Hilltown Community Health Center

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

BOARD MEETING
MAY 25, 2017
WORTHINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the April 27, 2017 Meeting Minutes

3. Finance Committee Report

4. Chief Executive Officer / Senior Manager Reports

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

6. Old Business

7. New Business
   - Policy Review:
     1. QI Policy – Annual Review
     2. Credentialing & Privileging Policy Annex – Annual Review
     3. Medical Policies – Annual Review
     4. Lab Results Tracking Policy (NCQA)
     5. Coordinating Care Transitions Policy (NCQA)

   - Employee Credentialing:
     1. Nicole Makris, FNP

8. Adjourn

HCHC BOARD OF DIRECTORS MEETING

Location: Worthington Health Center, Huntington, MA
Date/Time: 04/27/2017 5:30pm

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

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Approval of Minutes 03/23/2017	Nancy Brenner called the meeting to order at 5:35pm. The March 23, 2017 minutes were reviewed by the Board members present. **A motion was made by Tim Walter to approve the March 23, 2017. The motion was seconded by Kathryn Jensen. The motion to approve the March 23 minutes was approved unanimously.**	The March 23, 2017 minutes were approved	
Guest: Carol Liebenger-Healy, & Allison Bedard, Adelson & Company, PC	Frank introduced Carol and Allison to the Board and draft financial statements were handed out. There were no changes in the report layout from last year. Adelson & Company is issuing a clean opinion. It was reported that no suspicious activity was found, and overall, assets look good. 2016 ended with good working capital; net assets increased; operating activities had a small deficit; pharmacy income had a decrease; operating expenses increased; fundraising dropped slightly; personnel expenses are 79% of budget; there was less spent on advertising; less was spent on contracts and consulting; lease costs increased; supply costs were down; repairs and maintenance increased; No non-compliance issues were found.		

	It was noted that the concentration of risk note on page 10 of the report states that revenues from the insurances and HRSA should be disclosed. It was stated that we draw down on the HRSA grant for Amherst only after invoices have been received. It was asked if allowances from uncollectible accounts has increased? Yes, it has. Construction in progress was added to the report and the standard disclosure. No debt is expected for the Amherst project. This audit report is important. It's given to many organizations and grants throughout the year. The UFR is due by 5/15. Frank will submit. A vote was needed giving the Finance Committee authority to accept the final audit report and 990. **A motion was made by Lee Manchester to give the Finance Committee the authority to review and sign the final audit report and 990 for the full Board. Wendy Long seconded. With no further discussion, the motion was approved unanimously.** Following the audit report, it was discussed that Frank includes Investments in the operating budget, leading to a $104,000 loss according to Frank's numbers. This is a difference from the managerial and auditing statements reviewed at this meeting. Frank also informed the Board that on Page 19 of the report there are 3	Finance Committee given authority to review and sign the final audit report and 990 for full Board.	

	indirect cost rates which we never have done, but he wants to look into for the future. This would allow all grants to be considered for indirect rates and 10% of grants would be considered indirect costs. Frank has done indirect rates in the past. We would have to reapply yearly.		
Finance Committee	Tim Walter reported on the Finance Committee stating that the first quarter of 2017 was not great, but was better than first quarter of 2016. There were several closures due to snow; $50,000 was spent on joining the ACO; low productivity from the medical and dental departments contributed. Expenses were what we expected. It was asked if payments were budgeted correctly? Frank stated that reimbursements are off in some depts. There will be a department head meeting called to discuss the issues. It was also asked how are processes working? Workflows? Scheduling? It was stated that a new accountant has been hired full time to help free up Frank in order for him to have time to look into things in more detail. The Board should be aware that a $1.4 million contract has been signed for the Amherst contractor. Eliza asked the Board to vote to approve Eliza signing the contract. **Tim Walter moved to accept Eliza signing the $1.4 million contract for Wright Builders to work on the Amherst project. Wendy Long seconded the motion. Due diligence was done on the three bids that were received. With no further discussion needed, the motion was approved.** Frank asked the Board what	Eliza approved to sign $1.4 million contract for Wright Builders to work on the Amherst project.	

	documents they would like to see for review at each meeting. The response was the dashboard, the narrative and the financial statement prior to each meeting. With no further questions about the finance report, **a motion was made by Lee Manchester to accept the report. It was seconded by Kathryn Jensen. With no further discussion needed, the finance committee report was approved.**	Finance committee report was approved.	
CEO Report	Eliza's report was given to the Board for review. She reported that she is still in discussion with HRSA about last year's site visit. A new project officer has been in touch. She would like to know what we're doing about the question of CDH and Servicenet. It was understood that we need one, but the project officer wants an additional agreement. The Mass League has been contacted. Do we dissolve our referral relationship with CDH and Servicenet? It doesn't make sense to us. The project officer also wants us to pull 5 files for credentialing purposes that she will review. There's an employment issue that the Board should be aware of concerning the termination of an employee. It concerns a document in the employee's file written by the former executive director to be an agreement with the employee. It's believed that the statute of limitations has expired for this situation. If the employee has a legal standing, the health center could be sued. The employee is looking for monetary compensation from the health center.		

	Things with the ACO are moving along nicely. The Amherst site groundbreaking is scheduled for April 28 at 9am. Frank and Eliza were recently in Washington, DC for the annual National Association of Community Health Centers (NACHC) conference. It was learned that our FTCA coverage will cover volunteer providers next year. These volunteers will have to go through our credentialing process, but will have coverage. Eliza attended MA State House Day on April 12. Wendy and John attended with her.		
Executive Committee	There was no report from the Executive Committee this month.		
Recruitment, Orientation & Nominating (RON) Committee	Tim reported that the committee has not met recently. There is a potential candidate to meet with Eliza and John on May 9. After meeting him, he would be invited to the May Board meeting.		
Corporate Compliance Committee	The first all-staff meeting of 2017 was held April 6 where an annual review of corporate compliance was conducted. Training continues by sending emails to staff on a bi-weekly basis. HIPAA training was attended by Eliza and Janet on April 5.		
Facilities Committee	Alan reported that there was a recent meeting of the committee on April 21. Each site was toured. A piece of siding on the front of the Huntington site will be fixed shortly. The cost is approx. $1000. Fixes in Worthington will take place as well		

	by All-Star. Other items discussed for future fixing/repair include new flooring and carpet removal in Worthington. New signs for both sites have been ordered and will be ready next week. They will be installed shortly thereafter. A prioritized list of repairs will be worked on.		
Personnel Committee	Personnel committee minutes were distributed. Wendy reported that the committee continues to review the employee handbook and will make changes as needed. Each policy is also being reviewed.		
Quality Improvement Committee	March QI meeting minutes were distributed to the group. It was asked if each department reports using the same format or are they different? Each department reports quarterly and conducts peer reviews. Each department has pre-determined metrics to review. The QI policy and plan is scheduled to be reviewed next month. There was no April meeting of this committee. The next meeting is scheduled for May 16.		
Expansion Committee	Lee reported that the last meeting of this committee was held in March.		
Strategic Planning Committee	It was reported that the next step of the process is for the action plan to be worked on by senior management and department heads.		
Committee Reports	After all the committee reports had	Committee reports	

	been reviewed and discussed**, Kathryn Jensen made a motion to accept all committee reports. The motion was seconded by Tim Walter and without further discussion were approved.**	presented at this meeting were approved.	
Old Business	None		
New Business			
Annual Meeting	This year's Annual Meeting is scheduled to take place at Union Station on June 13. More Details will be forthcoming.		
Acceptance of Guidelines for Evidence-Based Care Policy	This policy outlines the national organizations where the providers follow recommendations from. **Kathryn Jensen moved to approve the Acceptance of Guidelines for Evidence-Based Care Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Acceptance of Guidelines for Evidence-Based Care Policy.**	Acceptance of Guidelines for Evidence-Based Care Policy was approved.	
Coordinating Care Transitions Policy	The Coordinating Care Transitions Policy was reviewed by the Board. **Kathryn Jensen moved to approve the Coordinating Care Transitions Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Coordinating Care Transitions Policy.**	The Coordinating Care Transitions Policy was approved.	
Diagnostic Imaging Tracking Policy	The Diagnostic Imaging Tracking Policy was reviewed. **Kathryn Jensen moved to approve the Diagnostic Imaging Tracking Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Diagnostic Imaging Tracking Policy.**	The Diagnostic Imaging Tracking Policy was approved.	
Tracking of Discharge Summary, newborn	This is a new policy that's required by NCQA for certification. **Kathryn**	Tracking of Discharge	

Screening and Hearing Tests for Newborn Visit Policy	**Jensen moved to approve the Tracking of Discharge Summary, newborn Screening and Hearing Tests for Newborn Visit Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Tracking of Discharge Summary, newborn Screening and Hearing Tests for Newborn Visit Policy.**	Summary, newborn Screening and Hearing Tests for Newborn Visit Policy was approved.	
Tracking Patient Referrals Policy	This policy was brought to the Board for review. **Kathryn Jensen moved to approve the Tracking Patient Referrals Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Tracking Patient Referrals Policy.**	Tracking Patient Referrals Policy was approved.	
Translation-Interpretive Services Policy	This is a new policy that's required by NCQA for certification. **Kathryn Jensen moved to approve the Translation-Interpretive Services Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Translation-Interpretive Services Policy.**	Translation-Interpretive Services Policy was approved.	
Referral and Release/Sharing of Information with State Agencies Policy	This is a new policy that's required by NCQA for certification. This policy comes in to play when dealing with DCF and other such entities. The community programs deal with this often. **Kathryn Jensen moved to approve the Referral and Release/Sharing of Information with State Agencies Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Referral and Release/Sharing of Information with State Agencies Policy.**	The Referral and Release/Sharing of Information with State Agencies Policy was approved.	
Patient Scheduling and Alternative types of	This policy was in place but requires some additional information for	The Patient Scheduling	

Clinical Encounters Policy	NCQA certification. We're required to track and evaluate 3rd next available appointments for providers. Thresholds need to be monitored and action is needed if thresholds are not met. Home visits were also added to this policy as an alternative type of clinical encounter. **Kathryn Jensen moved to approve the Patient Scheduling and Alternative types of Clinical Encounters Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Patient Scheduling and Alternative types of Clinical Encounters Policy.**	and Alternative types of Clinical Encounters Policy was approved.	
Transitioning Pediatric Patients to Adult Medicine Policy	This is a new policy that's required for NCQA certification. We're required to hand out materials and speak to adolescent patients about the changes that occur once a patient turns 18. **Kathryn Jensen moved to approve the Transitioning Pediatric Patients to Adult Medicine Policy as written. Tim Walter seconded the motion, and the Board voted unanimously to approve the Transitioning Pediatric Patients to Adult Medicine Policy.**	Transitioning Pediatric Patients to Adult Medicine Policy was approved.	
HIPAA Security Policies	Access Authorization policy; **a motion was made by Kathryn Jensen to approve the Access Authorization policy**. **The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Access Control policy; **a motion was made by Kathryn Jensen to approve the Access Control policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Assigned Security Responsibility policy; **a motion was made by Kathryn Jensen approve the**	Policies approved: • Access Authorization policy • Access Control policy • Assigned Security Responsibility policy • Audit Controls policy • Authorization or Supervision	

	Assigned Security Responsibility policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved. Audit Controls policy; **a motion was made by Kathryn Jensen to approve the Audit Controls policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Authorization or Supervision policy; **a motion was made by Kathryn Jensen to approve the Authorization or Supervision policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Business Associates Contracts policy; **a motion was made by Kathryn Jensen to approve the Business Associates Contracts policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Contingency Plan policy; **a motion was made by Kathryn Jensen to approve Contingency Plan policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Data Backup Plan policy; **a motion was made by Kathryn Jensen to approve the Data Backup Plan policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Device and Media Controls policy; **a motion was made by Kathryn Jensen to approve the Device and Media Controls policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Evaluation Policy; **a motion was made by Kathryn Jensen to approve**	policy • Business Associates Contracts policy • Contingency Plan policy • Data Backup Plan policy • Device and Media Controls policy • Evaluation Policy • Facility Access Controls Policy • Information Access Mgt Policy • Risk Analysis Policy • Sanction Policy • Security Awareness and Training Policy • Security Incident Response & Reporting Policy • Security Management Process and TOC Policy • Workforce Clearance and Security Policy • Workstation Acceptable Use Policy	

	the Evaluation policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved. Facility Access Controls Policy; **a motion was made by Kathryn Jensen to approve the Facility Access Controls policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Information Access Mgt Policy; **a motion was made by Kathryn Jensen to approve the Information Access Mgt policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Risk Analysis Policy; **a motion was made by Kathryn Jensen to approve the Risk Analysis Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Sanction Policy; **a motion was made to by Kathryn Jensen approve the Sanction Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Security Awareness and Training Policy; **a motion was made by Kathryn Jensen to approve the Security Awareness and Training Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Security Incident Response & Reporting Policy; **a motion was made by Kathryn Jensen to approve the Security Incident Response & Reporting Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Security Management Process and TOC Policy; **a motion was made by**		

	Kathryn Jensen to approve the Security Management Process and TOC Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved. Workforce Clearance and Security Policy; **a motion was made by Kathryn Jensen to approve the Workforce Clearance and Security Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** Workstation Acceptable Use Policy; **a motion was made by Kathryn Jensen to approve the Workstation Acceptable Use Policy. The motion was seconded by Tim Walter. Without further discussion, the policy was approved.** It was asked where our data is backed up? Frank answered by stating all our PHI is backed up by Cooley Dickinson. When we switch EMR vendors, all data will be backed up to the cloud. It was asked if we'd be liable if their servers were broken into by hackers? We can purchase cyber security insurance for cyber issues.		
Adjourn	A motion to adjourn the meeting was made by Lee Manchester and seconded by Wendy Long. The meeting adjourned at 7:20pm. The next regular Board meeting is scheduled for Thursday, May 25, 2017 at 5:30pm at the Worthington Health Center.		

