $30,166,000, respectively.

Restricted net position at June 30, 2023 and 2022, also consists of bond funds expected to be expended for specific purposes as defined in the bond agreement, in the amount of approximately $166,504,000 and $306,923,000, 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.

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, 2023 and 2022, active plan members, including the District, were required by statute to contribute at the actuarially determined rate of 12.17% (11.92% retirement, 0.11% health benefit supplement, and 0.14% long-term disability) and 12.41% (12.01% retirement, 0.21% health benefit supplement, and 0.19% 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

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

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.

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, 2023, the District reported a liability of approximately $369,080,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2022. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2021, and was rolled forward using generally accepted actuarial procedures to June 30, 2022. 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, 2022, the District's proportion was 2.26%, which represents no change from its proportion measured as of June 30, 2021.

At June 30, 2022, the District reported a liability of approximately $297,858,000 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2021. The total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of June 30, 2020, and was rolled forward using generally accepted actuarial procedures to June 30, 2021. The District's proportion of the net pension liability was

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

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, 2021, the District's proportion was 2.27%, which represents no change from its proportion measured as of June 30, 2020.

At June 30, 2023, the District reported a net (asset) of approximately ($12,635,000) for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2022. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2021, and was rolled forward using generally accepted actuarial procedures to June 30, 2022. 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, 2022 and 2021, the District's proportion was 2.30% and 2.31%, respectively.

At June 30, 2022, the District reported a net (asset) of approximately ($10,767,000) for its proportionate share of the net OPEB liability. The net OPEB liability was measured as of June 30, 2021. The total amount used to calculate the net OPEB liability was determined by an actuarial valuation as of June 30, 2020, and was rolled forward using generally accepted actuarial procedures to June 30, 2021. 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, 2021 and 2020, the District's proportion was 2.31% and 2.30%, respectively.

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

Within employee benefits, the District recorded pension expense of $47,306,000 and $33,298,000 for the years ended June 30, 2023 and 2022, respectively. At June 30, 2023, 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**
Employer contributions made after measurement date	**$ 33,719,162**	**$ –**
Differences between expected and actual experience	**3,144,779**	**–**
Changes in assumptions	**18,318,139**	**–**
Difference between projected and actual investment earnings	**–**	**(9,721,916)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**–**	**(969,137)**
Total	**$ 55,182,080**	**$ (10,691,053)**

At June 30, 2022, 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**
Employer contributions made after measurement date	$ 32,711,475	$ –
Differences between expected and actual experience	4,540,570	–
Changes in assumptions	38,768,596	–
Difference between projected and actual investment earnings	–	(94,371,882)
Change in proportion and differences between employer contributions and proportionate share of contributions	6,371,328	(779,921)
Total	$ 82,391,969	$ (95,151,803)

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

Of the amount reported as deferred outflows of resources as of June 30, 2023, $748,358 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, 2023. 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:	
2024	$ 16,797,286
2025	(4,706,275)
2026	(16,879,531)
2027	15,560,385

Within employee benefits, the District recorded OPEB expense of ($1,793,000) for the year ended June 30, 2023. At June 30, 2023, 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
Employer contributions made after measurement date	**$ 748,358**	**$ –**
Differences between expected and actual expenses	**111,843**	**(6,758,096)**
Changes in assumptions	**325,577**	**(874,912)**
Difference between projected and actual investments earnings	**–**	**(439,534)**
Change in proportion and differences between employer contributions and proportionate share of contributions	**94,455**	**(14,817)**
Total	**$ 1,280,233**	**$ (8,087,359)**

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

Within employee benefits, the District recorded OPEB expense of ($926,458) for the year ended June 30, 2022. At June 30, 2022, 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
Employer contributions made after measurement date	$ 1,536,765	$ –
Differences between expected and actual expenses	137,082	(3,937,296)
Changes in assumptions	709,100	(1,052,464)
Difference between projected and actual investments earnings	–	(4,498,749)
Change in proportion and differences between employer contributions and proportionate share of contributions	98,513	(19,710)
Total	$ 2,481,460	$ (9,508,219)

Of the amount reported as deferred outflows of resources, $1,537,000 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, 2022. 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:	
2024	$ (1,988,873)
2025	(2,174,578)
2026	(2,428,854)
2027	(352,442)
2028	(439,054)
Thereafter	(171,683)

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

Actuarial Assumptions

The June 30, 2021, 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	2.90% – 8.40% average, including inflation
Discount rate	7.00%

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

The June 30, 2020, 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	2.90% – 8.40% average, including inflation
Discount rate	7.00%

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

The June 30, 2021, 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	7.00%
Mortality rates	2017 SRA Scale U-MP
Health care trend rate	N/A

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

The June 30, 2020, 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	7.00%
Mortality rates	2017 SRA Scale U-MP
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, 2021 and 2020, pension and OPEB valuations were based on the results of an actuarial experience study for the period July 1, 2011–June 30, 2016. The ASRS Board adopted the experience study, which recommended changes, and those changes were effective as of the June 30, 2017, 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.

