Hilltown Community Health Center

BOARD MEETING
AUGUST 25, 2016
HUNTINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the July 28, 2016 Meeting Minutes

3. Finance Committee Report

4. Executive Director / Senior Manager Reports

5. Committee Reports (as needed)
   - Executive Committee
   - Recruiting, Orientation, and Nominating (RON)
   - Corporate Compliance
   - Facilities
   - Personnel
   - Quality Improvement
   - Expansion
   - Strategic Planning
   - Bylaws Ad-Hoc Committee

6. New Business
   - Bylaws Review and Discussion
   - Review of new Vision, Mission and Values
   - Smoke and Tobacco Free Work Place Policy

7. Adjourn

HCHC BOARD OF DIRECTORS MEETING
Location: Worthington Health Center, Worthington, MA
Date/Time: 07/28/2016 6:00pm

MEMBERS: Wendy Lane Wright, Clerk; Alan Gaitenby; Lee Manchester; Nancy Brenner, Vice President; John Follet, President; Wendy Long; Cheryl Hopson; Tim Walter; Kathryn Jensen
STAFF: Eliza Lake, Executive Director; Frank Mertes, CFO; Janet Laroche, Executive Assistant
ABSENT: Lew Robbins, Treasurer; Michael Purdy, CCCSO; Jeff Hagen, COO

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Approval of Minutes 06/09/2016	John Follet called the meeting to order at 6:10pm. The June 9, 2016 minutes were reviewed by the Board members present. **A motion was made by Alan Gaitenby to approve the June 9, 2016 minutes. The motion was seconded by Wendy Long. The motion to approve the minutes was approved unanimously.**	The June 9, 2016 minutes were approved	
Executive Director Report	Eliza reported that the Operational Site Visit report was received and was sent to all Board members for review. The report lists 1 fewer 'unmet' than was previously thought would be included. There's a chance that the voting that took place at the June meeting will need to be done again due to not having an assigned HRSA project officer. The date that the project officer was spoken to about making these changes in scope is in question. Eliza is waiting to hear back from someone at HRSA to determine if another vote is necessary. A work plan has been created to address the seven unmet items stated in the report. We have 90 days to develop plans to address the issues and report back to HRSA.		

	Alan asked which of the findings are a concern for resolving? It was stated that data collection and the financial management and control policies are concerns of Senior Management. It was also asked when will the project officer issue be resolved? Eliza answered by saying she's not sure. She may need to contact the head of the project officers to receive an answer. There is free technical assistance available from HRSA for Boards and Eliza asked if this is something the Board is interested in? The training is free because it was recommended by the consultants of the site visit. There is an application that needs to be submitted by Monday, August 1 if there's interest. A discussion began asking if there are expectations from HRSA by accepting this training and Eliza answered no, there are no expectations. It was also asked what training is needed? Eliza believes the Board can decide what topics would be a benefit to the group and there would be a list of topics to choose from. It was decided to have Eliza complete the application and submit. Eliza reported that the Amherst expansion project is going well. There is one concern which relates to the budget amount of $2.25 million that was voted upon previously. Due to construction costs rising and some additional costs, Eliza suggested increasing the fundraising budget goal from $1.25 million to $1.5 million, which would bring the total budget for this project to $2.5 million. The fundraising committee will only raise		

	as much as is needed. The current budget includes $172,000 coming from HCHC in kind, but it's been suggested that this amount be fundraised instead. It was asked if there is a downside to increasing the budget amount? If it's presented to donors in the correct way, it will work out. If the construction bids come in higher than anticipated, that could cause issues with donors if we had to go back to them to ask for additional funds. Raising the fundraising amount now will hopefully eliminate that problem. **Wendy Long made a motion to give the Executive Director authority to raise the fundraising goal amount for the Amherst expansion project from $1.25 million to $1.5 million. The motion was seconded by Nancy Brenner. With no further discussion needed, the motion was approved unanimously.** Interviews have taken place to hire an Owner's Project Manager (OPM) to manage the Amherst construction project. Eliza shared that the HRSA consultants named a best practice for us in the area of Board composition and inclusion for Amherst. HRSA's Delivery System Health Information Investment Grant for $49,988.00 was recently applied for. If received, the funds would be used for the purchase of new laptops, servers, some software changes, the hiring of a consultant to review our network, and some equipment for the Amherst site. Since all HRSA grants need Board approval, Eliza asked the group to consider approving the submission of this	Amherst fundraising budget goal raised from $1.25 million to $1.5 million.	

	grant application. **Alan Gaitenby made a motion to approve the submission of the Delivery System Health Information Investment Grant. Tim Walter seconded the motion. With no further discussion needed, the motion was approved.** The Board was informed that the Behavioral Health department will be fully staffed beginning in August. A new LMHC is starting on August 9. Eliza informed the Board that her performance evaluation that was approved in October, 2015 was not voted upon at that time. Copies of her evaluation were handed out for review. After a review of the document, **a motion was made by John Follet for the Board to approved Eliza's evaluation. It was seconded by Nancy Brenner and approved unanimously.** Dr. Cortney Haynes has given her resignation and will be leaving the health center in October. She's accepted a position in Springfield. Eliza and Frank are keeping up on the information coming out regarding the restructuring of MassHealth and how it plans to change the way services are paid for. Currently, only 25% of our patients are enrolled in MassHealth. According to the restructuring, if we can prove that we've controlled costs for these patients and saved money, we would be compensated, but if it cannot be proven, there will not be compensation. This system is planned for implementation in 2017. There's been discussions about forming a Massachusetts-wide ACO which would include health centers across the state. There's concerns	The Delivery System Health Information Investment Grant was approved for submission. Eliza Lake's performance evaluation was approved.	

	from these health centers regarding how this would work. Our expansion to Amherst may help to increase the number of MassHealth patients we currently see.		
Finance Committee	Tim reported for the Finance Committee with the absence of Lew at this meeting. For the month of June, there was a surplus of $4071.00, but the year-to-date loss is $155,496.00. Frank distributed and explained a new dashboard format for reviewing the financial data and the data will be in this format for future meetings. Also reviewed was a summary of the income statement, a balance sheet by month showing actual to budget information, and major variances by month. It was noted that there is an operating loss at this time. Fundraising has been separated from our net operating activities. There is currently 12.5 days cash on hand. Patient receivables are good at this time along with our ability to pay the bills. It was also noted that we're doing better now than we were at this point last year. We have a server backup system that costs more than $5,000.00 over the course of the year, so it's been brought to this meeting to be reviewed and voted upon. The yearly cost to back up the network is $8,940.00. **A motion was made to approve the $8,940.00 expense for the server backup system by Tim Walter, seconded by Alan Gaitenby and approved unanimously.** **A motion was made to approve the finance committee report by Alan Gaitenby. It was seconded by Nancy**	The server backup system expense of $8940 was approved. Finance Committee report was approved.	

	Brenner. Without further discussion needed, the motion to approve the finance committee report was approved. Alan asked if the net operating expenses include big ticket purchases and if there's a breakdown of these listed? Frank responded by explaining the second page of the report shows expenditures and what that includes. Because grants are cost reimbursed, this can cause variances to occur. Frank feels we need to do a better job at managing our grants and spending grant money timely.		
Corporate Compliance Committee	The committee did not report this month.		
Recruitment, Orientation & Nominating (RON) Committee	The committee did not report this month.		
Facilities Committee	The committee did not report this month.		
Personnel Committee	The minutes from the June 14 committee meeting were distributed. Sick leave time for per diem employees was discussed at the meeting. Mass state law requires that employees who work less than 20 hours per week and per diem employees receive sick leave time benefits at a rate of 1 hour for every 30 hours worked. To accommodate this new law, the policy needed to be changed and the employee handbook updated. **A motion was made by Nancy Brenner to accept the changes made by the committee regarding the new sick leave time benefits law. It was seconded by Wendy Lane Wright and approved unanimously.**	Sick leave time benefits changes approved.	
Quality Improvement	Cheryl reported for the committee.		