Submitted by,

Janet Laroche, Executive Assistant

Hilltown Community Health Centers
Income Statement

	Apr. 2017 Actual	Apr. 2018 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Cur.- YTD v. PY - YTD
OPERATING ACTIVITIES								
Revenue								
Patient Services - Medical	219,582	220,564	(981)	788,832	940,391	(151,559)	809,503	(20,672)
Visits	1,404	1,491	(87)	5,598	6,357	(759)	N/A	N/A
Revenue/Visit	$ 156.40	$ 147.93	$ 8.47	$ 140.91	$ 147.93	$ (7.02)		
Patient Services - Dental	158,978	154,264	4,714	559,516	657,577	(98,061)	574,279	(14,763)
Visits	1,270	1,401	(131)	4,911	5,972	(1,061)	N/A	N/A
Revenue/Visit	$ 125.18	$ 110.11	$ 15.07	$ 113.93	$ 110.11	$ 3.82		
Patient Services - Beh. Health	35,205	30,624	4,581	120,992	130,398	(9,405)	56,386	64,607
Visits	309	314	(5)	1,307	1,337	(30)	N/A	N/A
Revenue/Visit	$ 113.93	$ 97.53	$ 16.40	$ 92.57	$ 97.53	$ (4.96)		
Patient Services - Optometry	17,645	15,011	2,635	59,020	63,968	(4,947)	47,646	11,374
Visits	183	153	30	733	652	81	N/A	N/A
Revenue/Visit	$ 96.42	$ 98.11	$ (1.69)	$ 80.52	$ 98.11	$ (17.59)		
Patient Services - Optometry Hardware	3,601	6,833	(3,232)	18,399	27,333	(8,934)	25,054	(6,655)
Patient Services - Pharmacy	10,655	10,417	239	49,632	41,667	7,965	53,705	(4,073)
Quality & Other Incentives	950	-	950	2,420	-	2,420	14,822	(12,402)
HRSA 330 Grant	91,670	118,880	(27,210)	467,381	505,586	(38,205)	338,789	128,592
HIP	-	-	-	26,126	25,000	1,126	16,382	9,744
Other Grants & Contracts	65,184	57,958	7,226	271,386	264,832	6,554	386,804	(115,418)
Int., Dividends Gain /Loss Investmenst	12	417	(404)	28,697	1,667	27,031	4,487	24,210
Rental & Misc. Income	3,415	2,352	1,063	11,632	9,408	2,224	11,126	506
Total Operating Revenue	606,899	617,320	(10,421)	2,404,034	2,667,826	(263,792)	2,338,983	65,051
Compensation and related expenses								
Salaries and wages	419,417	416,990	2,427	1,773,170	1,772,207	964	1,683,869	89,301
Payroll taxes	30,519	31,753	(1,235)	140,706	134,883	5,822	140,237	469
Fringe benefits	42,160	37,529	4,631	162,668	159,498	3,169	135,843	26,825
Total Compensation & related expenses	492,095	486,272	5,823	2,076,544	2,066,588	9,955	1,959,948	116,596

Hilltown Community Health Centers
Income Statement

	Apr. 2017 Actual	Apr. 2018 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Cur.- YTD v. PY - YTD
Other Operating Expenses								
Advertising and marketing	6	2,354	(2,348)	1,749	9,417	(7,668)	4,056	(2,308)
Bad debt	22,042	-	22,042	26,618	-	26,618	(3,360)	29,978
Computer support	7,558	9,896	(2,337)	28,338	39,583	(11,245)	43,186	(14,848)
Conference and meetings	1,930	1,583	347	10,741	6,333	4,407	12,907	(2,167)
Continuing education	2,624	2,875	(251)	8,380	11,500	(3,120)	7,152	1,228
Contracts and consulting	4,397	4,917	(519)	21,030	19,667	1,363	25,402	(4,372)
Depreciation and amortization	13,695	18,114	(4,419)	54,779	62,050	(7,271)	55,529	(750)
Dues and membership	908	19,288	(18,380)	55,021	77,150	(22,129)	4,793	50,228
Equipment leases	1,755	1,941	(187)	8,248	6,765	1,483	6,974	1,275
Insurance	1,210	1,042	168	4,761	4,167	595	4,065	697
Interest	1,605	1,551	54	6,318	6,203	114	7,252	(934)
Legal and accounting	2,083	2,917	(833)	12,257	11,667	590	10,669	1,588
Licenses and fees	3,332	4,373	(1,041)	17,048	17,492	(444)	14,590	2,458
Medical & dental lab and supplies	16,318	19,833	(3,515)	59,987	67,333	(7,346)	46,396	13,590
Merchant CC Fees	1,615	892	724	4,545	3,267	1,279	3,430	1,115
Office supplies and printing	2,855	4,042	(1,186)	10,819	14,167	(3,348)	17,551	(6,732)
Postage	2,026	1,287	739	6,272	5,150	1,122	6,169	103
Program supplies and materials	14,435	19,000	(4,565)	61,374	69,500	(8,126)	60,134	1,241
Pharmacy & Optometry COGS	3,707	9,167	(5,460)	15,083	36,167	(21,084)	20,101	(5,019)
Recruitment	-	3,042	(3,042)	1,755	5,167	(3,411)	763	992
Rent	3,000	5,986	(2,986)	12,000	15,699	(3,699)	11,850	150
Repairs and maintenance	9,914	14,375	(4,461)	55,939	57,500	(1,562)	59,564	(3,626)
Small equipment purchases	2,000	2,375	(375)	2,958	9,500	(6,542)	6,084	(3,126)
Telephone	9,215	8,221	995	36,142	31,383	4,758	25,217	10,925
Travel	3,848	4,125	(277)	13,594	16,000	(2,406)	12,315	1,279
Utilities	3,230	4,166	(936)	17,753	14,667	3,086	14,369	3,384
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	135,310	167,360	(32,050)	553,509	617,492	(63,984)	477,158	76,351
Net Operating Surplus (Deficit)	**(20,506)**	**(36,312)**	**15,806**	**(226,019)**	**(16,255)**	**(209,764)**	**(98,123)**	**(127,896)**
NON_OPERATING ACTIVITIES								
Donations, Pledges & Contributions	47,185	12,977	34,208	78,375	129,771	(51,396)	110,959	(32,584)
Loan Forgiveness	-		-	-	-	-	17,333	(17,333)
Net Non-operating Surplus (Deficit)	**47,185**	**12,977**	**34,208**	**78,375**	**129,771**	**(51,396)**	**128,292**	**(49,917)**
NET SURPLUS/(DEFICIT)	**26,679**	**(23,336)**	**50,015**	**(147,644)**	**113,516**	**(261,160)**	**30,169**	**(177,813)**

Hilltown CHC
Summary Financial Results And Analytics - Dashboard
April 2017

	Budgeted FY 2017	Actual Q1 2017	Actual April 2017	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures						
Operating Days Cash	13	12	12	Measures the number of days HCHC can cover daily operating cash needs.	> 30-45 Days	Not Meeting Benchmark
Current Ratio	1.19	1.49	1.51	Measures HCHC's ability to meet current obligations.	>1.25	Doing Better than Benchmark
Patient Services AR Days	25	33	27	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	48	56	44	Measures HCHC's ability to pay bills	< 60 Days	Doing Better than Benchmark
Profitability Measures						
Net Operational Margin	-0.3%	-11.4%	-3.4%	Measures HCHC's Financial Health	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	14.7%	-9.7%	4.4%	Measures HCHC's Financial Health but includes non-operational activities	> 3%	Meeting Benchmark
Leverage						
Total Liabilities to Total Net Assets	24.1%	38.0%	38.4%	Measures HCHC's total Liabilities to total Net Assets	< 30%	Not Meeting Benchmark

Summary Financial Statements			
Stmt of Activities			
Net Patient Revenue	5,714,585	1,152,195	446,617
Grant Revenue	3,434,867	608,039	156,854
Other Revenue	28,225	36,901	3,427
Total Revenue	9,177,677	1,797,135	606,899
Employee Related Expenses	6,521,982	1,584,449	492,095
Facilities & Equipment	700,000	127,468	37,620
Supplies and Cost of Goods Sold	453,000	74,374	22,614
Depreciation	186,150	41,084	13,695
Other Expenses	363,327	175,273	61,381
Total Expenses	8,224,459	2,002,648	627,405
Net Operating Gain (Deficit)	**953,218**	**(205,513)**	**(20,506)**
Non-Operating Activities (Pledges, Donations, Investments, etc.)	394,312	31,190	47,185
Net Surplus Gain (Deficit)	**1,347,530**	**(174,323)**	**26,679**
Balance Sheet			
Cash - Operating Fund	244,570	264,566	222,786
Cash - Restricted	-	327,319	393,082
Net Patient Accounts Receivable	450,000	391,238	412,943
Other Current Assets	195,500	287,211	297,473
Total Current Assets	890,070	1,270,334	1,326,284
Net Property & Equip.	4,403,499	2,739,360	2,732,672
Other Long-term assets	500,000	527,296	527,379
Total	4,903,499	3,266,656	3,260,051
Total Assets	**5,793,569**	**4,536,990**	**4,586,335**
Liabilities & Net Assets			
Accounts Payable	265,000	321,677	295,346
Other Current Liabilities	445,637	497,917	510,636
Deferred Contract Revenue	40,000	33,370	71,960
Total Current Liabilities	750,637	852,964	877,942
Total Long Term Liabilities	374,657	395,866	393,554
Total Liabilities	1,125,294	1,248,830	1,271,496
Total Net Assets	4,668,275	3,288,160	3,314,839
Total Liabilities & Net Assets	**5,793,569**	**4,536,990**	**4,586,335**

Hilltown Community Health Centers, Inc.

Summary of Results for the Month Ended April 30, 2017

SEE STATEMENT OF ACTIVITIES FOR DETAIL

Revenue

1. Patient revenue services approximated the budget for the April 2017.
    a. Medical - $981 and 87 visits under budget.
    b. Dental - $4,714 over budget and while being 131 visits under budget.
    c. Behavioral Health - $4,581 over budget while being 5 visits under budget.
    d. Optometry - $2,635 and 30 visits over budget.
    e. Optometry Hardware $3,232 under budget and Pharmacy $239 over budget.
2. Grant revenues were approximately $20,000 under the budgeted amounts.

Compensation and Related Expenses

1. Wages, taxes and benefits were $5,823 over budget, or 1.2%.

Other Operating Expenses

1. Total operating expenses were $32,150 under budget, mainly due to timing differences involving dues and memberships and the ordering of supplies. The bad debt expense was $22,042 over budget, however this is a calculated reserve based on outstanding balances at month-end and is expected to self-adjust in future months.

Non-Operating Activities

1. Donations for April were $34,208 over budget. This is mainly a timing issue and is not expected to be a major variance by year end.

Net Surplus (Deficit)

1. The Net operating results for April ended as a deficit of $20,506. While this better than budgeted the YTD deficit is $209,764 and remains of concern.

Meeting Minutes

COMMITTEE: Personnel **Location: Worthington** **Date/Time: May 16, 2017/8:00am**

TEAM MEMBERS: John Follet, Wendy Long, Bridget Rida, Karen Rowe, Suzanne Kresiak

ABSENT: Lee Manchester, Pat Kirouac, Carolyn Sailer, John Bergeron

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Personnel Policies Handbook	**The following policies were reviewed for comments and revisions as an update: Unpaid Leave of Absence, Jury Duty, Continuing Education/Professional Development, Jury Duty, Travel Expenses, Standards of Conduct and Corrective Action, Appeals, Solving Policies and Grievances.**	**The Unpaid Leave of Absence policy will be replaced by two separate policies: Unpaid Medical Leaves of Absence, Unpaid Personal Leaves of Absence**	
Next Meeting			**Tuesday June 20, 2017 8:00am Huntington**

QI COMMITTEE
Location: Huntington Health Center
Date/Time: 05/16/2017 8:15am

TEAM MEMBERS Cheryl Hopson (chair); Sheri Cheung, Medicine Representative; Eliza Lake, CEO; Serena Torrey, Behavioral Health Representative; Janet Laroche, Admin & Lean Team Leader; Michael Purdy, CCCSO; Kim Savery, Community Programs Representative; Cynthia Magrath, Practice Manager; MaryLou Stuart, Dental Representative; Kathryn Jensen, Board Representative