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, 2022, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	1.95%
Fixed income	30	1.04
Real estate	20	1.20
Total	100%	4.19%

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, 2021, are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Equity	50%	2.45%
Fixed income	30	1.11
Real estate	20	1.14
Total	100%	4.70%

Discount Rate

The discount rate used to measure the overall pension liability as of June 30, 2023 and 2022, was 7.0%, and the OPEB liability as of June 30, 2023 and 2022, was 7.0%. 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.

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

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, 2023, using the discount rate of 7.0% 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 one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	**Discount Rate (7.0%)**	**1-Point Increase (8.0%)**
District's proportionate share of the net pension liability	**$ 544,566,115**	**$ 369,079,692**	**$ 222,751,434**

The following presents the District's proportionate share of the net pension liability reported at June 30, 2022, using the discount rate of 7.0% 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 one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	**Discount Rate (7.0%)**	**1-Point Increase (8.0%)**
District's proportionate share of the net pension liability	$ 468,505,634	$ 297,857,967	$ 155,585,029

The following presents the District's proportionate share of the net OPEB liability reported at June 30, 2023, using the discount rate of 7.0% as well as what the District's proportionate share of the net OPEB liability would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	**Discount Rate (7.0%)**	**1-Point Increase (8.0%)**
District's proportionate share of the net OPEB liability	**$ 8,883,591**	**$ 12,635,048**	**$ 15,835,147**

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

The following presents the District's proportionate share of the net OPEB liability reported at June 30, 2022, using the discount rate of 7.0% as well as what the District's proportionate share of the net OPEB liability would be if it were calculated using a discount rate that is one percentage point lower 6.0% or one percentage point higher 8.0% than the current rate:

	1-Point Decrease (6.0%)	Discount Rate (7.0%)	1-Point Increase (8.0%)
District's proportionate share of the net OPEB liability	$ 6,825,194	$ 10,767,083	$ 14,135,798

Pension and OPEB Plans Fiduciary Net Position

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

13. Commitments and Contingencies

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, 2023 and 2022, through disproportionate share settlements established in Laws 2016 Second Regular Session Chapter 122

14. Disproportionate Share Settlement (continued)

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 approximately $4,202,000 of disproportionate share settlements in other operating revenue in each of fiscal years 2023 and 2022.

15. Related-Party Transactions

During the years ended June 30, 2023 and 2022, net patient service revenues included approximately $3,776,000 and $3,037,000, respectively, of payments received from Maricopa County Correctional Health for medical services rendered, and approximately $8,704,000 and $1,789,000, respectively, in grant funds from the Maricopa County Department of Public Health.

During the years ended June 30, 2023 and 2022, nonoperating revenues included approximately $334,000 and $952,000 in payments received from Maricopa County Industrial Development Authority (MCIDA) for program support in the District's Simulation and Training Center in fiscal years 2023 and 2022, 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 the District has 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 years 2023 and 2022:

16. COVID-19 (continued)

- The District has attested to the receipt of distributions of Provider Relief Funds under the CARES Act and recorded $0 and $39,376,000 in other nonoperating revenue for the years ended June 30, 2023 and 2022, respectively. These distributions have been used to offset expenses to prevent, prepare for, and respond to the COVID-19, or lost revenues that are attributable to COVID-19.

- The District has elected to defer applicable payroll taxes from April 5, 2020 through December 31, 2020. The deferred amount was accrued, and repayment will be due in two equal installments on December 31, 2021 and December 31, 2022. The deferred amounts were approximately $0 and $5,649,000 at June 30, 2023 and 2022, respectively and were recorded under accrued expenses.

- In 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.

  – Recoupments began in fiscal year 2021. The amounts outstanding of $0 and $3,192,000 as of June 30, 2023 and 2022, respectively, were recorded under other current liabilities.

16. COVID-19 (continued)

- The District was awarded FQHC grants under the Families First and CARES Act totaling $4,109,000. Of this total, $295,000 and $1,396,000 has been received and recognized as nonoperating revenue in fiscal years 2023 and 2022, respectively.

- The District was awarded grants under the American Rescue Plan Act totaling $16,900,000. Of this total, $8,052,000 and $2,745,000 has been recognized as other revenue in fiscal years 2023 and 2022, respectively.

- The District has applied 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, 2023, 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 $96,225,000 of annual tax revenue. The tax revenue is to be used to support operations of the District.

Effective July 1, 2023, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $13,849,000 and $18,684,000 for the year five principal and interest debt service, respectively, related to the $422,125,000 third bond offering.

Effective July 1, 2023, the District elected to levy property tax on all taxable property in the defined surrounding area, in the amounts of $9,816,000 and $10,855,000 for the year three principal and interest debt service, respectively, related to the $244,070,000 fourth bond offering.