Committee	The minutes from the June 24 meeting were distributed for review. The dental department presented their quarterly report and addressed the concern of technology being down and patient care during those times. All issues related to this in the quarter were resolved and it's hoped that a grant being applied for will assist in working out the technology issues. Two patient complaints were addressed in the department. The medical department reported a case involving a patient's death. The covering provider process is being formalized as a result of this case. It was discussed that the Board would like follow up on the formalized process for covering providers. As a result of the recent HRSA visit, the Executive Director will now be attending QI meetings and all data and reports from all areas discussed at QI will be presented to the Board.		
Expansion Committee	The committee did not report this month.		
Strategic Planning Committee	Minutes from the June 21 meeting were reviewed. Nancy reported the committee's self-assessment is completed. A mission and vision are being worked on. The Board and all staff have been involved in the process for updating the mission and creating a vision and list of values. The suggested goal to have the strategic plan completed is the end of the year.		
Fundraising/Development Committee	This is not an official committee at this time. Fundraising is occurring and can continue without a formal committee. Eliza suggested that when the Amherst Capital Campaign is completed, she could ask Ellen		

	Leuchs to assist us in deciding if this committee is needed.		
Bylaws Ad-Hoc Committee	Kathryn, Lew and John formed an ad-hoc committee to work on updating the bylaws as recommended by the HRSA consultants. Updates needed include: adding the mission statement; authorities, function and responsibilities of the Board; Executive Committee authority while acting on behalf of the full Board; and Board dissolution clause. At the August meeting, an updated version of the bylaws will be distributed. A review and vote will take place at the September meeting. John also revisited the idea of term limits for officers. He believes term limits give everyone an opportunity to hold an officer position and to learn the inner workings of the Board. Limits also help deter complacency and burn out. At the present time, officers are elected for 1 year terms, but there is no limit to the number of terms that can be served. It was asked what the limit of terms would be? Three or six years was a recommendation with the option of re-election after a one year break. It was suggested to also stagger the terms of officers. It was asked if practice culture wording is needed and should be added to the bylaws? John felt this could be added to next month's agenda for discussion. It was asked if the bylaws should be reviewed by an attorney? John feels he has a good handle on the improvements needed and a review by counsel will not be necessary.		
Committee Reports	After all the committee reports had	Committee reports	

	been reviewed and discussed**, Wendy Long made a motion to accept all committee reports presented at the July 28 meeting. The motion was seconded by Nancy Brenner and without further discussion was approved.**	presented at this meeting were approved.	
Old Business	None		
New Business			
Policy Reviews	The policies reviewed and voted upon at this meeting include: Supervision of nurse practitioner agreement policy; Wendy Long **made a motion to approve the Supervision of nurse practitioner agreement policy. Without further discussion, the motion was seconded by Tim Walter and approved.** Credit and Collection policy; **Wendy Long made a motion to approve the Credit and Collection policy. The motion was seconded by Tim Walter.** Discussion occurred regarding this policy. Not all staff using the EMR have access to a patient's billing file. A staff member would need authorization in the system to be able to access these files. It was asked if a patient could be turned away if they have an outstanding bill? If the patient has Medicaid or Health Safety Net, they cannot be turned away. We don't currently turn away anyone, regardless of what insurance they have. Frank wants to review how many patients we do treat who have outstanding bills. **With no further questions, the motion was approved.** 340B Pharmacy Program policy; **Wendy Long made a motion to approve the 340B Pharmacy**	Policies approved: • Supervision of nurse practitioner agreement policy • Credit and Collection policy • 340B Pharmacy Program policy • Recruitment and Retention Plan	

	Program policy. The motion was seconded by Tim Walter. Discussion occurred by asking if the program will be available for patients in Amherst? There is currently not a Walgreens in the Amherst area or East of the Connecticut River. Could we start our own pharmacy? Frank responded that we're not ready to do that yet. **With no further questions, the motion was approved.** Recruitment and Retention Plan; **Wendy Long made a motion to approve the Recruitment and Retention Plan. The motion was seconded by Tim Walter. Without further discussion, the motion was seconded and approved.**		
Credentialing Committee	The credentialing checklist for the following new employee was brought to this meeting as being recommended for full privileges by the credentialing committee: Jillian McBride, LCSW. After a brief discussion of the candidates, **a motion was made by Nancy Brenner and seconded by Cheryl Hopson to approve full privileges for Jillian McBride. With no further discussion, full 2-year privileges were granted.** The re-credentialing checklists for the following current employees were brought to this meeting as being recommended for renewal of full privileges by the credentialing committee: Cortney Haynes, MD; Deb Lesko, Hygienist; Tim Gearin, DMD; Spretha Kadavath, DDS; Colleen Carpenter, MA; Stefanie Sudyka, MA. After a brief discussion of the candidates, **a motion was**	Credentials were reviewed for Jillian McBride. Re-credentialing was reviewed for Cortney Haynes, MD; Deb Lesko, Hygienist; Tim Gearin, DMD; Spretha Kadavath, DDS; Colleen Carpenter, MA; Stefanie Sudyka, MA.	Bridget Rida to notify all employees listed of the granted privileges.

	made by Tim Walter and seconded by Alan Gaitenby to renew full privileges for those listed above. With no further discussion, full 2-year privileges were re-approved.		
Meeting Time	It was decided to change the meeting time for this meeting to 5:30pm beginning in August. The finance committee will meet at 4:30pm beginning in August.		
Adjourn	The meeting adjourned at 8:05pm. The next meeting is scheduled for Thursday, August 25, 2016 at **5:30pm** at the Huntington Health Center. **Please note the change in start time for this meeting.**		

QI COMMITTEE
Location: Huntington Health Center
Date/Time: 07/29/2016 8:15am

TEAM MEMBERS: Cheryl Hopson, BOD; Kathryn Jensen, BOD; Kim Savery, Community Program Representative; Serena Torrey, Behavioral Health Representative; Mary Lou Stuart, Dental Representative; Eliza Lake, Executive Director; Janet Laroche, Admin & Lean Team Leader
ABSENT: Jon Liebman, ANP; Sheri Cheung, Medicine Representative; Jeff Hagen, COO; Michael Purdy, CCCSO; Cynthia Magrath, Practice Manager

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Review of June Minutes	The minutes from the June 24, 2016 meeting were reviewed. With no discussion needed, MaryLou Stuart made a motion to approve the minutes as written. Serena Torrey seconded the motion. The June 24, 2016 minutes were approved unanimously.	The June 24, 2016 minutes were approved.	
Old Business			
Department Reports	There was no quarterly report from Medical this month due to the absence of Sheri and Jon at this meeting. MaryLou reported for Dental that there are 2 new dentists starting soon. Serena reported for Behavioral Health that 1 new clinician has started and another will begin in August, bringing the department to full staff. The question of orientation for new employees was brought up. Orientation includes meeting staff throughout the organization, a tour, an intro email from HR to all staff, intro at semi-annual all-staff meetings.		
Call Center Planning Committee	There was no report at this meeting due to Cynthia's absence.		Cynthia will continue to report on this

PHO Group Participation	Eliza reported that there is a meeting set up to meet with the PHO on August 17. There's a long list of items to be discussed, some of which came from the HRSA consultants during the site visit. They expressed concerns with the PHO contract.	Meeting with PHO scheduled Aug 17.	Eliza will report on this at Aug meeting
1422 Grant	Kim reported that a Plan, Do, Study, Act (PDSA) was begun with Lora Grimes' team. The goal was to identify patients with undiagnosed Hypertension. If identified, the patient would be added to a list and followed up with. Six patients were identified, but this PDSA did not go as planned. More discussion was needed and roles of team members need to be better defined. Once ready, another PDSA will be conducted. Two Community Health Workers (CHWs) are to be hired and trained in diabetes prevention. They will work in conjunction with the Holyoke and Hampshire YMCAs for their year-long programs for diabetics. The CHWs will assist with the pre-screening process for candidates to be selected for this program. It's a big commitment for people who are accepted into the program, but they receive a 1 year membership to the Y and hands on help with their diabetes diagnosis. Serena shared that the behavioral health department will soon begin a 4-session intervention process for HTN and Diabetic patients. An insomnia session has already been tried with success. It was reported that the pharmacist consultant is working with small groups of diabetic patients. Marylou shared that many dental insurances will pay for 4 cleanings a year instead of 2 for diabetic patients.		