ABSENT: Jon Liebman, ANP

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Review of Minutes	The meeting was called to order by Cheryl Hopson, Chair, at 8:20 am. The minutes from the March 21, 2017 meeting were reviewed. With no discussion needed, Michael Purdy made a motion to approve the minutes as written. Cynthia Magrath seconded the motion. The March 21, 2017 minutes were approved unanimously.	The March 21, 2017 minutes were approved.	
Peer Review / Department Reports	**Oral Health/Dental department:** MaryLou Stuart reported that peer review was conducted by reviewing 3 charts per provider and hygienist, for a total of 39 charts. The same documentation errors from prior reviews are occurring. This will be discussed with the individual providers as well as at the next staff meeting. It seems to be the dentists who have been here a while who are having the issues. This will be reviewed with them. Items include a signature needed on medical history updates, the recording of perio probing, and the diagnosis missing for crown necessity. There have been 2 patient complaints: First, a patient with tooth pain. The provider informed the patient to take		

	over the counter pain relief, but the patient wanted stronger pain meds. The patient made an appointment with his HCHC medical provider and received 20 tabs of a pain med. MaryLou spoke to Jon about this. There was no communication by the medical provider with the dental dept before the pain medication was prescribed. Unfortunately, the EMRs in each department are not connected. MaryLou and Mary McClintock will plan to attend a medical provider meeting to review the communication process. The second complaint entails a patient who had all her teeth removed. Dentures were needed, but she needed to wait 6 months according to Masshealth. A temporary denture was created for the short term. The patient consulted MaryLou because she was unhappy with the temporary denture. The patient then saw her medical provider and there was a question of an allergic reaction to the temporary denture. MaryLou suggested she wear the dentures for 20 minutes so she could observe what might be happening, but the patient stormed out. There is also a Masshealth billing issue with this case as well. MaryLou also reported on a HRSA quality measure: children age 6-9 with sealable first permanent molar who received sealant the same year as an exam–37 children were in this category and 29 received at least one sealant, 76%. For the 330 grant, the number of children with 1 or more cavities in last year is being tracked. 2015 data showed 30% recurrent caries; 2016 showed 202 with recurrent caries out of 1000 patients. How many are high risk? Difficult to determine. There are 2 codes- medium and high risk - to be		

	implemented and reminders will be placed on the computers for providers. MaryLou was unable to determine which high risk patients had 2 cleanings and 2 varnishes in the last quarter. 890 exams completed, 857 cleanings and 787 varnishes. Gator Grins providers will be informed to be more specific with coding. **Eye Care department**: Peer review charts were mailed out but have not yet returned. Two quarters were sent. There have been no patient complaints. But, there have been a couple issues when a patient gets a bill and call the billing department only to be told to call Michael. A process needs to be worked out with the Billing dept. to remedy this. **Medical Department:** Sheri reported there was an unexpected death in March. The case was reviewed by Jon and Sheri. There are some concerns about care the patient received in the ER at CDH. Sheri's final analysis is that there's nothing that could have been done here to prevent this. The patient was an 88 year old WHC patient. She had a low oxygen level during exam. It was recommended that she go to the hospital and an ambulance would be called, but shed drove herself to the ER. She was found to be positive for flu and had a normal x-ray. She was eventually sent home. Melissa Lodzieski asked the ER to keep the patient. She did go home, but was back in the ER for a 2nd time a short time later and died in ER. Sheri feels everything was done correctly here. Sheri's not comfortable with how things went in the ER. She's not sure if the hospitalist was consulted. She feels the patient should have been admitted to the hospital the first visit to the ER. Jon spoke with the CDH ER director about this case. No feedback has been		

	received yet. It was asked if the patient refused the ambulance? If she had been sicker, would this case have gone differently? Some patients refuse the ambulance and that's ok if they are able to get there safely themselves. This patient drove herself. Lora Grimes is pursuing privileging for acupuncture. A change of scope is needed and Eliza is working on it. Serena reported this is going well. Providers are being educated through their provider meeting. Group pain management visits are now being looked into.		
New Business	None		
Old Business			
1422 Grant	Kim reported that in the past month, Jon Liebman suggested that a letter be sent to patients with pre-diabetic ranges. The letter included education for patients and information on what can be done. Janet Dimock, CHW sent 345 letters and some push back was received from patients. The receptionists didn't know the letter was sent and took some complaints when patients called. This has been a learning experience for all. A second letter has been altered and mailed. Training is being offered to receptionists if they receive calls about the letter. As a result of these letters, the 2nd diabetes prevention class is full. 12 patients have enrolled in the class through the YMCA. Also, the newest CHW has finished her training and may be located at HHC a few days per week. PDSAs for undiagnosed HTN were conducted with Lora Grimes. A meeting was held discuss the spreading of the process to HHC. Monthly registry is being reviewed by teams. Nurses are		Kim will continue to report on this

	reviewing and showing to providers. We're now partnered with Walgreens in Westfield for pharmacy services. Patient education is to begin, as well as group visits. Michael asked Sheri if eye patients who had a diabetic diagnosis at some point should continue to have that diagnosis listed in the problem list? Yes, Sheri said keep it there. Michael keeps appointments as diabetic eye exams for these patients as there's not enough studies out there to warrant a change.		
ACO Membership	No report this meeting		
Patient Satisfaction Survey	The new patient satisfaction survey follows the CAHPS survey and has been created in Surveymonkey. 2100+ surveys were emailed to medical patients on April 21. At present, there are 96 responses for WHC and 139 responses for HHC. The data will be tabulated after May 19. To meet NCQA requirements for this standard, an insert has been created and is being placed in the bills being sent to medical patients; posters have been hung in exam room with tear offs asking patients to take the survey; post cards are at each reception window; the survey is now available on the HCHC web site and the insert is also being mailed monthly to new patients in our welcome letter packet. Also, the suggestion box in Huntington has been placed in the waiting room. Janet will create signs to be hung next to the suggestion boxes to encourage patient feedback. The spring patient survey for the other departments is being distributed now and data should be available at the June meeting for review. It's been difficult to get surveys back from the departments in a timely manner. It was asked if BH		

	providers should hand out their own surveys? Serena said ok to this, but this could skew the data. If email addresses can be retrieved from ECW, an email could be sent to all BH patients. Janet will look into this.		
NCQA-PCMH	Janet reported that things are moving forward with preparations for the NCQA renewal process. Marie Burkart will soon being working on the report that will be submitted in September.		
QI Program and Policy	The QI policy was brought to the QI committee for view. There are a couple non-board member consumers on this committee who happen to be employees. There were a couple questions regarding the procedure of this policy: Is chart review a function of this committee? The procedure will be changed to reflect the assessment of the chart review information presented at each meeting. No coding is looked at by the medical representative. Coding errors have been found in the past during dental chart reviews. It was suggested that a billing dept representative conduct a coding review twice a year for a certain number of charts and present the findings. Changes will be made to QI procedure and presented at the next meeting.	Janet will update the procedure portion of this policy and present at the June meeting.	Janet 0 06-27-2017
Adjourn	There being no other business, Kathryn Jensen moved that the meeting be adjourned. After a second by Sheri Cheung, the meeting was adjourned at 9:15am. The next meeting is scheduled for **Tuesday, June 27, 2017** at 8:15am at the Huntington Health Center.		

Respectfully submitted,
Janet Laroche

Dental – Quality Quarterly Report

Peer review – 3 charts per provider (39 total)

Documentation still missing:

No recorded perio probing – 2 charts – if no change is made, the date and perio probing is not recorded

No diagnosis for crown necessity – 2 charts

No dentist signature on medical history updates – 5 charts

No treatment plan for recall appointment – 3 charts

No updated FMX – xrays not clear (last molars) 2 charts

Discussed individually and at staff meeting

Patient complaints/concerns

1) The patient presented with molar pain which was diagnosed by the dentist as furcation involvement and was treated under Novocain with scaling. The dentist told the patient if the pain/symptoms continued, she would call in an antibiotic. She also recommended a course of motrin and acetaminophen. The patient called on the way home after the appointment requesting stronger pain medications and the dentist emphasized the antibiotic and nonnarcotic pain regimen. The patient became angry and hung up, then called his medical doctor in Worthington for a visit where he was given 20 tabs of a narcotic medication.
2) The patient had her remaining teeth removed and a temporary denture placed. She was not happy with the temporary denture or the dentist. She returned for several visits to adjust and reline the temporary with another dentist. She was advised by both dentists that the bone would change and not stabilize for 6-12 months, at which time she would need a new denture. The final denture was inadvertently charged out to Mass Health after the temporary adjustment. When the error was discovered, Mass Health was informed and the money is to be deducted. The patient returned saying she can only wear the denture 20 minutes and then has swelling and vesicles. She says she saw our physician who agreed that the dentures were "strangling" the tissues. I subsequently spoke with the physician who did not remember examining the mouth and noted that the patient always has numerous issues. I checked the denture and found good occlusion and some retention. The tissues looked healthy. She had had a reline at another office since last seeing us. We suggested that the patient either stay or return after wearing the dentures for 20 minutes so we could reevaluate her tissues as she might be sensitive to the denture materials. The patient became very angry and left.

Quality Assurance May 2017 measurements

HRSA measure - % of children age 6-9 with sealable first permanent molar who received sealant same year as exam . We had 37 kids in this category and 29 received at least one sealant which is 76 %.

We plan to further refine data gathering beyond our present code for sealable molar present in high/medium risk kids by adding a code for completion of sealable molar same year as exam done.

330 grant

Number of children with one or more cavities within last year will be reduced the next year. The last measure from 2015 showed 30 % recurrent caries. 2016 showed of 1000 patients there were 202 with recurrent caries. We could not determine accurately which of these were high risk as the providers were not consistently putting in the risk codes. We plan to place a reminder on the side of the computers as to the required informational codes for each visit.

For the same reason, we were also unable to determine which of our high risk patients had 2 cleanings and 2 varnishes the last quarter. We did 890 exams, 857 cleanings, and 787 varnishes. The differences in these numbers – there may be exams without cleanings and not all parents allow fluoride varnish for the children

We plan to work with the Gator Grins providers to adjust the codes to be more specific and trackable for the information we need and to increase compliance in placing the codes.

Hilltown Community Health Centers, Inc.

Administrative Policy

SUBJECT: QUALITY IMPROVEMENT PROGRAM
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to follow regarding its organization's strategic objectives through the establishment and continued support of an organized Quality Improvement program.

Policy:

HCHC will attain its organization's strategic objectives through the establishment and continued support of an organized Quality Improvement program. The health center's quality improvement program requires that every major organizational initiative be measured against two criteria: will it improve clinical care and is it organizationally sustainable.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: APR 2010 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

HCHC is committed to providing safe optimal health care for its patients that is consistent with community standards and accepted standards of practice established by our clinical staff through a process of continuous performance improvement. HCHC is also committed to furthering operational sustainability by focusing on profitable growth and financial stability through a process of continuous performance improvement.

A. SCOPE

The scope of the quality improvement program is organization wide and includes activities that monitor and evaluate all phases of the health care delivery system through objective, criteria-based audits, outcome audits, tracking tools, and reporting systems.

B. OBJECTIVES

1. To ensure the delivery of patient care at the most achievable level of quality in a safe and cost effective manner.
2. To identify opportunities for improvement and institute continuous improvement strategies as appropriate
3. To develop a system of accurate, comprehensive data collection methods to track, trend and report quality indicators for the organization and for external reporting compliance.
4. To utilize information gained in quality assessment and improvement activities to direct staff development and clinical education at HCHC.
5. To increase knowledge and participation in quality improvement activities at HCHC.
6. To demonstrate the program's overall impact on improving the quality of care provided to our patients.
7. Timely resolution of identified problems that have a direct or indirect impact on Patient care including documentation of the effectiveness of corrective actions implemented.

C. QUALITY IMPROVEMENT COMMITTEE

1. Responsibilities of the Quality Improvement Committee:

    a. To direct HCHC staff to conduct studies and/or reviews as it deems necessary in order to further the strategic goals of the organization as endorsed by the Board of Directors.

    b. To prioritize specific performance improvement activities in each department in order to align these resources with the health center's strategic plan.

c. To assess the quality improvement strategies, activities, and outcomes as reported by organization staff and, where necessary, make recommendations for change.

d. To document activities and actions to demonstrate the program's impact on improving organizational sustainability and clinical quality.

e. The Board representative, independently or in conjunction with the QI Committee, will report semi-annually to the Board of Directors (1) the results of patient satisfaction surveys (2) make available departmental clinical goals as reported to the Bureau of Primary Health Care and progress made towards these goals (3) provides a trend analysis of quality indicators and a plan to improve those indicators.

f. The Board representative on the QI Committee will report to the Board the minutes from any 6 meetings evidencing oversight of QI/QA activities that took place during the course of the year.

g. To annually evaluate the quality improvement program to determine whether the program has been effective in meeting its goals and objectives and to make revisions to the program as deemed necessary and appropriate to be aligned with the health center's strategic plan.

h. To ensure that quality improvement activities are systematic, comprehensive, and integrated across the organization.

i. To be convened as an Ethics Committee as a committee of the whole to review individual cases where there is uncertainty about how to proceed clinically as sometimes arises, for example, when a patient refuses the professional's treatment plan or when the provider/patient team are in disagreement about a treatment plan.

2. Composition of the Quality Improvement Committee

The QI Committee is a Board level committee and will be chaired by a member of the Board of Directors. Other permanent members of the Committee are:

a. Medical Director
b. Dental Director
c. Chief Operations Officer
d. Director of Behavioral Health
e. Community Programs Director
f. One non-Board member consumer
g. Chief Clinical and Community Service Officer

Other staff members may be asked to attend meetings or assist the team as deemed appropriate.

3. Specifics of Quality Improvement Meeting

a. The Committee will meet no less than six times per year.

b. The Committee will identify specific areas in need of performance improvement and authorize that efforts be made in those areas to improve performance through rigorous project selection with measurable results and clear operational accountability

c. Minutes shall be maintained by a QI Committee designee and be signed by the Chair.

d. The clinical departments will conduct monthly meetings which include peer review monitoring. Quality dashboards (such as HEDIS, P4P, UDS, and other appropriate quality indicators) required by grants will be reviewed and assessed using process improvement methodology. Reports will be forwarded to the QI Committee.

e. The non-clinical departments will regularly report on their departmental dashboards and quality improvement activities.

D. MECHANISMS

1. Meeting focus will follow the *QI Reporting Calendar* with additional agenda items as deemed appropriate.

2. HCHC will utilize a tracking registry for maintaining and improving quality of care for common chronic diseases and assuring optimal delivery of preventive services.

3. Data Collection and Information Resources:
   a. Department specific indicators
   b. All clinical and community record reviews
   c. Established quality indicators such as AZARA and other third party aggregators
   d. Patient satisfaction surveys
   e. Employee satisfaction surveys
   f. Incident reports
   g. Results of trends developed as a result of systematic peer review
   h. Presentations of chart review assessments from departments
   i. Bi-annual presentation by the billing department
   j. Other methods as determined by the needs of a specific quality improvement team

4. Data Interpretation & Improvement plans

   The QI Committee will assess indicators by systematically evaluating HCHC performance against standardized quality measures. As the QI committee identifies opportunities for improvement they will direct the appropriate department to take action and report back with their action plan for improvement. This action plan must be data driven.

E. CONFIDENTIALITY

a. All documents, reports, minutes, findings, conclusions, recommendations, or other memoranda transmitted to or developed by the QI Committee shall be received and kept in confidence by the Chair and/or designees.

b. When the QI Committee conducts an audit, a code system will be devised in order to preserve the confidentiality of the audit, as well as to protect the individual(s) involved.