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*

	2023	2022	2021	2020	2019	2018	2017	2016	2015
District's proportion or the net pension liability	**2.26%**	2.27%	2.27%	2.14%	2.15%	1.96%	2.11%	2.15%	2.25%
District's proportionate share of the net pension liability	**$ 369,079,692**	$ 297,857,967	$ 394,058,778	$ 311,132,978	$ 300,238,443	$ 304,619,435	$ 339,937,627	$ 334,641,881	$ 332,820,645
District's covered payroll	**$ 270,682,087**	$ 252,938,151	$ 236,809,991	$ 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	**136.35%**	117.76%	166.40%	138.00%	141.66%	161.30%	173.76%	170.32%	163.16%
Plan fiduciary net position as a percentage of the total pension liability	**74.26%**	78.58%	69.33%	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.

73% 85% 60% 72% 71% 62% 58% 59%

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

Schedule of District's Proportionate Share of the Net OPEB Liability (Asset)

Last 10 Fiscal Years*

	2023	2022	2021	2020	2019	2018
District's proportion or the net OPEB liability (asset)	**2.30%**	2.31%	2.30%	2.17%	2.14%	2.14%
District's proportionate share of the net OPEB liability (asset)	**$ (12,635,048)**	$ (10,767,083)	$ 116,339	$ 812,445	$ 347,486	$ (361,250)
District's covered payroll	**$ 270,682,087**	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966
District's proportionate share of the net OPEB liability (asset) as a percentage of its covered payroll	**(4.67)%**	(4.26)%	0.05%	0.36%	0.16%	(0.19)%
Plan fiduciary net position as a percentage of the total OPEB liability (asset)	**132.71%**	125.56%	99.73%	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.

Schedule of Contributions — Pension Plan

Last 10 Fiscal Years

	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 33,719,162**	$ 32,711,475	$ 29,724,443	$ 28,321,667	$ 25,950,721	$ 22,402,719	$ 20,360,215	$ 21,226,490	$ 21,396,442	$ 21,827,065
Contributions in relation to the contractually required contribution	**(33,719,162)**	(32,711,475)	(29,724,443)	(28,321,667)	(25,950,721)	(22,402,719)	(22,259,196)	(21,387,917)	(21,690,643)	(20,471,268)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ –	$ –	$ –	$ (1,898,981)	$ (161,427)	$ (294,201)	$ 1,355,797
District's covered payroll	**$ 288,670,536**	$ 270,682,087	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
Contributions as a percentage of covered payroll	**11.68%**	12.08%	11.75%	11.96%	11.51%	10.57%	10.78%	10.85%	10.89%	10.70%

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

Schedule of Contributions — OPEB

Last 10 Fiscal Years

	2023	2022	2021	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 748,358**	$ 1,536,765	$ 1,375,302	$ 1,579,258	$ 1,396,082	$ 1,273,313	$ 1,321,018	$ 1,213,587	$ 1,395,848	$ 1,715,385
Contributions in relation to the contractually required contribution	**(748,358)**	(1,536,765)	(1,375,302)	(1,579,258)	(1,396,082)	(1,273,313)	(1,321,018)	(1,213,587)	(1,395,848)	(1,715,385)
Contribution deficiency (excess)	**$ –**	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –	$ –
District's covered payroll	**$ 288,670,536**	$ 270,682,087	$ 252,938,151	$ 236,809,991	$ 225,450,955	$ 211,945,416	$ 188,850,966	$ 195,634,317	$ 196,475,917	$ 203,989,176
Contributions as a percentage of covered payroll	**0.26%**	0.57%	0.54%	0.67%	0.62%	0.60%	0.70%	0.62%	0.71%	0.84%

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 of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States (Government Auditing Standards), the financial statements of Maricopa County Special Health Care District d/b/a Valleywise Health (the District), which comprise the consolidated statement of financial position as of June 30, 2023, and the related consolidated 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 November___, 2023.

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) as a basis for designing 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 a 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 or significant deficiencies may exist that were not 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 financial statements. 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.

_____, 2023

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 6.

FQHC CEO Report

FQHC Measures

Access

Average of Appointment Fill Rates MTD

89.7%

Third Available Appointment

New Patient	14.84
Establish Patient	7.76

No Show Rate MTD

16.6%

Referrals Ready to Book in ≤ 3 Days by Percentage

91.3%

Patient Satisfaction

Net Promoter Score (Month)

73.7%

Quality

Quality measures at or Above Target YTD

Meet or Exceeding Target Goal	92%
Within 10% of the Target Goal	0.07%
>10% Outside target Goal	0%

Financial

% Variance of Budget YTD

-4%

% Variance of Visits YTD

0.6%

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 6.