Lean Team Project	The Lean Team has been meeting monthly. Their Charter has been finalized and requires a signature from this committee (see attached). The team has identified 4 of the most common problems related to this project. Each problem will take time to work on and to find a solution, so the team will begin to meet every 2 weeks beginning in September.		Janet will continue to report on this
Reporting Measures Spreadsheet	There was no report at this meeting due to Sheri's absence.		Sheri will continue to report on this going forward
Patient Satisfaction Survey	The spring survey results were tabulated, but Janet identified that the number of surveys being turned in is not consistent for each department. The process of handing out surveys was reviewed and a discussion was held on how to capture more data, along with target numbers and time frames for collecting data. It was decided to try a new process this fall by creating instructions for handing out the survey and reviewing with each department ahead of time. Surveys will be handed out to every patient/client on a certain day until they have all been handed out. They will be coded so it's known which department the patient was rating. Eliza told the committee about a survey that's conducted by MHQP and is sent to our patients via mail. The results are then sent to Cooley Dickinson Hospital who shares them with us. The patients surveyed are those in the AQC with the PHO. This includes patients with Blue Cross Blue Shield insurance and Health New England insurance. The latest results from Feb. 2016 showed 90% of	Janet will create instructions for handing out the survey and it will be used this fall.	

	patients were reasonably happy and 10% were not.		
New Business			
HRSA Report	During our HRSA site visit in June, the consultants stated that the minutes from this committee need to include the reports, data, dashboards, etc. that are submitted at this meeting and are to be shared at the Board meetings. The Board should be seeing quality measures on a regular basis. A tracking system needs to be set up. Jon Liebman has started a spreadsheet of the measures that should be tracked. Eliza brought a printout to this meeting (see attached) of the performance measures set by HRSA. There are 3 health outcomes and 12 quality of care measures. She offered to create a dashboard template that all departments and committees could use for future tracking.	Eliza to create a dashboard template	Eliza will report on this next month
Adjourn	The meeting adjourned at 9:40am. The next meeting is scheduled for August 26, 2016 at the Huntington Health Center.		

Submitted by Janet Laroche, Executive Assistant

Charter updated: 07/26/2016

Project Charter for: HCHC – Improve the workflow of internal communications within the medical department

Problem Statement: Telephone encounters are not clear and concise which causes delays in patient care. The endless chain of encounters needs to be streamlined.

Aim Statement: Improve workflow of telephone encounters in HCHC's medical department by identifying and addressing the most common issues of why some telephone encounters are delaying patient care and to create a chain of command for communication.

Measures of Success: We will identify the 3 most common issues in processing telephone encounters and develop standardized practices to address these issues.

Scope: All departments using eCW

Boundaries:

- FTE neutral

Start Date: 03/04/2016
Planned End Date:

Sponsor(s): QI Committee

Facilitator(s) / Practitioner(s):

- Patti Igel, Medical Reception Spvsr
- Lee-Anne Cronin, Receptionist
- Andrea Reed, Nurse
- Janet Dimock, Community Health Worker

Coach(es): Janet Laroche

Team Members:

- All Medical Receptionists
- All Nursing Staff
- All Medical Providers
- All Medical Assistants
- All Community Health Worker
- All Behavioral Health Providers
- All Eye Care Staff
- Referrals Staff

Cheryl M. Hyson 7-29-16
Sponsor Approval & Date

Sponsor Approval & Date

Sponsor Approval & Date

What	Who	When	Status
Problems Identified:			
1. Multiple issues listed in one telephone encounter; too much information in one encounter leads to errors being made			
2. Duplicate telephone encounters get created which leads to errors being made			
3. Currently, all telephone encounters are assigned to nursing, but this should not be the case.			
4. There's innapropriate use of telephone encounters.			

Health Outcomes and Disparities

Performance measures used by the Health Center Program place emphasis on quality of care and health outcomes, and demonstrate the value of care delivered by health centers. These measures align with those of national standard setting organizations, and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations to assess quality performance.

HRSA selected these measures to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles. The majority of health centers with extensive experience working to improve the quality of perinatal, chronic, and preventative care services will be familiar with these measures.

HRSA-funded health centers are evaluated on a set of performance measures emphasizing health outcomes and the value of care delivered. In addition to Health Outcomes and Disparities, additional performance measure categories in Quality of Care and Financial Viability/Costs.

Diabetes

Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was greater than or equal to 9% at the time of the last reading in the measurement year

Numerator: Number of adult patients whose most recent hemoglobin A1c level during the measurement year is >= 9% among those patients included in the denominator

Denominator: Number of adult patients aged 18 to 75 as of December 31 of the measurement year with a diagnosis of Type I or II diabetes AND, who have been seen in the clinic for medical visits at least twice during the reporting year AND, do not meet any of the exclusion criteria OR a statistically valid sample of 70 of these patients

Hypertension

Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading

Numerator: Number of patients in the denominator whose last systolic blood pressure measurement was less than 140 mm Hg and whose diastolic blood pressure was less than 90 mm Hg

Denominator: All patients 18 to 85 years of age as of December 31 of the measurement year with a diagnosis of hypertension (HTN) AND who were first diagnosed by the health center as hypertensive at some point before June 30 of the measurement year AND who have been seen for medical visits at least twice during the reporting year OR a statistically valid sample of 70 of these patients

Birthweight

Related

Health centers annually report their performance in the Uniform Data System (UDS).

View Health Center Program Grantee Data at the national, state, and individual health center level.

View Health Center Program Look-Alike Data at the national and individual health center level.

Uniform Data System (UDS) Resources offer help with submission and reporting, types of data, and reporting requirements.

Uniform Data System (UDS) Program Assistance Letters provide the proposed and approved reporting changes.

Percentage of patients born to health center patients whose birthweight was below normal (less than 2500 grams)

Numerator: Number of children born with a birthweight of under 2500 grams

Denominator: Number of LIVE births during the reporting period for women who received prenatal care from the health center or a referral provider during the reporting period

More Performance Measures

Quality of Care

Financial Viability/Costs

Quick Links

- HRSA.gov
- Open HRSA Funding Opportunities
- BPHC Career Opportunities
- Annual Health Center Data
- Health Center Program Policies

Health Center Locator

Find a Health Center

Near: Enter a location

FIND CENTERS

Enter a City name, ZIP Code, such as "20002", address, State name, or place name

Search **Share** **Embed**

Contact Us

- Subscribe to weekly BPHC updates
- HRSA News & Events
- Key BPHC Staff
- BPHC Helpline or call 1-877-974-BPHC (2742)
  8:30 am to 5:30 pm ET, Monday through Friday (except Federal holidays)

Quality of Care

Performance measures used by the Health Center Program place emphasis on quality of care and health outcomes, and demonstrate the value of care delivered by health centers. These measures align with those of national standard setting organizations, and are commonly used by Medicare, Medicaid, and health insurance/managed care organizations to assess quality performance.