E. THE PROCESS IMPROVEMENT MODEL

1. HCHC uses a combination of QI processes and relies heavily on the underlying principles of LEAN—the relentless pursuit of the perfect process through waste elimination. Fundamental to the LEAN approach are the standardization of processes, making problems visible to supervisors and management, and identifying root causes.

Annex 7: HCHC Credentialing and Privileging Program

I. Introduction and History

Regular verification of the credentials of health care practitioners and definition of their privileges are required for increased patient safety, reduction of medical errors and the provision of high quality health care services. This has been previously recognized via the credentialing requirements required by the Health Centers by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Bureau of Primary Health Care (BPHC). The BPHC Health Center Program Expectations states that a Health Center credentialing process should meet the standards of a national accrediting organization such as the JCAHO or the Accreditation Association for Ambulatory Health Care, Inc., (AAAHC), in addition to the requirements for coverage under the Federal Tort Claims Act (FTCA). The JCAHO requires primary source verification of the credentials of only licensed independent practitioners. The AAAHC requires credentialing of all licensed healthcare practitioners. The Federally Supported Health Centers Assistance Act of 1992 (Act) requires that each deemed Health Center that participates in the FTCA must credential all its physicians and other licensed or certified health care practitioners. This requirement under the Act covers more health practitioners than the JCAHO or AAAHC requirement. In order to bring clarity to the requirements health centers must meet, BPHC has adopted a credentialing and privileging policy that is consistent with the broader requirement of the Federally Supported Health Centers Assistance Act of 1992. (*BPHC PIN 2001-16*)

II. Authority

The authority for this annex and all policies derived from this annex rests in the Public Health Service Act, Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I). Additional authority can be found in BPHC Policy Information Notice (PIN) 2001-16 and PIN 2002-22. Behavioral Health authority rests in 258 CMR 12.00, M.G.L. c. 13, § 84 and 258 CMR 8.05. Authority over dental activities rests in 234 CMR 2.00 and M.G.L. c.112, § 45. Medical auxiliary (RN, LPN, etc.) authority is found in M.G.L. c. 112 § 80B and 244 CMR 3.05(4) and (5). Optometry licensing, credentialing and privileging authority rests in 246 CMR 3.00: M.G.L. c. 112, § 67.

III. Definitions

Credentialing: the process of assessing and confirming the qualifications of a licensed or certified health care practitioner.

Privileging/Competency: the process of authorizing a licensed or certified health care practitioner's specific scope and content of patient care services. This is performed in conjunction with an evaluation of an individual's clinical qualifications and/or performance.

Licensed or Certified Health Care Practitioner: an individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is

located. These individuals include, but are not limited to, physicians, dentists, registered nurses, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners. As such, the credentialing and privileging requirements of these two groups may vary.

Licensed Independent Practitioner: physician, dentist, nurse practitioner, Licensed Independent Clinical Social Worker (LICSW), Licensed Mental Health Counselor (LMHC), and nurse midwife or any other "*individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.*" HCHC has the responsibility of determining which individuals (including staff that may not be covered under Federal Tort Claims Act such as volunteers, certain part-time contractors, and *locum tenens*) meet this definition based on law and the organization's policy.

The HCHC Credentialing program includes in this category the following:

1. Medical Doctors
2. Advanced Practice Providers (Nurse Practitioners)
3. Dentists
4. Licensed Independent Clinical Social Workers (LICSWs)
5. Licensed Mental Health Clinician (LMHCs)
6. Optometrists

Other Licensed or Certified Health Care Practitioner: An individual who is licensed, registered, or certified but *is not permitted by law to provide patient care services without direction or supervision*. Examples include, but are not limited to, laboratory technicians, Licensed Clinical Social Worker (LCSW), medical assistants, registered nurses, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians.

The HCHC Credentialing program includes in this category the following:

1. Registered Nurses (RNs)
2. Licensed Practical Nurses (LPNs)
3. Medical Assistants
4. Licensed Clinical Social Workers (LCSWs)
5. Dental Hygienists
6. Dental Assistants
7. Nutritionists & Dieticians

Primary Source Verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification

organizations. The Education Commission for Foreign Medical Graduates (ECFMG®), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Master file can be used to verify education and training. The use of credentials verification organizations (CVOs) or hospitals that meet JCAHO's "Principles for CVOs" is also an acceptable method of primary source verification.

Verification for some items must be obtained from primary sources and should be in writing from the primary source, although oral verification can be done. In the unlikely event that only oral verification is obtained, a dated and signed note in the credentialing file stating who at the primary source verified the item, the date of verification, and how it was verified is required.

Secondary Source Verification: Methods of verifying a credential that are not considered an acceptable form of primary source verification. These methods may be used when primary source verification is not required. Examples of secondary source verification methods include, but are not limited to, the original credential, notarized copy of the credential, a copy of the credential (when the copy is made from an original by approved HCHC staff).

Credentialing and Privileging Committee: Conducts an initial evaluation of the applicant's Credentialing & Privileging file and consists of the Executive Director, two Board members, and the Credentialing/Privileging Specialist.

- Recommends to the Board of Directors approval or denial of the provider's application.
- Records its actions and comments in the Credentialing/Privileging Review Sheet.
- The Credentialing/Privileging Review Sheets are signed and dated by the Board members of the Credentialing and Privileging Committee.
- The Board of Directors considers the Credentialing and Privileging Committee's recommendations, and votes on final approval or denial of the provider's application.

Credentialing Specialist: Provides executive support to the appropriate supervisor or his/her designee as follows:

- Gathering the providers' application and required supporting documentation.
- Following up with providers regarding unanswered questions and/or information on their application.
- Obtaining primary source verification or confirmation of current licensure, relevant training and experience, current competence, and ability to perform requested privileges.
- Reviewing and preparing initial file for Credentialing/Privileging Committee.
- Maintaining files of approved providers.
- Notifying the provider and his/her appropriate supervisor (or the supervisor's designee) in advance of the providers' anniversary date, so that the re-privileging process can begin.

IV. Credentialing

A. Initial Credentialing Requirements

1. Primary Source Verification

a) Initial credentialing of LIPs requires primary source verification of the following:
(1) Current licensure;
(2) Relevant education, training, or experience;
(3) Current competence, defined as verification of current competence based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.; and
(4) Health fitness, or the ability to perform the requested privileges, can be determined by a statement from the individual that is confirmed either by the director of a training program, chief of staff/services at a hospital where privileges exist, or a licensed physician designated by the organization.

b) Credentialing of other licensed or certified health care practitioners requires primary source verification of the individual's license, registration, or certification only. Education and training may be verified by secondary source verification methods. Verification of current competence is accomplished through a thorough review of clinical qualifications and performance.

2. Secondary Source Verification

a) Credentialing of LIPs and other licensed or certified health care practitioners also requires secondary source verification of the following:
(1) Government issued picture identification;
(2) Drug Enforcement Administration registration (as applicable);
(3) Hospital admitting privileges (as applicable);
(4) Immunization and PPD status; and
(5) Life support training (as applicable).

3. National Practitioner Data Bank

a) HCHC must also query the NPDB (as applicable) for these LIPs as part of the initial credentialing process.

These requirements are a minimum and do not restrict HCHC from credentialing other licensed or certified health care practitioners to similar standards as those used for LIPs.

The following table lists the minimum required activities identified in PIN 2002-22 for credentialing both LIPs and Other licensed or certified practitioners.

Table 1: Credentialing Requirements Matrix		
	Licensed Independent Practitioner (Physician, Dentist APRN, Optometrist, LICSW)	**Other licensed or certified practitioner** (RN, LPN, CMA, Registered Dietician, LCSW)
Activity	**Method**	
Verification of licensure, registration, or certification	Primary source	Primary Source
Verification of education	Primary source	Secondary source
Verification of training	Primary source	Secondary source
Verification of current competence	Primary source, written	Supervisory evaluation per job description
Health fitness (Ability to perform the requested privileges)	Confirmed statement	Supervisory evaluation per job description
Approval authority	Governing Body (usually concurrent with privileging)	Supervisory function per job description
National Practitioner Data Bank Query	Required, if reportable	Required, if reportable
Government issued picture identification, immunization and PPD status, and life support training (if applicable)	Secondary source	Secondary source
Drug Enforcement Administration (DEA) registration, hospital admitting privileges	Secondary source, if applicable	Secondary source if applicable

Source: BPHC PIN 2002-22

4. Advanced Practice Clinician Supervision Agreements

Advanced Practice Clinicians and physicians must have a signed Advanced Practice Clinician Supervision Agreement that complies with applicable laws and regulations.

5. Credentialing Process for Students, Trainees and Medical Residents

a) Proof of Professional Liability insurance in the amount $1M/$3M required
b) Signed contract with the school or other training facility permitting students or trainees to train at the health center
c) CORI check completed with no findings
d) Letter from the student stating ability to perform requested privileges
e) Current unrestricted license to practice in the State of Massachusetts (if applicable)
f) Current DEA certificate (if applicable)
g) Current MA Controlled Substance certificate (if applicable)
h) Government issued Photo I.D.
i) Proof of Immunizations/Titers as described in the Personnel Handbook
j) Name of HCHC's supervising provider
k) Release of Liability
l) Attestation

B. Types of Verification

1. Primary Source Verification

a) Current License or Certification as Appropriate to the Discipline: Verification of current Massachusetts license must be obtained by direct confirmation from the applicable Massachusetts licensing board. Online licensure verification is accepted.
b) Board Certification (if applicable): Board certification is verified from ABMS for physicians, or other appropriate certifying board for non-physicians. Online verification is accepted.
c) Verification of Graduation from Medical School or Training Program: Written verification will be requested directly from medical school or training program or through the AMA Master Profile or through DegreeVerify.com. If the provider is a graduate of a Foreign Medical School, he/she must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG). This information is then verified with ECFMG.
d) Verification of Completion of Residency Training (if applicable): Verification of completion of residency training is obtained from the institution(s) where the post-graduate medical training was completed or through the AMA Master Profile.
e) Professional Liability Claims History: Verification of claims history must be obtained from the current and/or previous carriers if the provider has been insured with the present carrier for less than five (5) years.

2. Secondary Source Verification

Secondary verification of information begins as soon as the application appears complete and is satisfied by presentation of original documents to the Credentialing Specialist for the following:

a) Government-issued photo ID
b) Proof of Immunizations/titers
c) Malpractice Insurance Coverage (if applicable)
d) Current DEA Certificate (if applicable)
e) Current MA Controlled Substance Registration (if applicable)
f) Hospital Privileges from the Applicant's Primary Admitting Facility (if applicable)
g) Verification of clinical privileges in good standing at the hospital designated by HCHC as its primary admitting facility must be confirmed in writing and must include the date of the appointment, scope of privileges, disciplinary actions, restrictions and

recommendations.

h) Certification (if applicable)

i) Work History (if applicable)

j) At least five (5) years of professional work history must be included in the file. Providers will be asked to explain any gap greater than one (1) year in his/her professional work history.

3. Other Verification

a) Current Competence: For initial credentialing, verification of current competence will be based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.

b) Ability to Perform Requested Privileges: For new providers, verification of ability to perform requested privileges will be based on 1) a statement from the applicant's primary care provider regarding health status, and 2) appropriate education/training to perform requested procedures.

4. Database Queries

The following databases will be queried for all practitioners, as applicable:

- National Practitioner Databank (NPDB)
- OIG List of Excluded Individuals
- Government Service Admin (GSA)/ SAM.gov
- MA State Exclusion List
- Mass.gov license verification

C. Credentialing Process

The determination that a practitioner meets the credentialing requirements must be stated in writing by the Health Center's governing board. Ultimate approval authority is vested in the HCHC Board of Directors which may review recommendations from the Credentialing and Privileging Committee. This responsibility may only be delegated to an appropriate individual by resolution and will be implemented based on approved policies and procedures (including methods to assess compliance with these policies and procedures).

Credentialing of other licensed or certified health care practitioners must be completed prior to the individual being allowed to provide patient care services and will follow the same procedure as that outlined for Independent Practitioners.

The Credentialing process will proceed as follows:

- The Credentialing Specialist will request and collect all the necessary documentation.
- Once all the necessary documents have been received and the file is completed, a Credentialing Review Sheet will be placed on top of the provider's application.
- The Credentialing / Privileging Specialist will sign off that a satisfactory review has been conducted
- The supervisor or his/her designee will review all applications and sign off on the Review Sheet.

- The Credentialing Specialist will present the provider's application to the Credentialing and Privileging Committee, which will review all items in the application and sign off on the Review Sheet if approved
- If the Committee approves the application, it will issue a recommendation to HCHC's Board of Directors for approval or denial. Approval or denial by the Board of Directors will be obtained within ninety (90) days of employment.
- In some cases, the supervisor and the Credentialing Specialist may agree to submit an incomplete application to the Committee for approval on a Pending status, noting the reason for this action in the blank section of the Credentialing Review Form. The Committee may approve the pending application with the requirement that the application be completed within 30 days.

After the vote of the Board is made, the following action is made:

- Approved File**:** A letter of approval is signed by the Board and sent to the provider by the Credentialing Specialist.
- Denied File: A letter of denial is signed by the Board and sent to the provider by the Credentialing Specialist.
- Pending File: The Credentialing Specialist will obtain additional information requested so that the file can be considered for approved.

D. Other

1. Right to Review Credentialing File

Each provider shall have the right to review all information obtained during HCHC's credentialing process and correct any erroneous or incorrect information. Each applying provider shall be notified of any information obtained during the credentialing process that does not meet HCHC's standards. HCHC will accept "corrected" information, subject to objective confirmation.

2. Orientation

As part of the department orientation, all newly hired providers will shadow the department director or designee for a designated period, depending on the length of experience and credentials. The department director will perform a series of chart reviews during the first two weeks of the new provider's orientation. Any and all findings are discussed with the provider.