FQHC CEO Report – FQHC Operational Dashboards

Valleywise Health

Ambulatory Pillars Dashboard

October 2023

Community Health Centers

Other FQHC Clinics

PATIENT EXPERIENCE - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total
Net Promoter Score FYTD *(Would recommend facility)*	≥73.0	72.5	72.2	67.9	79.2	69.0	74.3	74.1	71.0	83.2	85.4		73.9	72.9	73.2	77.6	81.3	72.9	72.6		73.3	73.7
	n-size	899	1,158	349	612	1,039	1,189	1,137	899	901	48		8,231	1,135	1,048	170	75	1,311	603		4,342	12,573

ACCESS - Ambulatory

	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total
Appointments Scheduled FYTD		10,166	11,804	4,798	10,522	11,347	12,778	13,221	8,797	14,280	769		98,482	14,987	13,295	5,821	1,680	11,045	9,240		56,068	154,550
Appointment Fill Rate FYTD		85.6%	91.6%	91.8%	92.7%	92.1%	95.4%	94.5%	91.2%	94.5%	90.3%		91.9%	87.1%	91.2%	100.0%	n/a	96.1%	75.3%		87.2%	90.4%
Scheduled Appointment No-Shows FYTD		1,228	1,600	837	1,674	1,877	2,401	2,666	1,619	3,148	161		17,211	2,015	1,921	495	385	1,885	1,747		8,448	25,659
No Show Rate FYTD	<18%	12.1%	13.6%	17.4%	15.9%	16.5%	18.8%	20.2%	18.4%	22.0%	20.9%		17.5%	13.4%	14.4%	8.5%	22.9%	17.1%	18.9%		15.1%	16.6%

FINANCE - Ambulatory

		Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen	McDowell **	McDowell - Mesa ***		VCHCs FYTD	Peoria Primary Care	Women's Clinic	Antepartum Testing	Diabetes Ed	Internal Medicine P	Peds Primary		Other FQHC-Peoria FYTD	Grand Total FQHC ****	FYTD FQHC *****
In-Person Visits FYTD		5,956	6,007	2,150	5,596	5,926	6,025	6,982	4,780	5,252	334		49,008	7,356	6,895	3,814	511	6,485	5,664		30,725		89,379
Virtual Visits FYTD		427	554	290	249	454	905	427	211	1,307	64		4,888	1,151	116	10	7	89	9		1,382		13,837
Total Actual Visits (includes Nurse Only Visits) FYTD		6,383	6,561	2,440	5,845	6,380	6,930	7,409	4,991	6,559	398		53,896	8,507	7,011	3,824	518	6,574	5,673		32,107		103,216
Budgeted Visits FYTD		4,467	7,218	2,908	6,332	6,777	6,864	7,182	5,505	5,529	333		53,115	9,517	6,753	3,222	484	6,725	6,011		32,712		102,588
Variance FYTD		1,916	(657)	(468)	(487)	(397)	66	227	(514)	1,030	65		781	(1,010)	258	602	34	(151)	(338)		(605)		628
Variance by % FYTD		42.9%	-9.1%	-16.1%	-7.7%	-5.9%	1.0%	3.2%	-9.3%	18.6%	19.5%		1.5%	-10.6%	3.8%	18.7%	7.0%	-2.2%	-5.6%		-1.8%		0.6%
Total Number of Patients seen by provider FYTD		6,202	6,373	2,338	5,375	6,136	6,683	7,256	4,778	5,541	294		50,976	8,287	6,336			6,470	5,501		26,594	77,570	

BEHAVIORAL HEALTH - Ambulatory

Finance	Target	Avondale	Chandler	Guadalupe	West Maryvale	Mesa	North Phoenix	S. Central Phoenix	S. Phoenix Laveen		BH Psychiatry		BH FYTD	PEC	PXC
In-Person Visits FYTD		191	144	117	125	375	190	51	99		59		1,780	235	194
Virtual Visits FYTD		722	488	612	309	942	344	1,015	552		1,407		7,567	1,176	0
Total Actual Visits FYTD		913	632	729	434	1,317	534	1066	651		1466		9,347	1,411	194
Budget Visits FYTD		1,029	590	532	496	1,304	440	1379	568		971		8,918	1,478	131
Variance FYTD		(116)	42	197	(62)	13	94	(313)	83		495		429	(67)	63
Variance by % FYTD		-11.3%	7.1%	37.0%	-12.5%	1.0%	21.4%	-22.7%	14.6%		51.0%		4.8%	-4.5%	48.1%

DENTAL - Ambulatory

Finance		Avondale	Chandler							McDowell **			Dental FYTD	PEC	PXC
Actual Visits FYTD		888	899							1,178			7,866	1,722	3,179
Budget Visits FYTD		711	900							1,214			7,843	1,701	3,317
Variance FYTD		177	-1							-36			23	21	-138
% Variance FYTD		24.9%	-0.1%							-3.0%			0.3%	1.2%	-4.2%

LEGEND:

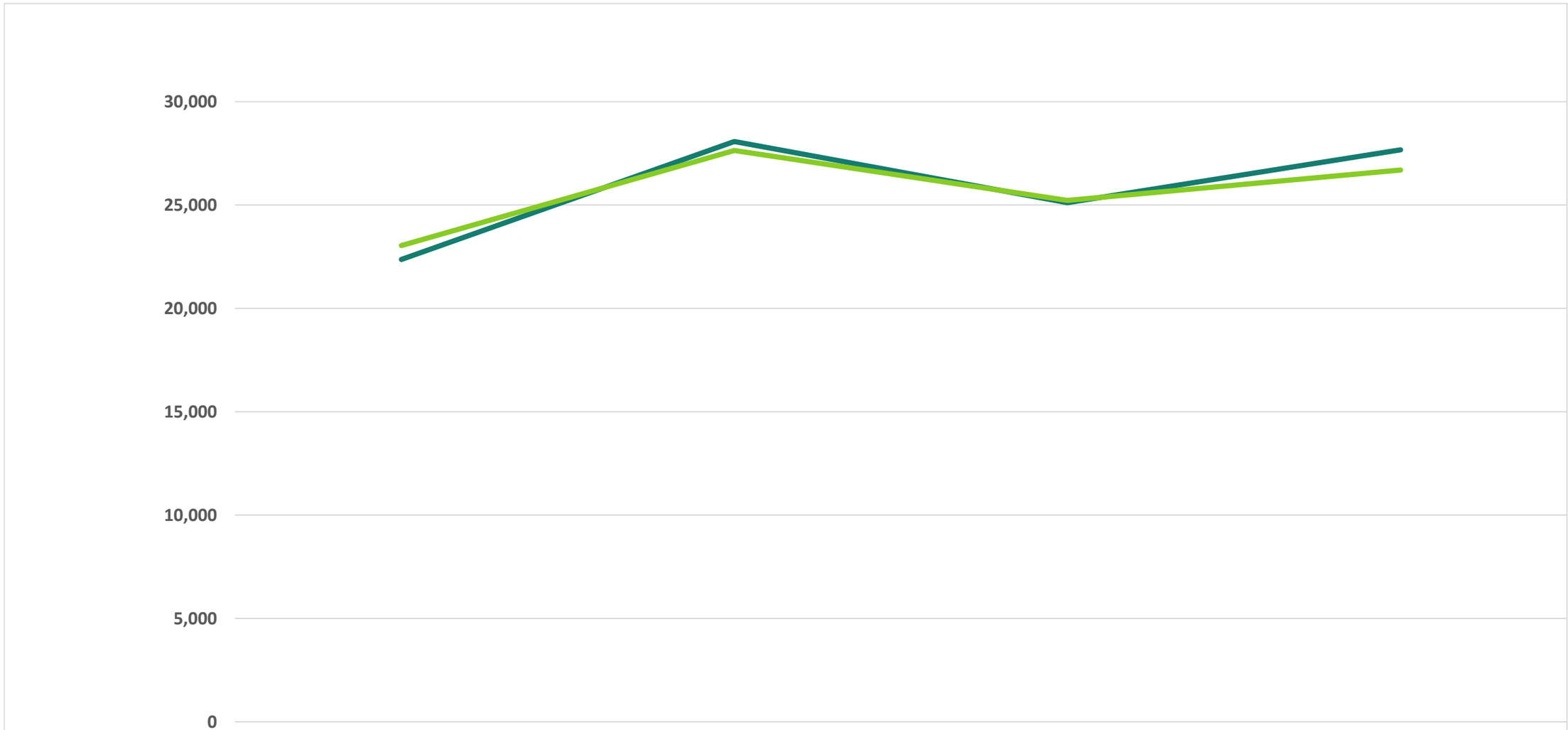
- Not in Target
- 5% less than the target
- Target ≥ 95%

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

Last Revised Date: 11/17/2023

Valleywise Health

FQHC Grand Total Actual vs Budgeted Visits
FY 2024 Trend



	Jul-23	Aug-23	Sep-23	Oct-23
FYTD Actual Visits	22,371	28,071	25,108	27,666
FYTD Budgeted Visits	23,039	27,639	25,218	26,692