HRSA selected these measures to provide a balanced and comprehensive representation of health center services, clinically prevalent conditions among underserved communities, and the population across life cycles. The majority of health centers with extensive experience working to improve the quality of perinatal, chronic, and preventative care services will be familiar with these measures.

HRSA-funded health centers are evaluated on a set of performance measures emphasizing health outcomes and the value of care delivered. In addition to Quality of Care, additional performance measure categories in Health Outcomes and Disparities and Financial Viability/Costs.

Access to Prenatal Care

Percentage of prenatal care patients who entered treatment during their first trimester

Numerator: Number of women entering prenatal care at the health center or with the referral provider during their first trimester

Denominator (Universe): Total number of women seen for prenatal care during the year

Childhood Immunization

Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their 3rd birthday.

Numerator: Number of children among those included in the denominator who were fully immunized before their 3rd birthday. A child is fully immunized if s/he has been vaccinated or there is documented evidence of contraindication for the vaccine or a history of illness for ALL of the following: 4 DTP/DTaP, 3 IPV, 1 MMR, 3 Hib, 3 HepB, 1VZV (Varicella), and 4 Pneumoccocal conjugate, prior to their third birthday

Denominator: Number of all children with at least one medical visit during the reporting period, who had their 3rd birthday during the reporting period or a sample of 70 of these children

Cervical Cancer Screening

Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer

Numerator: Number of female patients 24 - 64 years of age receiving one or more documented Pap tests during the measurement year or during the two years prior to the measurement year among those women included in the denominator; OR, for women

Related

Health centers annually report their performance in the Uniform Data System (UDS).

View Health Center Program Grantee Data at the national, state, and individual health center level.

View Health Center Program Look-Alike Data at the national and individual health center level.

Uniform Data System (UDS) Resources offer help with submission and reporting, types of data, and reporting requirements.

Uniform Data System (UDS) Program Assistance Letters provide the proposed and approved reporting changes.

who were 30 years of age or older at the time of the test who choose to also have an HPV test performed simultaneously, during the measurement year or during the four years prior to the measurement year

Denominator: Number of all female patients age 24 - 64 years of age during the measurement year who had at least one medical visit during the reporting year, or a sample of these women

Adolescent Weight Screening and Follow Up

Percentage of patients aged 3 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year

Numerator: Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year

Denominator: Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting year, and were seen by the health center for the first time prior to their 17th birthday OR a sample of these patients

Adult Weight Screening and Follow Up

Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented

Numerator: Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit OR within six months of the most recent visit AND if the most recent BMI is outside parameters, a follow-up plan is documented

Denominator: Number of patients who were 18 years of age or older during the measurement year, who had at least one medical visit during the reporting year, OR a sample of these patients

Tobacco Use Screening and Cessation

Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user

Numerator: Number of patients age 18 years and older who were screened for tobacco use one or more times in the measurement year or prior year and received tobacco cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user

Denominator: Number of patients age 18 years and older that had at least one medical visit during the measurement year and have been seen for at least two medical visits ever

Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)

Percentage of patients aged 18 years and older with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy

Numerator: Number of patients in the denominator who received a prescription for or were provided or were taking lipid lowering medications

Denominator: Number of patients who were seen during the measurement year after their 18th birthday, who had at least one medical visit during the reporting year, with at least two medical visits ever, and who had an active diagnosis of coronary artery disease

(CAD) including any diagnosis for myocardial infarction (MI) or who had had cardiac surgery in the past – OR a sample of these patients

Ischemic Vascular Disease (IVD) and Aspirin or Other Anti-Thrombotic Therapy

Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic

Numerator: Number of patients in the denominator who had documentation of aspirin or another anti-thrombotic medication being prescribed, dispensed or used

Denominator: Number of patients who were aged 18 and older at some point during the measurement year, who had at least one medical visit during the reporting year, who had an active diagnosis of ischemic vascular disease (IVD) during the current or prior year OR had been discharged after AMI or CABG or PTCA in the prior year—OR a sample of these patients

Colorectal Cancer Screening

Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer

Numerator: Number of patients aged 51 through 74 with appropriate screening for colorectal cancer

Denominator: Number of patients who were aged 51 through 74 at some point during the measurement year, who had at least one medical visit during the reporting year

Depression Screening and Follow Up

Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented

Numerator: Number of patients age 12 years and older who were (1) screened for depression with a standardized tool during the measurement year and, if positive, (2) had a follow-up plan documented

Denominator: Number of patients age 12 years and older who had at least one medical visit during the measurement year

This performance measure requires health centers to report the number of patients age 12 and older screened for depression and receiving a follow-up plan (if diagnosed).

- Program Assistance Letter 2014-01: Approved Uniform Data System Changes for Calendar Year 2014
- Screening Tools for Depression
- Screening Tools for Behavioral Health Disorders by Age Group

HRSA provides additional resources to help you integrate behavioral health into your primary care setting.

HIV Linkage to Care

Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis

Numerator: Number of patients in the denominator who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis

Denominator: Number of patients first diagnosed with HIV between October 1 of the prior year through September 30 of the current measurement year

HRSA provides additional resources to help you integrate HIV services into primary care .

Oral Health

Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period

Numerator: Subset of children in the denominator who received a sealant on a permanent first molar tooth in the measurement year

Denominator: Number of health center patients, age 6–9 years old, who had an oral assessment or comprehensive or periodic oral evaluation visit and are at moderate to high risk for caries in the measurement year

More Performance Measures

Health Outcomes and Disparities

Financial Viability/Costs

Quick Links

- HRSA.gov
- Open HRSA Funding Opportunities
- BPHC Career Opportunities
- Annual Health Center Data
- Health Center Program Policies

Health Center Locator

Find a Health Center

Near: Enter a location

FIND CENTERS

Enter a City name, ZIP Code, such as "20002", address, State name, or place name

Search Share Embed

Contact Us

- Subscribe to weekly BPHC updates
- HRSA News & Events
- Key BPHC Staff
- BPHC Helpline or call 1-877-974-BPHC (2742)
  8:30 am to 5:30 pm ET, Monday through Friday (except Federal holidays)

HCHC STRATEGIC PLANNING MEETING

Location: Worthington Health Center, Worthington, MA
Date/Time: 07/26/2016 5:30pm

COMMITTEE MEMBERS PRESENT: Wendy Lane Wright, BOD Clerk; Nancy Brenner, BOD Vice President; Eliza Lake, HCHC Executive Director; Frank Mertes, HCHC CFO; Alan Gaitenby, BOD Member; ***John Follet, BOD President***
ABSENT: None.