E. HCHC Re-Verification Process

While there is no requirement specified in any regulatory guidance to conduct a formal re-credentialing process, the requirement does exist to re-verify no less often than every two years, based on the expiration date of the practitioners' license, the following:

- current licensure, registration, or certification
- current competence, which is verified by the practitioner's supervisor through primary sources, including peer review and/or performance improvement data for LIPs, and through supervisory evaluation per job description for other licensed or certified practitioners.

When a Department Head makes an adverse decision on a practitioner's re-verification of current competence, LIPs are afforded an opportunity for a fair hearing and appellate review by the Credentialing and Privileging Committee in accordance with the appeal provisions outlined in the Grievance Policy of the Personnel Policies.

V. Privileging

A. Privileging Requirements

Policy Information Notice 2001-16 requires privileging of each licensed or certified health care practitioner specific to the services being provided at each of HCHC's care delivery settings.

1. The initial granting of privileges to LIPs is performed by the health center. Ultimate approval authority is vested in the HCHC Board of Directors which may review recommendations from either the Chief Clinical and Community Services Officer (CCCSO), the Department Head, or a joint recommendation of the clinical staff (including the CCCSO) and the Chief Executive Officer. This responsibility may only be delegated to an appropriate individual by resolution or an amendment to the by-laws and will be implemented based on approved policies and procedures (including methods to assess compliance with these policies and procedures).
2. For other licensed or certified health care practitioners, privileging is completed during the orientation process via a supervisory evaluation based on the job description.
3. Temporary privileges may be granted if the Health Center follows guidelines specified by JCAHO (see Section H).

B. Privileging of Licensed Independent Practitioners

Due to the wide range of clinical services provided by HCHC, privileging requirements will be necessarily be slightly different based on clinical specialty and position. Approval will be granted by the Credentialing and Privileging Committee of the Board for up to two years and must be renewed at that time.

1. Medical Practitioners

a) Family Practice Physicians

Initial privileging for the following procedures does not require additional documentation of proficiency beyond residency training:

Skin procedures	Gynecology procedures	Orthopedic procedures
Punch biopsy	IUD insertion and removal	Injection of knee
Shave biopsy	Endometrial biopsy	Injection of shoulder
Excisional biopsy		Injection of hip
Cryotherapy		Other joint injection
Suturing		
Incision and drainage		
Toenail removal		
Cyst removal		

b) Medicine/Pediatrics, Internal Medicine and Pediatric Physicians

Initial privileging for skin procedures including incision and drainage, cryotherapy and suturing does not require additional documentation of proficiency beyond residency training.

Initial privileging for other skin procedures including punch biopsy, shave biopsy, excisional biopsy and nail removal, and for joint injections, require documentation of appropriate training in residency, or training in a post-graduate CME or program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. There are no specific requirements as to the number of procedures performed in order to maintain privileging.

Initial privileging to perform IUD insertion and/or endometrial biopsy requires proof of appropriate training in residency, or training in a post-graduate CME program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. Maintenance of privileging requires competent insertion of a device or performance of an endometrial biopsy at least five (5) times per year.

c) Nurse Practitioners

Initial privileging for the procedures identified in the table below requires documentation of proficiency beyond completion of a nurse practitioner program, to include CME or other post-graduate training, or specific on-site training by a privileged clinician and observation and approval by a privileged provider.

Skin procedures	Orthopedic procedures
Punch biopsy	Injection of knee
Excisional biopsy	Injection of shoulder
Shave biopsy	Injection of hip
Cryotherapy	Other joint injection
Suturing	

Incision and drainage	
Toenail removal	
Cyst removal	

Initial privileging to insert IUDs and/or perform endometrial biopsy requires proof of appropriate training in a post-graduate CME program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician. Maintenance of privileging requires competent insertion of a device or performance of an endometrial biopsy at least five (5) times per year.

d) Applicable to All Medical LIPs

Initial privileging to perform cervical colposcopy requires successful completion of the Colposcopy Mentorship Program of the American Society for Colposcopy and Cervical Pathology (ASCCP), or demonstration of equivalent training in a post-graduate CME program; and observation and approval by a privileged clinician. Maintenance of privileging requires competent performance of a minimum of five (5) colposcopies per year.

Initial privileging to perform subdermal contraceptive implant (e.g. Nexplanon) insertion and removal requires proof of appropriate training either by the manufacturer or as part of a CME program. Maintenance of privileging requires competent insertion of at least three (3) devices per year.

Providers already on staff at the time of adoption of this policy may request a waiver of the above process for any specific procedure. For each procedure, the practitioner should submit a summary of the training they have received, the approximate time they first began doing the procedure, the approximate number of procedures they have done, and a statement as to their competency to perform the procedure. The QI Director for Medicine will be responsible for reviewing a sample of charts for visits in which the procedure was performed, and making a recommendation to the Board. Following initial privileging, each clinican is responsible for:

- Prompt reporting of any adverse outcome or complication to the Medical Director;
- Performance of the specified minimum number of procedures specified above, or evidence of appropriate CME or other training to maintain skills.

2. Behavioral Health Practitioners

a) Licensed Independent Clinical Social Workers and Licensed Mental Health Clinicians

Pursuant to 258 CMR 12.00: M.G.L. c. 13, § 84 and 258 CMR 8.05, LICSWs and LMHCs may provide all services listed below without supervision. Primary source verification of their MA license to practice shall suffice for verification of competency.

Behavioral Health Competencies		
Individual Counseling	Couples Counseling	Counseling of Children
Counseling of Adolescents Outpatient Level of Treatment of Substance Abuse	Family Counseling Outpatient Level Treatment of Mental Disorders	Group Counseling Assessment
Diagnosis	Treatment Planning	Psychotherapeutic Intervention
Psycho-education	Referrals	Case Management
Collateral Communication	Refer client for Section 12	

3. Dental/Oral Health Practitioners

a) Licensed Dentists

Pursuant to 234 CMR 2.00 and M.G.L. c.112, § 45, all applicants for dental licensure in the Commonwealth are required to submit a full, accurate, and complete application for licensure on forms provided by the Board, and to provide proof that they have:

- graduated with a DDS or DMD degree from a dental college accredited by the Commission on Dental Accreditation;
- successfully passed the national board exams, the written and clinical parts of the Northeast Regional Board Examination (NERB) (or other regional exam accepted by the Board of Registration in Dentistry), and the Massachusetts Ethics and Jurisprudence Exam.

A primary source verification of MA dental licensure shall be sufficient proof of competency in the following areas:

Oral Health Competencies for Licensed Dentists		
Perform clinical and regional oral exams including oral cancer screening	Perform patient medical and dental history	Perform oral diagnosis
Develop comprehensive treatment plans with full explanation of risks and alternatives	Order and interpret radiology tests	Order and interpret laboratory tests
Refer to diagnostic medical or dental providers when necessary	Provide consultation services	Prescribe medications for patients
Prescribe anxiolytic	Administer IM/SC	Restorative care including

Oral Health Competencies for Licensed Dentists		
medications and narcotics for patients using the Mass reference system	injections	amalgams, composites, crowns, and implant restorations
Root canals – anterior teeth	Root canals – posterior teeth	Periodontics – gingivectomies
Prosthodontics – removable/fixed full dentures, removable/fixed partial dentures, full/partial overdentures	Palliative treatment	Simple extractions
Surgical extractions	Tissue impacted teeth extractions	Abscess incision and drainage
Frenectomies	Local anesthesia	

4. Eye Care Practitioners

a) Optometrists

The minimum training requirements for privileging for Optometrists consist of

1. Graduation from an accredited optometry program
2. Successful passing of all parts of the National Board of Examiners in Optometry
3. Successful passing of the Massachusetts law exam

Optometric Privileges:		
Photo-documentation	Medical laboratory studies	Ocular imaging studies
General Optometric exam/diagnosis/optical therapy	Diagnostic pharmaceutical agents	Extended posterior segment evaluation
Visual fields testing/evaluation	Low vision management	Contact lens management
Oculomotor/perceptual/pupillary problems	Non-invasive management of lid conditions	Non-invasive care of external eye injuries/burns
Epilation of lashes	Conjunctivitis therapy with topical medications	Non-invasive lacrimal function evaluation
Corneal abrasion care	Non-perforating foreign substance removal	Management of keratitis-sicca and other epithelial keratitis (non-microbial)
Gonsioscopy	OTC oral medications for ocular disease	Emergency treatment of life/sight/threatening condition prior to referral
Ultrasound measurement /	Punctum	Anterior uveitis care

evaluation	dilation/plugs/irrigation	
Medical hyphema management	Co-manage open angle glaucoma	Co-manage acute glaucoma
Lids and periorbital skin	Keratitis	Episcleritis
Post-surgical eye care		

C. Other Licensed or Certified Practitioners

Privileging for other licensed or certified practitioners requires primary source verification of their license to practice as well as supervisory evaluation of competence per employee job description. HCHC requires job descriptions be reviewed during employee orientation. Once reviewed, they will be signed by both the employee and supervising nurse and filed in the employees file in Human Resources.

Initial evaluation will be conducted during their orientation period. Validation of competence shall be documented on a new hire 90-day performance evaluation or using a competencies checklist when indicated by law.

1. Medical Practitioners

a) Medical Auxiliaries

(1) Registered Nurses

Pursuant to M.G.L. c. 112 § 80B, privileges accorded to registered nurses, by virtue of MA Board licensing shall include, but not be limited to:

1. the application of nursing theory to the development, implementation, evaluation and modification of plans of nursing care for individuals, families and communities;
2. coordination and management of resources for care delivery,
3. management, direction and supervision of the practice of nursing, including the delegation of selected activities to unlicensed assistive personnel.

(2) Licensed Practical Nurses

Pursuant to M.G.L. c. 112 § 80B, privileges accorded to licensed practical nurses, by virtue of MA Board licensing shall include, but not be limited to:

1. participation in the development, implementation, evaluation and modification of the plans of nursing care for individuals, families and communities through the application of nursing theory;
2. participation in the coordination and management of resources for the delivery of patient care;
3. managing, directing and supervising safe and effective nursing care, including the delegation of selected activities to unlicensed assistive personnel.

(3) Medical Assistants

In accordance with 244 CMR 3.05, selected nursing activities may be delegated to unlicensed personnel such as Medical Assistants (MA). Said delegation must occur within the framework of the MA's job description and be in compliance with 244 CMR 3.05(4) and (5).

2. *Behavioral Health Practitioners*

a) Licensed Clinical Social Workers

LCSWs may provide all services listed in the table provided one hour per week of supervision by a LICSW is provided and documented. Primary source verification of their MA license to practice shall suffice for verification of competency.

3. Dental/Oral Health Practitioners

a) Dental Auxiliaries

Dental auxiliaries include the following positions:

(1) Registered Dental Hygienist (RDH)
(2) Certified Dental Assistant (CDA)
(3) Formally Trained Dental Assistant (FTA)
(4) On-the-job training Dental Assistant (OJT)

The above positions are classified as Other Licensed or Certified Practitioners for the purposes of privileging and credentialing and, as such, require supervisory evaluation of skills per job description. They are permitted by law to perform all delegated functions listed in the table below under certain levels of supervision.

- General supervision (G) - Supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of a supervising dentist during the performance of those procedures.
- Direct Supervision (D) - Supervision of dental procedures based on instructions given by a licensed dentist who remains in the dental facility while the procedures are being performed by the auxiliary.
- Immediate Supervision (I) - Supervision of dental procedures by a licensed dentist who remains in the dental facility, personally diagnoses the condition to be treated, personally authorizes the procedures, and before dismissal of the patient, evaluates the performance of the auxiliary.

Delegated Procedure	**Appropriate Supervision**			
	RDH	**CDA,**	**FTA**	**OJT**
Give oral health instruction	G	G	G	G
Perform dietary analysis for dental disease control	G	G	G	G
Take and record vital signs	G	G	G	G
Chart dental restorations and record lesions	G	D	D	D
Take intra-oral photographs	G	G	G	G

Delegated Procedure	Appropriate Supervision			
	RDH	CDA,	FTA	OJT
Retract lips, cheek, tongue and other oral tissue parts	G	G	G	G
Place temporary restorations	G	D	D	I
Irrigate and aspirate the oral cavity	G	D	D	D
Isolate the operative field	G	G	G	D
Take impressions for study casts, athletic mouth guards, custom trays	G	G	G	I
Take wax bite registrations for identification purposes	G	G	G	D
Apply topical anesthetic agents	G	I	I	I
Take oral cytologic smears	D			
Remove sutures	G	G	G	D
Place and remove periodontal dressings	G	G	G	D
Place and remove rubber dam	G	G	G	D
Irrigate and dry root canals	I	I	I	I
Expose radiographs	G	G	D	D
Remove gingival retraction cord	D	D	D	D
Apply cavity varnish	I	I	I	I
Remove temporary restorations with hand instruments	G	I	I	N/A
Place and remove wedges	G	D	D	I
Place and remove matrix bands	G	D	D	I
Place gingival retraction cord	D	D	D	D
Cement and remove temporary crowns and bridges	G	G	G	I
Insert and/or perform minor adjustment of athletic mouth guards and custom fluoride trays	G	G	G	I
Polish teeth after dentist or dental hygienist has determined that teeth are free of calculus	G	G	G	N/A
Apply anti-cariogenic agents	G	G	G	D
Remove surgical dressings	G	G	G	N/A
Apply dental sealants	G	I	I	N/A
Place surgical dressings	G	G	G	N/A
Perform pulp testing	D	N/A	N/A	N/A

Delegated Procedure	Appropriate Supervision			
	RDH	CDA,	FTA	OJT
Select and try stainless steel crowns or other pre-formed crown for insertion by dentist	I	I	I	I
Perform periodontal charting	G			
Conduct dental screenings	G			
Perform preliminary examination to determine needed dental hygiene services	G			
Perform sub-gingival and supra-gingival scaling	G			
Perform root planing and curettage	G			
Polish amalgam restorations	G			
Apply identification microdisks	G			
Perform minor emergency denture adjustments to eliminate pain and discomfort in nursing homes and other long term care facilities	G			

Table obtained from 234 CMR-2.04

Administration of local anesthesia is limited to hygienists who have been trained in accordance with 234 CMR 6.00 and requires additional privileging, in writing, by the HCHC Board of Directors

D. Privileging Revision or Renewal Requirements

The revision or renewal of a LIP's privileges must occur at least every 2 years and will include primary source verification of expiring or expired credentials, a synopsis of peer review results and/or any relevant performance improvement information. Similar to the initial granting of privileges, approval of subsequent privileges is vested with the HCHC Board of Directors.