Ambulatory Care

Ambulatory Care	Reporting Program	2022 UDS National Average	2021 UDS National Average	CYTD 2022	Desired Direction	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	YTD
Quality /Regulatory Metrics																		
Unified Data System																		
Body Mass Index (BMI) Screening and Follow-Up Plan	HRSA	> 61.04%	> 61.32%	66.13%	↑	✓ 89.54%	✓ 91.66%	✓ 92.88%	✓ 93.32%	✓ 93.53%	✓ 93.69%	✓ 93.79%	✓ 93.93%	✓ 92.11%				✓ 92.11%
Numerator						10,145	15,782	23,877	29,014	33,454	37,711	40,393	43,747	46,251				46,251
Denominator						11,330	17,218	25,707	31,092	35,767	40,250	43,068	46,575	50,211				50,211
Cervical Cancer Screening	HRSA	> 53.99%	> 52.95%	53.62%	↑	✓ 54.68%	✓ 54.81%	✓ 54.76%	✓ 54.84%	✓ 55.10%	✓ 55.59%	✓ 55.83%	✓ 56.38%	✓ 56.45%				✓ 56.45%
Numerator						3,969	5,732	8,060	9,516	10,814	12,130	12,918	14,018	14,766				14,766
Denominator						7,259	10,458	14,718	17,351	19,625	21,821	23,137	24,865	26,158				26,158
Childhood Immunization Status (CIS)	HRSA	> 33.23%	> 38.06%	9.40%	↑	✗ 3.13%	! 36.63%	✓ 38.85%	✓ 40.77%	✓ 39.78%	✓ 39.51%	✓ 39.72%	✓ 39.07%	✓ 38.40%				✓ 38.40%
Numerator						11	200	312	373	397	416	431	436	442				442
Denominator						352	546	803	915	998	1,053	1,085	1,116	1,151				1,151
Colorectal Cancer Screening	HRSA	> 42.82%	> 41.93%	51.39%	↑	! 37.75%	✗ 33.64%	✗ 35.97%	! 37.79%	! 38.80%	! 39.90%	! 40.89%	! 42.43%	✓ 43.24%				✓ 43.24%
Numerator						2,222	3,712	5,666	6,988	8,078	9,164	9,910	10,937	11,642				11,642
Denominator						5,886	11,034	15,750	18,494	20,820	22,969	24,237	25,777	26,927				26,927
Controlling High Blood Pressure	HRSA	> 63.40%	> 60.15%	53.68%	↑	✗ 46.59%	✗ 48.74%	✗ 51.35%	✗ 53.49%	! 55.36%	! 56.29%	! 58.15%	! 59.19%	! 59.10%				! 59.10%
Numerator						2,337	3,618	5,467	6,690	7,757	8,695	9,291	9,786	9,979				9,979
Denominator						5,016	7,423	10,647	12,506	14,012	15,448	15,977	16,532	16,886				16,886
Diabetes: Hemoglobin A1c Poor Control	HRSA	< 30.42%	< 32.29%	30.28%	↓	✗ 61.15%	✗ 53.74%	✗ 45.41%	✗ 40.59%	✗ 37.29%	! 34.46%	! 32.94%	! 31.56%	! 30.76%				! 30.76%
Numerator						2,128	2,764	3,356	3,496	3,570	3,607	3,618	3,662	3,741				3,741
Denominator						3,480	5,143	7,390	8,612	9,574	10,467	10,983	11,605	12,160				12,160
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	HRSA	> 76.83%	> 78.25%	75.07%	↑	! 74.29%	! 75.78%	! 76.58%	! 76.74%	! 76.87%	! 77.07%	! 76.87%	! 76.53%	✓ 76.83%				✓ 76.83%
Numerator						526	782	1,076	1,237	1,386	1,529	1,592	1,683	1,738				1,738
Denominator						708	1,032	1,405	1,612	1,803	1,984	2,071	2,199	2,262				2,262
Screening for Clinical Depression and Follow-Up Plan if positive screen	HRSA	> 70.02%	> 67.42%	54.67%	↑	✗ 48.25%	✗ 50.16%	✗ 52.84%	✗ 55.06%	✗ 58.36%	! 62.93%	! 65.53%	! 68.52%	✓ 70.21%				✓ 70.21%
Numerator						5,466	8,347	12,821	15,980	19,407	23,547	26,303	29,801	32,400				32,400
Denominator						11,328	16,642	24,265	29,022	33,252	37,418	40,136	43,490	46,147				46,147
Tobacco Use: Screening and Cessation Intervention	HRSA	> 84.60%	> 82.34%	88.88%	↑	✓ 85.29%	✓ 86.69%	✓ 87.81%	✓ 88.43%	✓ 88.77%	✓ 89.03%	✓ 89.29%	✓ 89.61%	✓ 89.49%				✓ 89.49%
Numerator						2,707	6,160	11,639	15,999	20,038	24,367	27,457	31,389	34,567				34,567
Denominator						3,174	7,106	13,254	18,093	22,572	27,369	30,750	35,027	38,627				38,627
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	HRSA	> 69.81%	> 68.72%	78.55%	↑	✗ 51.04%	✗ 54.62%	✗ 58.55%	✗ 60.81%	! 63.25%	! 67.00%	✓ 70.29%	✓ 73.96%	✓ 74.47%				✓ 74.47%
Numerator						932	1,796	3,115	4,014	4,858	5,950	6,944	8,243	8,848				8,848
Denominator						1,826	3,288	5,320	6,601	7,681	8,881	9,879	11,145	11,881				11,881
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	HRSA	> 76.07%	> 73.10%	71.68%	↑	✓ 76.56%	✓ 77.44%	✓ 77.70%	✓ 77.41%	✓ 77.19%	✓ 77.00%	✓ 76.74%	✓ 76.83%	✓ 76.63%				✓ 76.63%
Numerator						3,492	5,031	7,204	8,344	9,295	10,183	10,666	11,313	11,697				11,697
Denominator						4,561	6,497	9,272	10,779	12,041	13,224	13,898	14,725	15,264				15,264
Breast Cancer Screening	HRSA	> 50.28%	> 46.29%	59.89%	↑	✓ 51.10%	✓ 51.68%	✓ 54.03%	✓ 56.03%	✓ 56.79%	✓ 57.83%	✓ 58.79%	✓ 59.93%	✓ 60.17%				✓ 60.17%
Numerator						1,675	2,465	3,626	4,363	4,908	5,465	5,825	6,291	6,556				6,556
Denominator						3,278	4,770	6,711	7,787	8,642	9,450	9,908	10,498	10,896				10,896
HIV Screening	HRSA	> 43.82%	> 38.09%	63.40%	↑	✓ 69.14%	✓ 68.38%	✓ 68.00%	✓ 67.91%	✓ 67.88%	✓ 67.86%	✓ 67.74%	✓ 67.66%	✓ 67.55%				✓ 67.55%
Numerator						8,707	12,621	18,066	21,472	24,466	27,419	29,292	31,665	33,327				33,327
Denominator						12,594	18,457	26,567	31,620	36,043	40,408	43,239	46,797	49,334				49,334