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Meeting Open at 5.30			
Eliza Lake passed out copy of ***BOD and staff results/responses*** (un-synthesized) to "strategic planning self-assessment" as jumping point into "Vision, Mission, Values" portion of strat. Planning (refer to worksheet); Eliza Lake passed out copy of existing Mission Statement	Nancy Brenner begins on the journey by helping us to concentrate our efforts on vision statements. Sequential processing of staff and BOD's responses to look for language. Terms such as "access for all (i.e. no barriers)," "empowerment." Frank Mertes raises concerns w/ use of "empowerment" as it implies a power imbalance. Eliza Lake suggest "engagement" is better, e.g. "communities engaged for health," or "an engaged community for health."	To be continued in context of mission statement and beyond.	Nothing specific – or as they develop.
Mission Statement	Discussion of the role of a mission statement as it relates to the vision. Instead of listing all services, Frank Mertes proposes "integrated health" as a good replacement, e.g., "Creating access to high quality integrated health care in our communities." Wendy Lane Wright suggests perhaps growing the mission statement w/ another sentence. Eliza suggests we could grow it through the "access" component, but there seemed to be	We proposed to continue cogitating on mission statement	None – or rather - continued

	some attachment to the shorter original. John Follet raises the issue that "health care" maybe is too specific and might be read so as to exclude behavioral and community services. More discussion of mission statement as a broader statement of what we do. Eliza reads us several versions from HCHC analogs in Ma. and elsewhere (which were longer than our version). "Health care" seems to be the term we are fixated on, it doesn't tell the whole story – or enough of it. "Healthy Communities" is a term of art that we might use, or "health". New version possibly, "Creating healthy communities through access to integrated [high quality] health care," "Promoting and creating access to health and well-being for individuals, families, and our communities."		
Onto Values	Eliza suggests we define our terms by again looking to analogs, brainstorm, iteration, and synthesis into a statement. Values should be a concatenated list. John suggests that we are moving to a more "empathic model" moving beyond the old doctor / patient services (and power relationship) for hire. "*Empathy/Respect*" comes up a lot. "Curiosity" comes up a lot too – but perhaps is too invasive. "*Collaboration/teamwork/Integration*" too. "*Innovation*" and "*efficiency*" and "*curiosity"* too. "Creativity" too. "*e*" too – John says "cooperative" also is used here. For staff / operations – as well as patients, "dignity," "respect, "empathy". Some more, "transparency," "*open communication and accountability*."	We are going to write a sentence for each of our italicized values for next.	
Adjourn and schedule	8/16 WHC @ 5.30		

next meeting			

Executive Director Report: August 24, 2016

As is always the case, the summer has flown by. From a financial perspective, this is a good thing – patient volume is always lower in the summer, and we look forward to the fuller schedules of Fall. We are happy that we will be fully staffed with providers for the fall, despite some turnover in the medical department, particularly. Once things have settled down in October and November, we anticipate that we will be able to turn our attention more fully to the needs of our new site in Amherst, which should be opening in Summer 2017.

This fall will be a time of transition. A number of providers will be leaving or coming, and we are working hard to ensure continuity of care whenever possible, and ensure access for patients. We will also be working to make sure that the departure of Jeff Hagen, the Chief Operating Officer, is not any more disruptive than it has to be. Last week Frank Mertes, our CFO, and Michael Purdy, our Chief Clinical and Community Services Officer and I developed a short term plan that divided Jeff's four immediate reports between the two of them: Daniel Worpek (IT), Russ Jordan (Facilities), and Briana Blanchard (EHR Specialist) will report to Frank. Cynthia Magrath, the Practice Manager, will report to Michael. I have informed all of the staff of these changes, and also told them that, for those areas that Jeff provided direct support to the organization, we are developing a plan that could include reassignment of responsibilities, new training, and/or new hire(s).

We are going to use this time as an opportunity to reassess the management structure that we put into place three years ago, and there will likely be some more changes. We are gaining a better understanding of the gaps in our current capabilities, and some places where there are inefficiencies. Just before Frank left on vacation we developed a list of the needs that we either have now or anticipate in the next year, and when he returns we will begin to develop a plan to address these. These could include the areas of IT, data collection and analysis, HR, office management (particularly once we open Amherst), finance reporting, clerical support for the clinical departments, etc. As we develop this plan, I will certainly share it with you. For the moment, however, you should know that we are not planning on replacing Jeff in the short-term.

As I will talk about below, we have a little more information about how we will meet the conditions laid out in the OSV report from HRSA. One of the confusing ones for me is the requirement that the Board oversee the "measurement and evaluation of the organization's progress in meeting its annual and long-term programmatic goals." I have not received clear guidance about how this differs from the next paragraph in the report, which states"… The HCHC Board of Directors must receive financial and clinical performance indicators in order to measure and evaluate the organization's progress in meeting its annual and long-term programmatic and financial goals." This requirement we are addressing through the provision of dashboards for both financial and clinical indicators (which are specifically outlined by HRSA). The financial dashboard you will see every month, and have already seen last month. The clinical dashboard is in development, and will be discussed at the QI meeting Friday morning, but will likely be presented quarterly. The template, however, which is focused on the medical measures, will likely be used by all departments for their QI reports.

After our call with the Project Officer, Frank and I discussed the possibility that my monthly reports will include a structured section that addresses any other annual and long-term programmatic goals, and I would be interested in any Board input into what would be most helpful. Looking back at the last few reports, I think that I have consistently reported on expansion activities, health care financing system changes, and interactions with HRSA, which govern a wide range of goals. When we have the new Strategic Plan, I can certainly take my cue from that, as well. In any case, I am going to stick with this format for the moment, but as it is the Board's responsibility to ensure that you're getting the information you need, I want to make sure to get your input.

HRSA: Last week, Frank and I had our first conversation with our new BPHC Project Officer, Betty Davis. We went over the seven conditions and clarified how we can meet them in a timely manner, and how we will document our efforts to HRSA. With the exception perhaps of the requirement that we have contracts for Required and Additional Services that meet our Sliding Scale Discount Program, we anticipate having all the conditions met by the 90 day deadline, which is October 19th. If we do not meet the condition, we will then have 60 days to meet it, and we do not anticipate having any difficulty doing so.

Last week we also received word that we received $45,000 from HRSA, which is a one-time grant to recognize and provide support for health centers with one or more sites with new and/or continued patient centered medical home recognition. We will be using this to support our on-going quality improvement activities. These activities will include addressing the need for HCHC to reapply for NCQA recognition. This process is onerous and is getting more complicated, and we are contemplating hiring an outside consultant to come in and help us address any needed changes in our documentation and workflow processes; we know that some changes will be required. Again, we will keep you informed of our progress on this issue, but it is very clear that NCQA certification itself, not just the attendant practices, is crucial to operating a medical clinic in the current financing environment. This grant is just another reminder of that fact.

Amherst: Things have been very quiet this month. The fundraising continues with a few donations and pledges coming in, but we have a number of big asks scheduled for September. The architect is making good progress – finally! – in ironing out issues with the town re: fire suppression, and I anticipate the plan being finalized very soon. Frank and Marie worked while I was gone on vacation to hire a Owner's Project Manager, and while I have not yet signed the contract, it looks like we will be hiring Peter Graham at MBL Development. His role will be to keep the project moving forward and representing HCHC's interests in getting the construction completed. This will be a huge help both in terms of the time we have available to do this work, and in terms of expertise. On a lighter note, I will bring the board with all the paint and flooring samples to the meeting tomorrow, so you can see what things will look like. We will likely use the same colors for new painting that occurs at our existing sites – luckily they match our existing trim and floors!

MassHealth Restructuring and Value-Based Payment Structures: There has been one big development in the discussion re: ACOs and HCHC. Frank and I had a conversation with the director of Community Care Cooperative (CCC), an ACO that was just created by eight health centers in Massachusetts. This ACO, which was just selected as one of the pilot projects by MassHealth, will be comprised of only FQHCs, and already has members from across the state. Frank and I were very intrigued by the conversation, as the only requirement to be able to join (for a fee) is to be an FQHC that is an on-going interest and that has NCQA certification. I then organized a call with the CCC Director and my colleagues at the other small FQHCs in our discussion group, and we all agreed to have an in-person meeting in September to talk about specifics. This is the most promising development we've seen, and we will certainly update you next month on what we learn and what we think will make sense.