1. The revision or renewal of privileges of other licensed or certified health care practitioners should occur at a minimum of every 2 years. Verification is by:
    a. supervisory evaluation of performance that assures that the individual is competent to perform the duties described in the job description based on the following:
        i. for LIPs: Primary source based on peer review and/or performance improvement data.
        ii. for Other Licensed or Certified Practitioners: Supervisory evaluation per job description
    b. verification of current licensure, registration, or certification through primary source
2. When a Department Head makes an adverse decision on a practitioner's re-privileging, LIPs are afforded an opportunity for a fair hearing and appellate review by the

Credentialing and Privileging Committee in accordance with the appeal provisions outlined in the Grievance Policy of the Personnel Policies.

E. Temporary Privileging

The Joint Commission has determined that there are two circumstances for which the granting of temporary privileges would be acceptable:

1. To fulfill an important patient care need

In some circumstances, temporary privileges can be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved. Examples would include, but are not limited to:

a) a situation where a physician becomes ill or takes a leave of absence and an LIP would need to cover his/her practice until he/she returns (locum tenens)

b) a specific LIP has the necessary skills to provide care to a patient that an LIP currently privileged does not possess

In these circumstances, temporary privileges may be granted by the Executive Director upon recommendation of either the applicable clinical department chairperson head or the CCCSO provided there is verification of current licensure and current competence, as defined above.

2. When an applicant with a complete, clean application is awaiting review and approval of the Credentialing and Privileging Committee and the Board of Directors.

In the second circumstance temporary privileges may be granted when the new applicant for medical staff membership or privileges is waiting for a review and recommendation by the Credentialing and Privileging Committee and the Board of Directors. Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the Executive Director upon recommendation of either the applicable clinical department head or the CCCSO provided:

- there is verification of
  - current licensure
  - relevant training or experience
  - current competence as defined above
  - ability to perform the privileges requested
  - other criteria required by medical staff bylaws
- the results of the National Practitioner Data Bank query have been obtained and evaluated
- the applicant has:
  - a complete application
  - no current or previously successful challenge to licensure or registration
  - not been subject to involuntary termination of medical staff membership at another organization

- not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

Temporary privileges are not to be routinely used for other administrative purpose such as the following situations:

1. the LIP fails to provide all information necessary to the processing of his/her reappointment in a timely manner
2. failure of the staff to verify performance data and information in a timely manner

In the above situations, the LIP would be required to cease providing care in the facility until the reappointment process is completed.

Hilltown Community Health Centers, Inc.

Clinical Department Policy
Medical Department

SUBJECT: BAYSTATE REFERENCE LABORATORY (BRL) WORK FLOW
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for providing laboratory services in conjunction with BRL presence on site(s).

Policy:

1. HCHC will consider providing lab coverage during hours when the BRL lab is closed as manning permits. The exception is Point of Care (POC) testing.
2. HCHC will continue to provide (POC) testing for patients during and after normal lab hours.
3. POC proficiency testing will be tracked by operations.
4. PT/INR tracking will be done by the Nursing department using BRL reports, when available.
5. Reconciliation of extraneous labs will be performed by the Clinical Teams using reports generated by the Medical Operations Manager at an interval to be determined jointly.
6. Unless interfaced, results of labs for diabetic patients, as well as Pap tests will be input by the Medical Assistants as part of pre-visit planning using results attached to labs.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: JUN 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

Off-Hours Lab Coverage

1. Patients needing lab draws done during the time the lab(s) are closed for lunch will have the option of either waiting for the lab to reopen or of having a lab slip printed to obtain the draw elsewhere.
2. HCHC will staff the lab(s) for complete phlebotomy services during non-working hours as available staffing permits.

Point of Care Testing

1. Glucose - drawn by ordering doctor's M.A. or float.
2. Hemoglobin - drawn by ordering doctor's M.A. or float.
3. Mono - drawn by ordering doctor's M.A. or float.
4. Urinalysis.
    a. Routine UA's for physicals, hypertension, and urine tox will be bagged to send out by phlebotomist, daily.
    b. UA's to rule out UTI will be done by M.A. of ordering doctor if it is a doctor visit, or by Nursing staff if it is a Nurse visit.
5. Rapid Strep - M.A. of ordering doctor if it is a doctor visit, nursing staff if it is a nurse visit.
6. Urine pregnancy test - M.A. of ordering doctor if a doctor visit, nursing staff if it is a nurse visit.

PT/INR tracking will be done by the Nursing department.

1. **Daily in the morning:**
    a. Print site Lab Schedule from eCW & highlight patients scheduled for PT/INR
    b. Monitor pt.'s lab jelly bean for results
    c. Baystate Reference Lab to fax list of patients drawn twice daily
2. **Results received:**
    a. Enter date and INR result on flow sheet
    b. Prepare instructions according to Nurse Coumadin Protocol and initial
    c. Open new telephone encounter
        i. Click drop down in reason field. Click on PT/INR results
        ii. Click browse in message field. Click on Please review and complete PT/INR flow sheet and send to nursing for further follow up
        iii. Click browse in Action taken. Click on Prepared instructions according to nurse Coumadin Protocol
        iv. Send telephone encounter to PCP. If PCP not working, send to covering provider who will review, note changes if any and return to nursing
    d. Telephone encounter received back from provider

i. Review flow sheet and encounter for any changes in dosing. Provider to initial flow sheet. If no changes, provider will note "agree" in action section of telephone encounter
ii. Call pt. with Coumadin instructions and date next INR needed.
iii. Document call on flow sheet and initial.
iv. Document call in action taken section of telephone encounter and address encounter.

e. Schedule next lab appointment
i. After appointment scheduled, right-click on appointment in schedule
ii. Click View Progress Notes in pop-up menu
iii. When note opens, click arrow by appropriate diagnosis in problem list
iv. Order PT/INR lab as a current order
v. Click the Quick Transmit button
vi. Assign to Nurse HHC or WHC as appropriate
vii. Click the drop-down arrow by the Transmit button
viii. Click Transmit Only

f. Update Patient PT/INR Tracking List

3. <u>Results received from outside lab, Anticoagulation Clinics or Phillips Home PT/INR Monitoring:</u>

a. Front desk scanner will assign results to general nursing lab jelly bean in each site.
b. Nursing to monitor jelly bean throughout the day
c. Nursing to follow Results received process above.

4. <u>General Items:</u>

a. End of day, check general lab jelly bean to monitor for any outstanding PT/INRS
b. Monitor and update the Patient PT/INR Tracking List biweekly and sooner if able

Required POC Proficiency training will be maintained by operations and will be conducted by appointed personnel as required.

Reconciliation of extraneous labs will be performed by the Clinical Teams

1. Operations Manager will generate a report of labs ordered on a weekly basis.
2. Clinical team members will filter report.
3. Lab orders more than 1 month old, with no results received, will be deleted.
   a. Access patient's hub
   b. Access Labs
   c. Check the desired lab
   d. Click Delete.

Unless interfaced, results of labs for diabetic patients, as well as Pap tests will be input by the Medical Assistants as part of pre-visit planning using results attached to labs.

1. Lab results returned via fax are transferred to patient documents, attached to the applicable lab order and routed to the team Medical Assistant.
2. Medical Assistant will enter the lab attribute results for diabetic patients and enter Normal or Abnormal for Pap results.
3. Resulted lab will be routed to the ordering provider for review.

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: DISPOSAL OF OUTDATED CONTROLLED SUBSTANCES OR PRESCRIPTION MEDICATIONS
REGULATORY REFERENCE: 105 CMR 700.000: M.G.L. c. 94C, § 2.

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the disposal of outdated prescription medications and controlled substances.

Policy:

1. Outdated prescription medications and prescription medications which have not been administered due to a change in the prescription or a stop order shall be disposed of and the disposal documented in accordance with policies established by the program, provided that disposal occurs in the presence of at least two witnesses and in accordance with any policies of the Department of Public Health

Questions regarding this policy or any related procedure should be directed to the Medical Operations Manager at 413-238-4138.

Originally Drafted:_____ Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: DOCUMENTING TELEPHONE / WEB CLINICAL ADVICE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for documenting clinical advice given via telephone or portal messaging **during and after** hours of operation.

Policy:

1. Telephonic requests for clinical advice will be initiated using telephone encounters.
2. Telephonic / Portal requests for clinical advice will be answered within one business day with the exception of prescription refill requests which will be answered within 48 hours.
3. All clinical advice will be entered using the appropriate tab of the telephone / web encounter and routed according to protocol.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: JAN 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

During Normal hours of Operation

Telephonic requests for clinical advice will be initiated using telephone encounters.

1. Reception will initiate telephone encounters for patient contact requiring clinical advice or interaction.
2. Unless a standing order is in force, telephone encounters will be sent to the facility-specific Nursing queue in the EMR.
3. Nursing staff will monitor the Telephone / Web Encounter queue and triage telephone encounters according to priority.
4. A patient will be able to send a message to the health center from the patient portal. They will have the ability to select a particular provider.
5. Incoming messages will be routed according to the default facility listed in the patient's demographics. In other words, if a patient is seen at the Worthington office, messages sent by that patient will be routed to the Nurses queue in Worthington.
6. Once sent, patients will be able to track their sent messages the same as our "M" messaging or email.
7. Messages are received in the "T" jellybean as web encounters. The subject of the message will be listed as the reason.
8. Routing a message from the portal is essentially the same as routing a telephone encounter. There are a few additional options.
9. Note the title "Web Encounter" at the top of the screen. Also notice the addition of the Reply to Patient button next to the Add Action Taken button.

Telephonic / Portal requests for clinical advice will be answered within one business day with the exception of prescription refill requests which will be answered within 48 hours.

1. Unless marked emergency, telephone encounters will be triaged within one business day and the patient contacted by nursing or the provider.
2. Messages received through the patient portal as web encounters will be treated in the same manner as telephone encounters, except that nursing will acknowledge receipt of the encounter immediately using the reply to patient button.
3. Telephone or web encounters for prescription refills will be answered within 48 hours in accordance with published policy.

All clinical advice will be entered using the appropriate tab of the telephone / web encounter and routed according to protocol

1. All clinical advice will be documented using the Action Taken button. This will apply to encounters received during normal operating hours as well as to all calls routed to the on-call provider after hours.
    a. Lab / Imaging orders will be documented on the Labs / DI tab or the encounter

b. In the event more detailed clinical information is obtained from the patient, use the Virtual Visit tab to document.

<u>After hours of Normal Operation</u>

Telephonic requests for clinical advice will be initiated using telephone encounters.

1. The provider designated with on-call duty will ensure that they have access to the electronic medical record (EMR) either via laptop computer through VPN or Citrix or through the eClinicalMobile application.
2. The answering service will forward calls to the on-call physician as designated in the monthly listing made available to them.
3. Upon receipt of a forwarded call, the on-call physician will start a telephone encounter and document the nature of the call and any/all action taken.
4. Unless the on-call physician is the patient's primary care provider (PCP), the encounter will be routed to the appropriate PCP for follow up action on the next business day.
5. In the event that the EMR is not available after hours, the on-call physician will document the nature of the call and advice given in written format and enter the information into the EMR within one business day.

Portal requests for clinical advice will be answered within one business day with the exception of prescription refill requests which will be answered within 48 hours.

Because the electronic portal communication is designated for non-emergent communication, the procedures outlined for responses during normal hours of operation will apply for portal requests received during hours when the office is closed.

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: DEPARTMENT OF TRANSPORTATION (DOT) PHYSICALS
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for conducting Department of Transportation (DOT) physicals.

Policy:

1. DOT physicals will be scheduled with providers certified to perform DOT physicals.
2. Clients requesting a DOT or CDL physical will be scheduled for a DOT visit type.
3. The cost of the DOT physical will be $75.00 and will be paid by the patient upon check-in.
4. The visit will be coded using the E & M code 99DOT.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: DEC 2014 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

DOT physicals will be scheduled with providers certified to perform DOT physicals.

1. All HCHC providers are certified for DOT physicals EXCEPT Jon Liebman, NP
2. Physicals for bus drivers require that an MD conduct the physical and sign off on the Medical Examination Report; schedule accordingly.

Clients requesting a DOT or CDL physical will be scheduled for a DOT visit type.

1. Reception will schedule DOT physicals for any and all people requesting this service.
    a. If the requester is a current patient, schedule per usual protocol
    b. If requester is not a current patient, add requester to the patient database as a New Patient, filling in the required fields and identify as a **SELF PAY** in the demographics screen. The PCP will be identified as **NONE, None**. The Rendering Provider will be left blank.
    c. In the event a current, active patient is also due for a complete physical, it is advisable to schedule consecutive appointments, one for the DOT and one for the CPE. Each appointment will be 30 minutes in duration and charted separately.
2. Patients will be informed that, due to current insurance regulations, insurance will not cover a DOT physical and that payment of $75.00 is required upon check-in.
3. The visit code DOT will be used to schedule these physicals
4. Patients will be mailed the appropriate Medical Examination Report forms and instructed to ensure that they bring them to the appointment.
5. Reception will take payment upon check-in and provide the patient with a receipt. Patients are free to file for reimbursement with their employer.

The cost of the DOT physical will be $75.00 and will be paid by the patient upon check-in

In the event a person fails the initial DOT physical, a subsequent follow-up will be charged at $35.00, payable at check-in.

The visit will be coded using the E & M code 99DOT.