‡ -

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

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

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

	Data Source	Owner	Frequency	System
PATIENT EXPERIENCE - Ambulatory				
Net promoter score (Would recommend facility)	A customer loyalty index calculated based on a patient's response on a scale of 1-10 to the question "How likely would you be to recommend this facility to your family and friends?". The NPS = % Promoters (9 or 10 responses) - % Detractors (0-6 responses) *Scores are limited to include only FQHC departments by clinic cost center on this dashboard for: 416603, 416608, 416609, 416704, 416707, 416711, 416601, 416701, 416613, 476707, 576130, 576101, 476101, 476102, 476104, 476106, 476105* *Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments within each community health center are excluded from locational roll ups*	NRC Real Time Score Summary *pulled by Amanda Jacobs	Monthly	NRC Health - Department Summary Report
ACCESS - Ambulatory				
Appointments Scheduled FYTD	All appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD. *Note: For active providers only - FYTD does not account for historical provider information	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
Appointment Fill Rate FYTD	Provider schedule utilization metric calculated by number of patients to appointment slots available. *For FYTD.	Provider Schedule Utilization - All Clinics (Prior Month) Report *last modified by Jim Trulock 9/29/2020 *pulled by Amanda Jacobs	Monthly	EPIC Report
Scheduled Appointment No-Shows FYTD	All No- show appointment visits are included, except from Dental, Financial Counseling, Lab, Radiology, Ophthalmology, and other Specialty departments. *For FYTD.	FQHC Appointment Statistics by Clinic Details (Prior Month) Report *last modified 6/2/2020 by Vondra Dee Nason *pulled by Amanda Jacobs	Monthly	EPIC Report
No Show Rate FYTD	Percentage of Scheduled Patients who were a "No show" patient or same day cancellation. *For FYTD.	Amanda Jacobs	Monthly	Formula
FINANCE - Ambulatory				
In-Person Visits FYTD	Total Actual Visits (includes nurse only visits) FYTD - Virtual Visits FYTD	Nancy Horskey	Monthly	Axiom
Virtual Visits FYTD	Virtual Telemedicine Visits (telephonic/audio/visual/other virtual type) FYTD	Nancy Horskey	Monthly	Axiom
Total Actual Visits (includes nurse only visits) FYTD	All visits per Clinic (visit count methodology). For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Budgeted Visits FYTD	All budgeted visits per Clinic (visit count methodology) For the Fiscal Year to Date	Nancy Horskey	Monthly	Axiom
Variance FYTD	Actual Visits FYTD (includes nurse only visits) - Budgeted Visits FYTD. For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Variance by % FYTD	Variance FYTD / Budgeted Visits FYTD (%) For the Fiscal Year to Date	Amanda Jacobs	Monthly	Formula
Total Number of Patients seen by provider	Completed visits for provider only	Maria Aguirre	Monthly	Epic - Clarity Query
Grand Total FQHC	Includes Month Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula
FYTD FQHC	Includes FYTD Totals from Community Health Centers, Dental, Other FQHC, and OP Behavioral Health clinics	Amanda Jacobs	Monthly	Formula

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

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

Valleywise Health

Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
QUALITY - Ambulatory					
Quality /Regulatory Metrics	**Required by:**		Quality	Monthly	
Body Mass Index (BMI) Screening and Follow-Up	**CMS69v11**	**Description:** Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the measurement period AND who had a follow-up plan documented if BMI was outside of normal parameters **Numerator:** Patients with a documented BMI during the encounter or during the measurement period, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the measurement period **Denominator:** All patients aged 18 and older on the date of the encounter with at least one eligible encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms069v11*	Quality	Monthly	EPIC/UDS
Cervical Cancer Screening	**CMS124v11**	**Description:** Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: * Women age 21-64 who had cervical cytology performed within the last 3 years * Women age 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years **Numerator:** Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria: * Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test * Cervical human papillomavirus (HPV) testing performed during the measurement period or the four years prior to the measurement period for women who are 30 years or older at the time of the test **Denominator:** Women 24-64 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms124v11*	Quality	Monthly	EPIC/UDS
Childhood Immunization Status (CIS)	**CMS117v11**	**Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three or four H influenza type B (Hib); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday **Numerator:** Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday **Denominator:** Children who turn 2 years of age during the measurement period and who have a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms117v11*	Quality	Monthly	EPIC/UDS

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Ambulatory Pillars Dashboard