As always, please let me know if you have any questions about anything contained in this report.

Senior Management Reports

Clinical and Community Services:

Dental:

1) With the new dentists, discussed below in the HR report, we are fully staffed until Amherst opens.

Medical:

1) The provider teams are in a period of transition as we prepare for the departure of Cortney Haynes. We have the addition of Miranda Balkin, who is settling in very well, and are expecting Melissa Lodzieski to come back from maternity leave and Beth Coates to take a leave of absence in August/September.
2) The Family Nurse Practioner for the SBHC is preparing to join the team. Current plans have her in the SBHC three days a week and two days a week in Huntington. The alternate times Sela Fermin-Schon will be in the SBHC.

Behavioral Health:

1) The department is currently fully staffed and referrals are again being accepted
2) The department, in collaboration with the medical department, is looking at piloting an initiative on alternative pain management, and Marie Burkart in Development is exploring a possible funding source to support staff time devoted to the effort. Dr. Lora Grimes would be involved, which would be the beginning of her duties as the Director of Integrative Medicine.
3) Sent out a survey to the medical providers regarding their priorities with Behavioral Health, and identified that the top three priorities are
    - BH clinicians available to assist during a psychiatric crisis
    - BH clinicians offering on-going, scheduled, in-house therapy to HCHC patients,
    - Creating targeted interventions for specific diagnoses.

The Behavioral Health department currently offers the first two, and will continue to work to develop more targeted interventions, such as the diabetes pilot intervention which was implemented with a few patients last fall. They have begun to create additional Holistic Response protocols for specific medical issues, including a 4-session intervention to support patients suffering from insomnia, and, in the future, hypertension.

Community Programs:

1) The American Cancer Society has invited HCHC to apply for another round of funding under the NFL Crucial Catch program, which focuses on increasing screening for breast cancer. The first year of our program was extremely successful, and we are very hopeful about future funding.

Operations Report:

Given the recent departure of Jeff Hagen, we do not have a full Operations update, but there were no large events to note in August. Issues that are currently in discussion is the migration of eCW from Cooley Dickinson's servers to either another local host or to the cloud. Frank will be working with staff to determine the best course of action and will shepherd the project. The School-Based internet project, which will bring them into the larger organizational network, is complete. Daniel is working to create a robust back-up system for the network, and will have a full assessment with recommendations completed by a consultant in the fall, to ensure against future system breakdowns.

Finance Report:

Finance Department:

1. Started preparing annual Medicare cost report, due August 31, 2016.
2. Working to clear OSV conditions
3. 990 tax form completed and filed
4. Working with HCHC team to hire an owner representative for Amherst project.

Billing Department:

Completed upgrade of thee administrative module of Dentrix and set up new clearing house for processing Health Safety Net Claims. Currently we are experiencing difficulty in getting the claims properly submitted. We are working with the vendors to resolve the issues. In the meantime we expect a delay in HSN dental payments. Billing has taken on the role of provider credentialing since June 23, 2016 with the departure of Meg Bartos. It has been a difficult transition but all is starting to come together and we have started a cross/training process to eliminate any future disruption.

Human Resources Department:

- Christopher Larsen, RN, left on 8/12/16 to work at the VA.
- Spretha Kadavath, Dentist, will be leaving us at the end of August. She's moving to CT.
- Cortney Haynes, MD, will be leaving us in the beginning of October. She's going to work in Springfield so that she can teach.

- Aaron Tieger, a new BH Clinician, began 8/9/16. He will be stationed mostly in Worthington.
- Mary McClintock, DDS, a new dentist, is tentatively starting 8/29 (depending on licensing and credentialing)
- Andrew Adams, DDS, a new dentist, will start sometime in September (depending on licensing and credentialing)
- Brenda Jaeger, a new NP, will be starting in September. She has been interning here for a few months now, so she's a familiar face at the Huntington site, and will be working primarily at the School-Based Health Center.
- Bridget is attending a workers comp training in October to learn more about how the process works
- Our semi-annual All-Staff In-Service is tentatively scheduled for early November. We will test all-staff for TB, and provide flu shots for anyone who may want it. This also serves as our annual training for Sexual Harassment, HIPAA, and Fire Safety.
- Current position openings:
    - PT Nutritionist
    - FT Receptionist
    - PT Outreach Enrollment Worker (Navigator)
    - FT Community Health Worker (CHW)
    - FT Dental Assistant
    - FT RN/LPN

BYLAWS

of

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

As Amended Effective

September , 2016

TABLE OF CONTENTS

BYLAWS OF

HILLTOWN COMMUNITY HEALTH CENTERS, INC.

As Amended Effective September , 2016

ARTICLE I
Name and Purposes

Section 1.1 Name and Purposes. The name and purposes of this Corporation, Hilltown Community Health Centers, Inc., shall be as set forth in its articles of organization, as may be amended or restated from time to time. The Corporation is organized exclusively for charitable, educational, and scientific purposes within the meaning of Massachusetts General Laws, Chapter 180 and Section 501(c)(3) of the Internal Revenue Code, as amended, and to carry on activities in furtherance of such purposes.

Section 1.2 Mission Statement. Hilltown Community Health Center's mission is to "provide high quality, accessible medical, dental, behavioral health, eye care, and community services to people in Western Massachusetts and surrounding areas. We seek to understand and respond to the needs of our community. We deliver all services in a caring and professional manner within a context of a partnership between persons served and staff. To achieve our mission we promote employee growth and job satisfaction, and we offer continuity of care through our relationships with other organizations."

ARTICLE II
No Members

Section 2.1 No Members. The Corporation shall have no members. Any action or vote required or permitted by Massachusetts General Laws, Chapter 180, as may be amended, to be taken by members shall be taken by action or vote of the same percentage of directors of the Corporation in accordance with Section 3 of said Chapter, as may be amended.

ARTICLE III
Board of Directors

Section 3.1 Number, Term, and Election. The number of directors shall be at least nine and no more than fifteen of which a majority shall be users of the services of the Corporation. The Directors that are users of the Corporation's services shall reasonably represent the individuals who are served by the health center in terms of race, gender, and ethnicity. Of the other Directors, no more than 50 percent shall be persons who derive ten percent or more of their income from the direct providing of health care. The term of a director shall be three years, and directors are eligible for re-election. The Chief Executive Officer shall also serve ex-officio as a non-voting member of the Board. Other individuals who are employees of the Corporation and the members of their immediate family may not serve as directors. The Directors may elect individuals to the Board of Directors at the annual meeting of the directors or at any monthly meeting of the directors. Individuals shall be elected to the Board of Directors so that the terms

of approximately one-third (or as close as practicable) of the directors shall expire each year.

Section 3.2 Powers. The Board of Directors shall have and may exercise all the powers of the Corporation, consistent with relevant law and the Articles of Organization, as may be amended from time to time. Unrestricted authorities, functions, and responsibilities of the Board include:

- Approval of the selection and dismissal of the Chief Executive Officer of the health center;
- Performing an annual performance evaluation of the Chief Executive Officer, which shall be conducted by the Executive Committee and reviewed and approved by the full Board;
- Regularly attend meetings and participate at a committee level;
- Selection of the services to be provided by the center;
- Approval of the hours during which services will be provided;
- Approval of all of the center's HRSA grant applications including the section 330 grant application;
- Approval of the center's annual budget and annual audit;
- Approval of the sliding fee scale, nominal fee, and yearly federal guidelines;
- Establishment of general policies for the center (including personnel, health care, fiscal, and quality assurance/improvement policies);
- Monitoring organizational assets and performance, fiscal and clinical;
- Participation in organizational strategic planning and approval of a strategic plan;
- Conduct self-evaluations annually;
- Ensuring that the health center is operating in accordance with applicable federal, state and local laws and regulations, as well as its own established policies and procedures;
- Measurement and evaluation of the organization's progress in meeting its annual and long-term programmatic goals;
- Oversight of the measurement and monitoring of patient satisfaction.