1. Providers may use the template **HCHC DOT Physical**. This template contains the following information:
    a. E & M Code – 99DOT for the visit
    b. DTAUD – CPT code for Audiometry, Pure Tone DOT, $0.00
    c. DTVIS – CPT code for Visual Acuity Screen DOT, $0.00
    d. DTURI – CPT code for Urinalysis-No micro DOT (IH), $0.00
    e. Lab Order for Urinalysis DOT (IH)
    f. Assessment V70.5 Encounter for CDL exam
    g. General Examination template

2. Since these visits are not billable to insurance companies, the CPT codes reflect a zero charge when a claim is created.
3. Providers should use the ICD-9 Code V70.5 – Encounter for CDL (commercial driving license)
4. Providers should use the E & M code 99DOT if they choose not to use the template
5. It is not permissible to use V70.0 for the ICD-9 Code since this applies to an annual physical and should be combined with an age-specific 993XX, Preventive Care visit code.
6. The Medical Examination Report will be completed and forwarded to scanning into the patient's documents (attached to the DOT visit).

Hilltown Community Health Centers, Inc.

Clinical Department Policy
Medical
Eye Care
Oral Health
Community Services
Behavior Health

SUBJECT: EMPLOYEE EXPOSURE TO BLOOD OR OTHER POTENTIALLY INFECTIOUS MATERIAL
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to minimize risk of infection when an employee is exposed to a potentially infectious material.

Policy:

Definition of terms:

1) Occupational Exposure: Contact between open skin, eye, or mucus membranes and blood or other potentially infectious material that my result from the performance of an employee's duties.
2) Other potentially infectious materials include: Any bodily fluid visibly contaminated with blood or any bodily fluids in situations where it is difficult to differentiate between body fluids: semen, vaginal secretions, cerebrospinal fluid, and fluid from sterile body cavity or contaminated saliva.

When an exposure as defined above occurs:

1) The employee will perform first aid
2) The employee or his/her designee will contact the nursing staff
3) The nurse will coordinate care for the employee and patient
4) The nurse will assist the employee with completing an incident report form which will be located at the Medical and Dental reception area

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: FEB 2016 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

1. When an exposure as defined above occurs, the employee will perform first aid to the affected area immediately as follows:
   a. Needle sticks and cuts should be washed with soap and water promptly for 3-5 minutes;
   b. Splashes to the nose, mouth or skin should immediately be flushed with water for 3-5 minutes;
   c. Eyes should be irrigated immediately with clean water, saline or sterile irrigate for 3-5 minutes.
2. A nurse should be notified immediately. This nurse will be responsible for coordinating the immediate care for the employee and the patient. In the event that a nurse is not on site, the employee will contact a working medical provider or call the on-call provider and furnish the incident report to nursing the following morning.
3. The nurse will speak to the patient and request permission for testing the patient for HIV ab/ag, Hepatitis C ab, Hepatitis B surface ag, Hepatitis B surface ab, and Hepatitis B core ab. If the patient agrees to testing, consent forms for Release of Medical Information will be completed to allow the reporting of test results to the employee's primary care provider or another medical provider who will be caring for the employee, and to the patient's primary care provider.
4. The patient will be directed to the laboratory for the requested blood work. If the lab is closed, arrangements will be made to facilitate testing, via standing orders, as quickly as possible, and the nurse will follow up as appropriate to assure that testing is performed. The patient can provide a receipt for the requested lab fees to HCHC for reimbursement.
5. The medical director or his/her designee will coordinate with the Front Desk to manage other patients who may need to be rescheduled;
6. The nurse will assist the employee in completing an incident report form, a copy of which will be forwarded to the appropriate department Director, and in arranging prompt evaluation by the employee's primary care provider or by the Emergency Department at Cooley Dickinson Hospital. If the employee opts to be evaluated at

the Emergency Department, the nurse will call to alert them that the employee is to be seen for evaluation and consideration of post-exposure prophylaxis. The employee should be evaluated within 24 hours of the incident.

7. If the exposed person is a student, the student will inform their academic institution within 24 hours and follow any additional guidelines from that institution.
8. The Department Director will be responsible for informing the QI Committee of the incident, and for promptly informing the Human Resource department of the incident. The original Incident Report form will be transferred to the Human Resource department for OSHA reporting.
9. The employee is responsible for notifying the Human Resource department as to whether post-exposure prophylaxis was initiated, whether there is evidence of acquisition of infection with HIV, HCV or HBV by the employee, and when all follow-up testing has been completed.

Hilltown Community Health Centers, Inc.

Operations Policy
Medical
Behavioral Health
Optometry

SUBJECT: EXTERNAL MEDICAL RECORDS REQUEST POLICY
REGULATORY REFERENCE: **45 CFR, Part 160 and Part 164, subparts A and E**

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to expedite medical records requests in a timely manner while ensuring the process is HIPPA compliant with all state and federal regulations.

Policy:

1. All record requests will be routed to the Reception supervisor.
2. All record requests will be tracked using actions in the EMR.
3. Any fees will be collected prior to copying the records.
4. Records will be scanned as PDF files and burned to a CD whenever possible.

Questions regarding this policy or any related procedure should be directed to front desk supervisor.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: MAR 2015 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

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John Follet, MD
Chair, HCHC Board of Directors

Procedure:

All record requests will be routed to the Reception supervisor

All medical records requests will be routed to front desk supervisor to ensure record releases are HIPPA compliant. If the request form received is not HIPAA compliant, a HCHC "Authorization to Disclose Health Information Form" will be mailed to the requestor asking them to complete a HCHC "Authorization to Disclose Health Information Form."

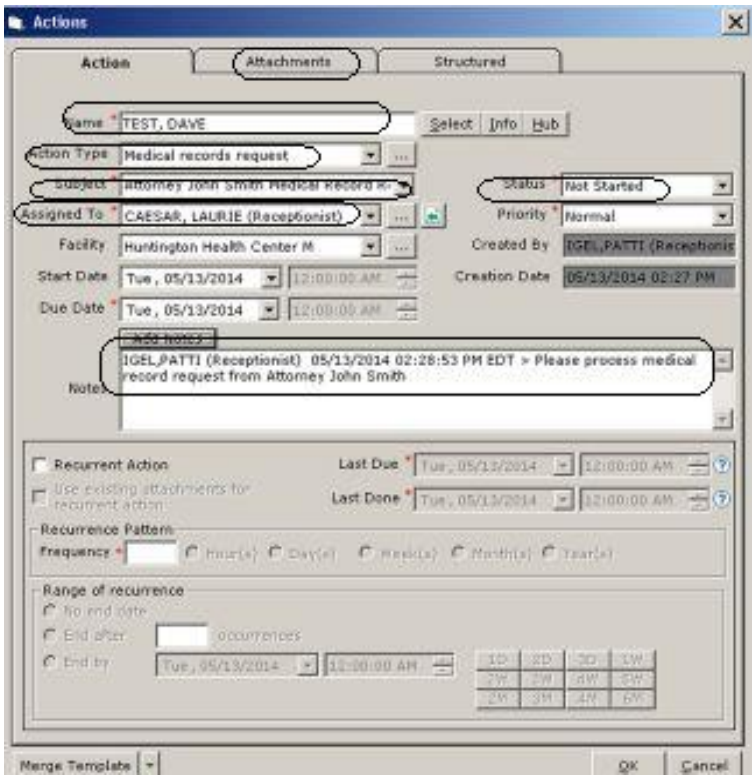
1. All subpoenas received will be routed to front desk supervisor ensuring the subpoena has written patient authorization or written satisfactory assurances regarding patient notification. If not, use subpoena letter template in eClinicalWorks and send to attorney to get satisfactory written assurance regarding patient notification.
2. Requestor will be contacted for payment before record request is processed. Payment will be recorded on day sheet with note on side of sheet "record copying charge".

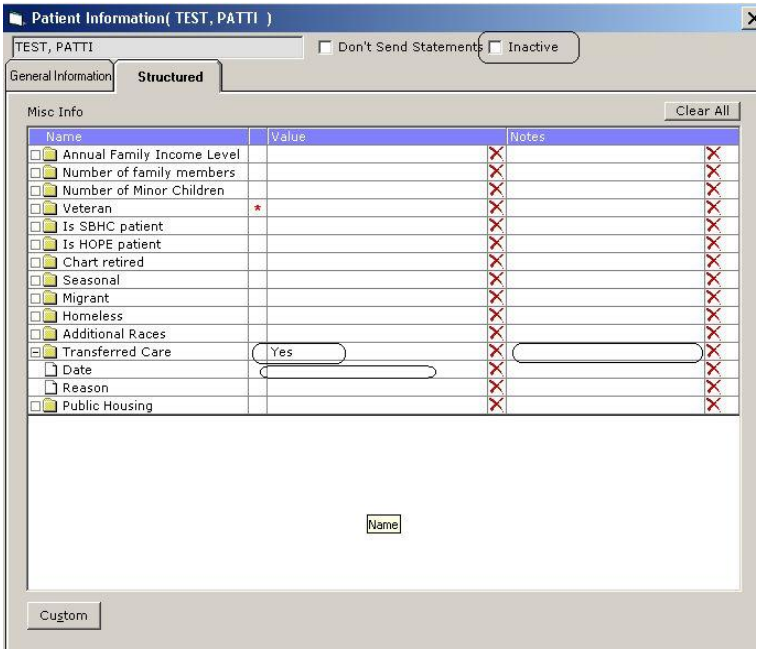
All record requests will be tracked using actions in the EMR.

1. An Action will be started and record request will be scanned and attached to the action and assigned to EMR Specialist to process request.
2. Action will be in "not started" status. The EMR Specialist will change to "in process" status when working on it. When completed, the specialist will forward the compact disc to the team receptionist who will contact the requestor to ascertain if they want the CD mailed or if they will be picking it up. The EMR Specialist should make note in action with date completed and reassign to the team receptionist.
3. If requestor will not accept records on a compact disc, that information will be annotated in the action and the EMR Specialist will process in paper form. Action will be in "not started" status.

4. Action should be changed to "completed status". Requestor will be notified records are complete and will be mailed or faxed.

5. All requests for complete transfer of records (i.e. when the patient is leaving the practice) will be processed through eClinicalWorks. Please document the following information in the structured data field in eClinicalWorks: Date transferring, reason for transfer, and in the notes field name of the practice the patient is transferring to. Make the patient inactive.





12. Any medical record requests or billing requests that need to be certified will require the certification letter template in eClinicalWorks.
13. When the care team receptionist or EMR Specialist is uncertain about a specific request, they should consult with the front desk supervisor.

Any fees will be collected prior to copying the records

Fees Charged For Processing Medical Records Requests:

1. Life Insurance Requests $50
2. Attorneys $.25 Page
3. Social Security Disability Requests Come With Payment Page which is a flat fee.
4. Disability or Motor Vehicle Requests coming directly from insurance companies cannot charge.
5. Personal Request for Records $20.00 if paper, $5.00 for CD
6. Patient Transferring Care $20.00 paper copy, compact disc copy $5.00. N/C if sent directly to new PCP, additional copy $20.00 if lost or resent.

Requests other than Social Security Disability must be prepaid before any copying is begun. All requests may take up to 2 weeks to process after the receipt of your payment.

Electronic Records Went Live:

- WHC 06/2010
- HHC 12/2010

Hilltown Community Health Centers, Inc.

Clinical Policy
All Departments

SUBJECT: FORMATION AND TRAINING OF CLINICAL CARE TEAMS
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring that clinical care teams are formed and trained to provide the best possible care for HCHC patients.

Policy:

1. Care Teams will be determined by the Medical Director and will consist of a provider/nursing staff/reception staff/medical assistant.
   a. All members of the care team will help coordinate care for individual patients.
   b. All members of the care team will contact community health workers as needed.
   c. Providers and nursing will determine hierarchy of the patient medical needs.
2. Care Teams will participate in education/training sessions every month.
   a. Content and time will be determined by Medical Director and Nursing supervisors.
   b. All content of staff education will be directly related to providing exceptional patient care.
   c. Training attendance will be recorded.
   d. In the event of a conflict, the Medical Director will have final approval over the content and time.
3. It is the responsibility of each team member to verbalize any burden they may feel in this process.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: NOV 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Hilltown Community Health Centers, Inc.

Operations Policy
Medical Department

SUBJECT: HOSPITAL / ER FOLLOW UP
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for identifying and contacting HCHC patients following an Emergency Room visit or a hospitalization.

Policy:

1. HCHC will maintain a protocol for ensuring patients are contacted within 2 business days following discharge from a hospital or an emergency room.
2. HCHC will document follow up patient contact in the electronic medical record (EMR).

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: JUN 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

1. Nursing will be notified of all Hospital / ER visits
    a. When scanners receive Hospital or ER records, they will create a telephone encounter (TE) and send to nursing queue.
    b. When providers receive hospital/ER lab or DI results, they will create TE and send to nursing queue.
    c. Prior to creating a new TE, ensure that one doesn't already exist for the incident.
2. Team or covering team nurse will contact the patient by phone or letter within 2 business days.
    a. If contact made by phone, nurse will assess the patient and complete the appropriate template. This includes reviewing the discharge instructions with the patient
    b. Patient will be sent a letter ONLY if it is clear that no follow up is needed and will complete the appropriate template
    c. Nursing will ensure that all pertinent medical information is received from the hospital or ED, including discharge summaries, lab reports, diagnostic imaging reports, etc.
    d. Nursing will arrange follow up visit, if needed or enter a referral if patient is to follow up with outside specialist.
3. TE will be forwarded to the PCP for review.

Hilltown Community Health Centers, Inc.

Operations Policy
Medical
Behavioral Health
Optometry

SUBJECT: INTERNAL PAPER CHART RETRIEVAL REQUEST POLICY
REGULATORY REFERENCE: **None**

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to pull, track and refile paper chart.

Policy:

1. All paper charts will be requested through an action in eClinicalWorks.
2. The turnaround time for chart requests is 24 business hours.
3. Worthington Health Center staff is responsible for retrieving and refiling patient charts.

Any questions regarding this policy or any related procedure should be directed to front desk supervisor.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: MAR 2015 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

All paper charts will be requested through an action in eClinicalWorks.