Data Dictionary

Federally Qualified Health Centers

		Data Source	Owner	Frequency	System
Colorectal Cancer Screening	**CMS130v11**	**Description:** Percentage of adults 45-75 years of age who had appropriate screening for colorectal cancer **Numerator:** Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: * Fecal occult blood test (FOBT) during the measurement period * Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period * Colonoscopy during the measurement period or the nine years prior to the measurement period * FIT-DNA during the measurement period or the two years prior to the measurement period * CT Colonography during the measurement period or the four years prior to the measurement period **Denominator**: Patients 45-75 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms130v11*	Quality	Monthly	EPIC/UDS
Controlling High Blood Pressure	**CMS165v11**	**Description**: Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period **Numerator:** Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period **Denominator:** Patients 18-85 years of age by the end of the measurement period who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms165v11*	Quality	Monthly	EPIC/UDS
Diabetes: Hemoglobin A1c Poor Control	**CMS122v11**	**Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period **Numerator:** Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period. **Denominator:** Patients 18-75 years of age with diabetes with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms122v11*	Quality	Monthly	EPIC/UDS
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	**CMS164v7**	**Description:** Percentage of patients 18 years of age and older who were diagnosed with acute myocardial infarction (AMI), or who had a coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCIs) in the 12 months prior to the measurement period or who had an active diagnosis of IVD during the measurement period, and who had documented use of aspirin or another antiplatelet during the measurement period **Numerator:** Patients who had an active medication of aspirin or another antiplatelet during the measurement year **Denominator:** Patients 18 years of age and older with a visit during the measurement period who had an AMI, CABG, or PCI during the 12 months prior to the measurement year or who had a diagnosis of IVD overlapping the measurement year ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS164v7.html*	Quality	Monthly	EPIC/UDS

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Screening for Clinical Depression and Follow Up Plan	**CMS2v12**	**Description:** Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Numerator:** Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter **Denominator**: All patients aged 12 years and older at the beginning of the measurement period with at least one qualifying encounter during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms002v12*	Quality	Monthly	EPIC/UDS
Tobacco Use: Screening and Cessation Intervention:	**CMS138v11**	**Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Numerator:** *Patients who were screened for tobacco use at least once during the measurement period and *Who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user **Denominator:** Patients aged 18 years and older seen for at least two medical visits in the measurement period or at least one preventive medical visit during the measurement period. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms138v11*	Quality	Monthly	EPIC/UDS
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**CMS155v11**	**Description:** Percentage of patients 3–17* years of age who had an outpatient visit with a primary care physician or OB/GYN and who had evidence of height, weight, and body mass index (BMI) percentile documentation, who had documentation of counseling for nutrition, and who had documentation of counseling for physical activity during the measurement period **Numerator:** Children and adolescents who have had: *their height, weight, and BMI percentile recorded during the measurement period and *counseling for nutrition during the measurement period and *counseling for physical activity during the measurement period **Denominator:** Patients 3 through 17 years of age by the end of the measurement period, with at least one outpatient visit with a PCP or OB/GYN during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms155v11*	Quality	Monthly	EPIC/UDS

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Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	**CMS347v6**	**Description:** Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: *All patients with an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or ever had an ASCVD procedure; OR *Patients aged >= 20 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia; OR *Patients aged 40-75 years with a diagnosis of diabetes **Numerator:** Patients who are actively using or who receive an order (prescription) for statin therapy at any time during the measurement period **Denominator:** All patients who have an active diagnosis of clinical ASCVD or ever had an ASCVD procedure. Patients aged >= 20 years at the beginning of the measurement period who have ever had a laboratory result of LDL-C >=190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia. Patients aged 40 to 75 years at the beginning of the measurement period with Type 1 or Type 2 diabetes. ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms347v6*	Quality	Monthly	EPIC/UDS
Breast Cancer Screening	**CMS125v11**	**Description:** Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period **Numerator:** Women with one or more mammograms any time on or between October 1 two years prior to the measurement period and the end of the measurement period **Denominator:** Women 52-74 years of age by the end of the measurement period with a visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms125v11*	Quality	Monthly	EPIC/UDS
HIV Screening	**CMS349v5**	**Description:** Percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for Human immunodeficiency virus (HIV) **Numerator:** Patients with documentation of an HIV test performed on or after their 15th birthday and before their 66th birthday **Denominator:** Patients 15 to 65 years of age at the start of the measurement period AND who had at least one outpatient visit during the measurement period ***Exclusions/Exceptions Outlined via eCQI Resource Center:*** *https://ecqi.healthit.gov/ecqm/ec/2023/cms349v5*	Quality	Monthly	EPIC/UDS

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 7.

Board Report

No Handout

Valleywise Community Health Centers Governing Council Meeting

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Item 8.

Valleywise Health CEO Report

No Handout

Valleywise Community Health Centers Governing Council Meeting

December 6, 2023

Item 9.

Closing Comments

No Handout

Valleywise Community Health Centers Governing Council Meeting

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Item 10.

Staff Assignments

No Handout