Section 3.3 Chief Executive Officer. The Board of Directors shall select a Chief Executive Officer and shall determine the terms of his or her employment. The duties and powers of the Chief Executive Officer shall be those generally assigned to the chief executive officer or executive director of a non-profit corporation, and shall include the general charge and supervision of the affairs of the Corporation and the power and responsibility to enforce these bylaws and any rules and regulations made by or under the authority of the Board of Directors or the Executive Committee, to see that all requirements of law and appropriate governmental authorities are duly observed in the conduct of the affairs of the Corporation, and to execute in the name of the Corporation all deeds, leases, contracts, and similar documents. It shall also be the duty of the Chief Executive Officer to plan, organize, maintain and control the operation of the Corporation within the policies established by the Board of Directors. The Chief Executive Officer shall analyze, and report and advise the Board of all material matters on a timely basis, and shall attend and participate in all appropriate committee meetings in order to maintain a high degree of communication and cooperation within the Corporation. The Chief Executive Officer may also be included in executive session meetings, provided the session is not pertaining to the

Chief Executive Officer. The Chief Executive Officer shall normally be the official representative and spokesperson for the Corporation.

Section 3.4 Annual and Regular Meetings. The annual meeting and regular meetings of the Board of Directors shall be held at such places, within or without the Commonwealth of Massachusetts, and at such times as the Board of Directors may by vote from time to time determine. Regular meetings shall be held monthly. No notice shall be required for any annual or regular meeting held at a time and place fixed in advance by vote of the Board of Directors.

Section 3.5 Special Meeting. Special meetings of the Board of Directors may be held at any time and at any place, within or without the Commonwealth of Massachusetts, when called by the Chair or by two or more directors, reasonable notice thereof, stating the purposes of such meeting, being given to each director by the Clerk, or, in case of the death, absence, incapacity or refusal, of the Clerk, by the Chair or by the directors calling the meeting, or at any time without call or formal notice, provided all the directors are present or waive notice thereof by a writing which is filed with the records of the meeting. In any case, it shall be deemed sufficient notice to a director to send notice by mail (paper or electronic) at least three (3) days before the meeting, addressed to the director at his or her usual or last known business or residence address.

Section 3.6 Quorum. At any meeting of the directors, a majority of the directors then in office shall constitute a quorum. When a quorum is present at any meeting, the affirmative vote of a majority of the directors present or represented at such meeting and voting on the matter shall, except where a larger vote is required by law, by the Articles of Organization or by these Bylaws, decide any matter brought before such meeting. If a quorum is not present at any meeting, such a meeting shall only be an informational meeting.

Section 3.7 Consent in Lieu of Meeting. Any action by the directors may be taken without a meeting if a written consent thereto is signed by all the directors and filed with the records of the directors' meetings. Such consent shall be treated as a vote of the directors for all purposes. Board members may not vote by proxy.

Commented [EL1]: I believe this is something that HRSA folks said we should include. The lawyer struck it out, perhaps because it is forbidden anyway(?).

Section 3.8 Presence Through Communication Equipment. Unless otherwise prohibited by law or the Articles of Organization, members of the Board of Directors may participate in a meeting of the Board by means of a conference telephone or similar communication equipment by means of which all persons participating in the meeting can hear and speak to each other at the same time, and participation by such means shall constitute presence in person at a meeting.

Section 3.9 Resignations and Removal. Any director or committee member may resign at any time by delivering his or her resignation in writing to the Chair or Clerk or to a meeting of the Board of Directors. The Directors may, by two-thirds vote at any meeting called for that purpose, remove from office any director or committee member, with or without cause.

ARTICLE IV
Committees

Section 4.1 Committees. There shall be an Executive Committee, a Finance Committee, a Corporate Compliance Committee, a Quality Improvement Committee and such other standing or ad hoc committees of the Board as the Board may determine. Except as otherwise set forth in these Bylaws, the Chair of the Board shall nominate the chair and members of any such committee, who shall be appointed by and shall serve at the pleasure of Board of Directors. Except as otherwise set forth in these Bylaws or as may be determined by the directors, committees shall conduct their affairs in the same manner as is provided in these Bylaws for the directors. Each committee shall keep regular minutes of its meetings and report the same to the Board of Directors.

Section 4.2 Scope of Committees. The Executive Committee shall be chaired by the Chair of the Corporation and shall consist of the Chair, Vice-Chair, Treasurer and Clerk of the Corporation. Unless the directors shall otherwise determine prior to any such action by the Executive Committee, the Executive Committee, between meetings of the Board of Directors, shall be entitled to act all matters as to which the Board of Directors would have been entitled to act and as to which it is permitted under law, these Bylaws, and the Articles of Organization, to delegate to the Executive Committee. If acting on behalf of the Board, motions will be brought back to the full Board for approval at the next Board meeting.

Commented [EL2]: Again, she struck this out.

The Treasurer shall serve as the chair of the Finance Committee. The Finance Committee shall provide advice and recommendations to the Board in all matters pertaining to the fiscal affairs of the Corporation, including the annual budget. The Corporate Compliance Committee shall consist of the same individuals serving on the Executive Committee, and shall provide advice and recommendations to the Board in all matters pertaining to corporate compliance. The Quality Improvement Committee shall assure that quality care is given in all clinical areas through peer review, dashboard metric review, and patient complaint review and ensures that the Corporation is compliant with federal and state data reporting requirements with regard to quality of care.

ARTICLE V
Officers

Section 5.1 Election. The officers of the Corporation shall consist of a Chair, Vice-Chair, Treasurer, Clerk and such other officers as the Board of Directors may determine. All officers shall have one year terms and shall be eligible for reelection. All officers shall be elected by the directors at the annual meeting of the directors, or at any meeting of the directors called for that purpose, and shall serve at the pleasure of the directors. Vacancies in any office shall be filled by the directors.

Section 5.2 Qualification and Powers. Officers shall be directors. So far as is permitted by law, any two or more offices may be filled by the same person. Subject to law, to the Articles of Organization, and to these Bylaws, each officer shall hold office until his or her successor is elected, or until such officer sooner dies, resigns, is removed, or becomes

disqualified. Each officer shall, subject to these Bylaws, have in addition to the duties and powers herein set forth, such duties and powers as are commonly incident to such office, and such duties and powers as the Board of Directors may from time to time designate.

Section 5.3 Chair. The Chair shall preside at all meetings of the Board of Directors and shall be, ex officio, a member of all committees with the right to vote.

Section 5.4 Vice Chair. The Vice Chair shall have and may exercise all the duties and powers of the Chair during the absence of the Chair or in the event of the Chair's incapacity or other inability to act. The Vice Chair shall have such other duties and powers as the directors may determine.

Section 5.5 Treasurer. The Treasurer shall, subject to the direction and under the supervision of the Board of Directors, have general oversight of the financial concerns of the Corporation.

Section 5.6 Clerk. The Clerk shall be responsible for the keeping of a record of all meetings of the Board of Directors. In the absence of the Clerk from any such meeting, the Assistant Clerk, if any, or a Temporary Clerk designated by the directors, shall perform the duties of the Clerk. The Clerk shall also ensure that all minutes of board and committee meetings are stored with the Board of Directors files, after their approval by the Board.

Section 5.7 Resignation and Removal. Any officer may resign at any time by delivering his or her resignation in writing to the Chair or Clerk or to a meeting of the Board of Directors. The Directors may, by two-thirds vote at any meeting called for that purpose, remove from officer any officer with or without cause.

ARTICLE VI
Distribution Upon Dissolution

Section 6.1 Distribution Upon Dissolution. Upon the liquidation or dissolution of the Corporation, after payment of all liabilities of the Corporation or due provision therefore, all of the assets of the Corporation shall be distributed to one or more organizations exempt from federal income tax under the provisions of Section 501(3)(c) of the Internal Revenue Code (or described in any corresponding provision of any successor statute). Such organizations shall be determined by the directors of the Corporation at or before the time of such liquidation or dissolution, and in accordance with Chapter 180 of the General Laws of the Commonwealth of Massachusetts.

ARTICLE VII
Fiscal Year

Section 7.1 Fiscal Year. Except as may be from time to time otherwise determined by the Board of Directors, the fiscal year of the corporation shall end on the last day of December.

ARTICLE VIII
Indemnification

Section 8.1 Officers and Directors. The Corporation shall, to the extent legally permissible, indemnify its officers and directors, and their respective heirs, executors, administrators or other representatives from any costs, expenses, attorneys' fees, amounts reasonably paid in settlement, fines, penalties, liabilities and judgments incurred while in office or thereafter by reason of any such officer or director being or having been an officer or director of the Corporation or by reason of such officer or director's serving or having served at the request of the Corporation as committee member, officer, director, trustee, employee, or other agent of another organization, or in any capacity with respect to any employee benefit plan, unless, with respect to the matter as to which indemnification is sought, the officer or director shall have been or is adjudicated in any proceeding not to have acted in good faith in the reasonable belief that his or her action was in the best interests of the Corporation, or, to the extent that such matter relates to service with respect to an employee benefit plan, in the best interests of the participants or beneficiaries of such employee benefit plan. Such indemnification may include payment by the Corporation of expenses incurred in defending a civil or criminal action or proceeding in advance of the final disposition of such action or proceeding upon receipt of an undertaking by the person to be indemnified to repay such payment if he or she shall be not entitled to indemnification under this paragraph.

Section 8.2 Employees and Agents. The Corporation, to the extent legally permissible, may indemnify its employees and other agents, including but not limited to its volunteers and persons acting as members of committees of the Corporation, from any costs, expenses, attorneys' fees, amounts reasonably paid in settlement, fines, penalties, liabilities and judgments incurred while in office or thereafter by reason of any such person's being or having been an employee or agent of the Corporation or by reason of such person's serving or having served at the request of the Corporation as committee member, officer, director, trustee, employee, or other agent of another organization, or in any capacity with respect to any employee benefit plan, unless, with respect to the matter as to which indemnification is sought, the employee or agent shall have been or is adjudicated in any proceeding not to have acted in good faith in the reasonable belief that his or her action was in the best interests of the Corporation, or, to the extent that such matter relates to service with respect to an employee benefit plan, in the best interests of the participants or beneficiaries of such employee benefit plan. Such indemnification may include a payment by the Corporation of expenses incurred in defending a civil or criminal action or proceeding in advance of the final disposition of such action or proceeding upon receipt of an undertaking by the person to be indemnified to repay such payment if he or she shall be not entitled to indemnification under this section. In determining whether to provide indemnification under this paragraph, the Corporation may consider, among other factors, whether and to what extent insurance is or was available to the person seeking indemnification and whether and to what extent insurance is available to the Corporation for such indemnification.

ARTICLE IX
Conflicts

Section 9.1 Conflicts. Each director has the responsibility to disclose fully to the Board

of Directors, at such time and in such a manner as may be appropriate and consistent with policies of the Corporation, either by voice at the meeting at which the measure concerned is to be considered or in writing to the Clerk prior to such meeting, the existence of any dual interest of such director in transactions or other matters involving the Corporation in which such director may have, directly or indirectly, a separate personal interest of any nature, and such further information as may be materially relevant for consideration by the Board of Directors concerning any such matter or transaction, and to refrain, except for such disclosure and as otherwise may be appropriate, from participating in such consideration and the decision of the Board of Directors with respect to such matter or transaction, in order that the Board of Directors may at all times continue to act in the best interests of the Corporation.

ARTICLE X
Amendments

Section 10.1 Amendments. The directors may, by vote of a majority of such directors then in office, at any duly called regular or special meeting, amend or repeal these Bylaws in whole or in part provided that: (1) the general substance of the proposed amendment to the Bylaws was discussed at the immediately prior duly called regular or special meeting of the Board of Directors, as reflected in the minutes of such meeting approved by the Board, and (2) notice of the proposed amendment to the Bylaws, including a copy of the general substance of such proposed amendment, is included in the notice provided to directors of the meeting at which such amendment vote is to take place.

ARTICLE XI
Anti-Discrimination

Section 11.1 Anti-Discrimination. In all matters of its operation including, without limitation, treatment of patients, selecting and dealing with employees and contractors and selecting members, directors and officers, the Corporation shall not discriminate against any person or the basis of race, religion, gender, sexual orientation, age or national origin. The Corporation shall also, consistent with law, encourage the utilization of minority contractors wherever possible.

I hereby certify that these By-laws of Hilltown Community Health Centers, Inc. are a complete and accurate copy of the original documents as adopted on September , 2016.

_____ _____

Signature of Clerk Date

_____

Printed Name

Approved by the Board of Directors at a meeting held on July 31, 2007.
Re-approved by the Board of Directors at a meeting held on August 27, 2012.
Approved with changes by the Board of Directors at a meeting held on November 26,

2012.
Approved with changes by the Board of Directors at a meeting held on May 26, 2016.
Approved with changes by the Board of Directors at a meeting held on September , 2016.

Hilltown Community Health Center

58 Old North Road
Worthington, MA 01098
413-238-5511
www.hchcweb.org

Vision, Mission, and Values
DRAFT

Vision
What future do we want for our world/community?

Communities Engaged for Health

Mission
What do we do?

Creating access to high quality integrated health care and promoting wellbeing for individuals, families and our communities.

Values
How do we do it?

We listen, consider and care. We respect the individual strengths and diverse experiences of the people we serve and all of our employees.

We commit to working together. We provide integrated care through teamwork and collaboration.

We hold ourselves accountable. We work to the best of our abilities and commit to open communication (and transparency?).

We encourage curiosity and growth. We strive to continually improve through innovation and the use of best practices.

We insure sustainability through efficient practices and management.

Hilltown Community Health Centers, Inc.

Operational

SUBJECT: SMOKE AND TOBACCO FREE WORK PLACE
REGULATORY REFERENCE: None

Purpose:

To ensure that Hilltown Community Health Center maintains a safe and healthy environment for all employees and patients, the company prohibits the use of tobacco, or electronic cigarettes on the company premises.

Policy:

It is the Company's policy to maintain a tobacco and smoke free environment. Tobacco products and the use of electronic cigarettes are not permitted on the HCHC premises, and are expressly prohibited inside any buildings.

Questions regarding this policy or any related procedure should be directed to the Chief Clinical and Community Services Officer at 413-667-3009.

Originally Drafted: AUG 2016 Reviewed or Revised: AUG 2016

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Executive Director, HCHC

_____
John Follet, MD
President, HCHC Board of Directors

Procedure:

1. Signage expressing the content of this policy will be posted at all entrances in a location that is conspicuous to all.

2. Failure on the part of an employee to comply with the policy may result in disciplinary action.

3. Failure on the part of a patient to comply with the policy may result in termination of appointment and personnel should follow the Disruptive Patient policy.