1. Go to the patient's hub, start a new action.
    a. **Action Type**: Medical Records Request
    b. **Subject**: Paper Chart Request
    c. **Assign to**: Any WHC Front Desk Receptionist
    d. **Add Note**: Paper Chart Request
    e. **Status**: Change to In Progress
    f. **Priority**: Should be normal unless urgent request and then it should be high.

Worthington Health Center staff is responsible for retrieving and refiling patient charts.

1. WHC front desk receptionist receiving the action will put patient's name on the list posted at the front desk for the staff member that retrieves and refiles charts.
2. Once paper chart is given to WHC front desk staff member they will put a note in action.
    a. If it is an HHC staff member requesting, add this note in action: "Chart in bag to HHC".
    b. If it is a WHC staff member requesting, add this note in action: "Chart given to requestor".
3. Action should say "in progress" and be reassigned to the requestor be on the lookout for the paper chart.
4. Once requestor is finished with the paper chart, add this note to action: "Paper chart sent to be refiled" and complete the action.
    a. In HHC, the chart will go back to WHC in the interoffice bag to be refiled.
    b. In WHC, the chart will go on the cart in the reception area to be refiled.

Hilltown Community Health Centers, Inc.

Operational Policy
Medical Department
Behavioral Health Department
School-Based Health Center
Optometry

SUBJECT: LOCKING OF CLINICAL NOTES
REGULATORY REFERENCE: **None**

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that medical progress notes generated in the electronic medical record (EMR) are available for billing in a timely manner

Policy:

1. Progress notes will be marked as **DONE** upon completion.
2. Provider notes will be locked within 72 business hours of the close of a patient visit. Additional information of a clinical nature will be added to a locked note using an addendum. Progress notes completed on the last day of the month must be locked by close of business on the first business day of the following month to facilitate a timely month-end close.
3. Progress notes resulting from nurse visits will be completed and assigned to the appropriate provider prior to close of business on the day of the visit. The exception will be injection/immunization only visits which will be locked by the nurse upon completion of the visit.
4. Unlocked notes will be monitored by the Department Manager.
5. Deviations from this policy will be referred for appropriate disciplinary action.

Questions regarding this policy or any related procedure should be directed to the Chief Operations Officer at 413-238-4138.

Originally Drafted: SEP 2010 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Hilltown Community Health Centers, Inc.

Operational Policy
Medical Reception
Medical Referrals
Nursing

SUBJECT: NARCOTIC PRESCRIPTION POLICY
REGULATORY REFERENCE: **None**

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the prescribing of narcotic medications.

Policy:

1. Patients being prescribed narcotics for an extended period of time must sign a Controlled Substance Agreement.
2. Narcotic refills will be given for a period of 28 days from the date of the last refill. Other periods may be at the discretion of the provider.
3. Patients taking greater than 50mg Morphine or the equivalent per day must have an office visit at least twice per year.
4. Patients on a narcotic regimen will have a Utox lab every six months at a minimum.
5. Narcotic refills will be recorded as a telephone encounter or in a Progress Note, if refilled during an office visit, and documented on the Controlled Substance flow sheet located in the patient documents.
6. Narcotic refills prescriptions will NOT be mailed to the patient but may be picked up by a third party designated by the patient or mailed to a pharmacy.
7. HCHC will not prescribe daily doses greater than 150mg oxycodone (or the equivalent).

Questions regarding this policy or any related procedure should be directed to the Medical Operations Manager at 413-238-4138.

Originally Drafted: MAR 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Procedure:

Patients being prescribed narcotics for an extended period of time should sign a Controlled Substance Agreement.

1. The agreement will be completed by either nursing or the provider during or immediately following the visit where the narcotics were prescribed.
2. The staff member completing the agreement with the patient will explain the specifics as required prior to releasing the prescription.
3. The signed agreement will be scanned into the patient's chart and the patient will receive a copy of the signed agreement.

Narcotic refills will be recorded as a telephone encounter or in a Progress Note, if refilled during an office visit, and documented on the Controlled Substance flow sheet located in the patient documents.

1. Upon receipt of a telephone encounter for a narcotic refill, nursing will check the flow sheet and / or chart for the following:
    a. Refill date due
    b. If the patient is tapering their narcotics (should be noted on the flow sheet)
    c. If the patient has had a UTOX screen in the last 6 months.
    d. Check the chart for the last visit date and the next visit date.
    e. Check patient documents to ensure the presence of a Controlled Substance Agreement. If no agreement is filed, complete one with the patient prior to refill.
2. If the patient is overdue for a visit, nurse/MA will notify the patient to make an appointment.
3. If refill is due, nurse/MA will enter the Rx into a telephone encounter, enter the last and next visit (or visit due if no visit scheduled) for the patient, and print with "do not fill until due date x"on the blue controlled substance prescription paper.
4. Nurse/MA will update the flow sheet with the med dose, instructions, # disp, and the next due date 28 days after the last due date(their pickup day should stay the same every month, for example, always a Thursday) and initial.
5. Nurse/MA will forward the telephone encounter to the provider with the Rx with the title "controlled substance Rx" or with the name of drug.

6. The provider will review and initial the flow sheet and sign the Rx
7. If the provider wishes to change the Rx, the provider will update the Rx, print the Rx, and update the flow sheet.
8. Provider documents “ok to pickup” in the telephone encounter sends to nurse TE box
9. Nurse/MA notifies patient Rx ready for pickup and addresses the telephone encounter
10. If the provider prescribes a narcotic during a visit, they will print the Rx and update the flow sheet. They may request their MA/nurse to print the Rx and update the flow sheet.

Patients on a narcotic regimen will have a Utox lab every six months at a minimum.

1. If the patient is overdue for a UTOX, order the UTOX and arrange to collect this when the patient comes to the health center (can be for pick-up, other appointments such as labs, dental, etc). Note in “comment section” of the flow sheet that it has been ordered or done.
2. Nursing may also order Utox in less than 6 months at their discretion, noting this on flow sheet. Likewise, they may ask a patient to come in for a pill count.
3. If patient unable to void, nursing staff can offer water to drink. Nursing may use discretion in determining whether to withhold Rx until urine sample is collected or defer testing.

Narcotic refills prescriptions will NOT be mailed to the patient but may be picked up by a third party designated by the patient or mailed to a pharmacy.

1. If the patient cannot pick up prescription, ***we do not mail prescriptions to the patient***.
2. If they need to have someone else pick up the prescription, they must arrange this ahead of time with a member of the health center team.
3. They must give a specific name of who can pick-up the Rx in a signed document which is witnessed by health center staff and then scanned into ECW.
4. When that person picks up the script, reception will ask for photo ID and compare name to the designated pick-up person. They can photocopy the ID if not known to the receptionist.

HCHC will not prescribe daily doses greater than 150mg oxycodone (or the equivalent).

1. This is roughly equal to 225mg morphine/day or 100 fentanyl patch. (morphine 30mg=oxycodone 20mg=12.5 fentanyl)
2. Because Hydrocodone (Vicodin) only comes as a combination with acetaminophen, the dose is already limited.
3. Providers will address this with their patients and discuss options, including tapering dose, referral or transfer.

Hilltown Community Health Centers, Inc.

Operations Policy
Medical Department

SUBJECT: SUPERVISION OF MEDICAL ASSISTANTS
REGULATORY REFERENCE: **None**

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the supervision of Medical Assistants in the performance of their assigned duties.

Policy:

1. The medical assistants, Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) will report directly to the Director of Nursing.
2. The medical assistants will maintain state certification.
3. A detailed list of Medical Assistant duties will be included in the job description.

Questions regarding this policy or any related procedure should be directed to the Chief Operations Officer at 413-238-4138.

Originally Drafted: APR 2014 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

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John Follet, MD
Chair, HCHC Board of Directors

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: SUPERVISION OF NURSE PRACTITIONERS
REGULATORY REFERENCE: 244 CMR 4.0 and 263 CMR 2.01-6.02

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure the supervision of Nurse Practitioners.

Policy:

Hilltown Community Health Centers (HCHC) ensures the supervision of Nurse practitioners as allowed by the applicable laws and regulations of the Commonwealth of Massachusetts Department of Public Health Boards of Registration in Medicine, and Nursing.

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

Originally Drafted: FEB 2015 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

A. Scope of Practice for Nurse Practitioners

1. In accordance with Massachusetts Regulations governing the practice of Nurse Practitioners, 244 CMR 4.0, the nature and scope of practice within HCHC includes assessing the health status of individuals and families by obtaining health and medical histories, performing physical examinations, diagnosing health and developmental problems and caring for patients with acute and chronic diseases, including ordering diagnostic tests, treatments, and medications. HCHC Nurse Practitioners provide primary care to individuals and populations as determined by the scope of practice delineated by their certification. Treatment may include the prescription and administration of oral and parenteral therapies.
2. Nurse Practitioners provide care either independently and/or collaboratively with a supervising physician by managing therapeutic regimens in a manner consistent with generally accepted medical and nursing practice, including HCHC policies and practice guidelines.
3. Nurse Practitioners seek physician consultation in cases where the practitioner feels physician expertise is indicated, including procedures or diagnoses which the practitioner determines to be beyond their expertise, and in the case of any life threatening situation. A designated physician is available on-site or by telephone at all times. Appropriate consultation with a physician may include brief, informal consultation; formal review of a patient's records; collaborative management of a patient in which the patient periodically sees the physician in addition to the NP; or transfer of the care of the patient entirely to a physician. It is the expectation that NPs will seek consultation as appropriate to their level of training and experience, and that physicians will respond in an appropriate timeframe to a request for consultation, collaborative management, or transfer of care.
4. In the setting of a clinical emergency, depending upon the assessment of the NP and provisions of advance directives, if any, the NP activates the Emergency Medical Services system by calling 911 or the relevant local telephone number; initiates Basic Life Support procedures; and/or arranges for emergency transport, as needed.

B. Prescribing Guidelines

1. Nurse Practitioners are required to provide a copy of a current Massachusetts RN license with appropriate expanded role designation from the Massachusetts Board of Registration in Nursing.
2. Nurse Practitioners prescribing medication are required to provide to HCHC a copy of valid registration to issue written or oral prescriptions for controlled substances from the Massachusetts Department of Public Health & U.S. Drug Enforcement Administration.
3. Each NP prescribing medication is covered by the Health Center's malpractice liability insurance policy.

4. Each NP will have a signed agreement with a designated supervision physician. Additional staff physicians may be designated to cover. According to the Code of Massachusetts Regulations, a supervising physician is defined as a licensee holding an unrestricted full license in the Commonwealth, who: (a) has completed training in the United States approved by the Accreditation Council for Graduate Medical Education (ACGME) or in Canada approved by the Royal College of Physicians and Surgeons in Canada (RCPSC) in a specialty area appropriately related to the NP's area of practice, is Board certified in a specialty area appropriately related to the NP's area of practice, or has hospital admitting privileges in a specialty area appropriately related to the NP's area of practice; (b) holds valid registration(s) to issue written or oral prescriptions or medication orders for controlled substances from the Massachusetts Department of Public Health and the U.S. Drug Enforcement Administration; (c) provides supervision to a nurse midwife, a nurse practitioner, a psychiatric clinical nurse mental health clinical specialist, nurse anesthetist, or physician assistant as provided for in the applicable law or regulations of the Boards of Registration in Medicine in Nursing and Physician Assistants; (d) collaborates with the NP engaged in prescriptive practice to sign mutually developed guidelines; and (e) reviews the NP's prescriptive practice as described in the guidelines.
5. Prescription from NPs must include the name of the supervising physician.
6. Medications prescribed by an NP may include any oral, transrectal, transvaginal, transdermal, topical or injectable medication within the limits of their prescriptive privileges as specified by their Massachusetts and federal Controlled Substances Registration. Intravenous therapies will not be prescribed by NPs, nor will medications not commonly used in primary care medical practice. Implantable devices and medications, including IUDs and long-acting implantable contraceptives, will only be prescribed or implanted by clinicians who have received appropriate training in their use.
7. The initial prescription of Schedule II drugs must be submitted to the supervising physician, or his/her clearly established designee, within 96 hours. This may be done electronically. It is the responsibility of the supervising physician to document their review of the prescription, and to communicate directly with the NP should they have concerns.

C. Procedure

1. Routine Audits:

   As required under state regulation, a review of each NP’s charts will be conducted at least quarterly by the designated supervising physician, focusing on the appropriateness of the prescription of medications. The results of this review will be documented, and submitted to the Medical Director or Medical Council, and to the NP. This mandatory review will be conducted as part of the regular, ongoing quality improvement process at HCHC. A copy of the audit summary sheet is kept by the NP.

This document is intended to comply with Massachusetts regulations governing the practice of nursing in the expanded role, 244 CMR 4.0. Signature below indicates understanding of the above conditions for practice, and willingness to comply.

Physician/Nurse Practitioner

Signature: _____
Name: _____
Date_____

Supervising Physician

Signature: _____
Name: _____
Date_____

Additional Designated Physicians

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Signature: _____
Name: _____
Date_____

Personnel Committee Member

Signature: _____
Name: _____
Date_____

Expiration Date:_____
(Two years from signature date)

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: LAB RESULT TRACKING
REGULATORY REFERENCE: **None**

Purpose:

Purpose: Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that lab results are received in a timely fashion and improve patient care.

Policy:

1. Providers or medical team staff using standing orders will order labs as either current (to be drawn on the day they are ordered) or future.
2. Medical team staff will reconcile lab orders on a weekly basis during pre-visit planning or other dedicated time.
3. Lab results received via fax or mail will be scanned (if thru mail) and attached to the original order and results will be entered manually for certain orders.
4. Manually reconciled lab results will be assigned to the appropriate Provider.
5. Anticoagulation lab results will be tracked by nursing in accordance with the PT/INR standing order.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: NOV 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____
Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Procedure:

Providers or Medical team staff using standing orders will order labs as either current (to be drawn on the day they ordered) or future.

1. Only labs to be drawn today should have today's date and be ordered under TODAY in the EMR.
2. If the labs are not to be drawn today, they should be ordered under FUTURE with the date that they should be done.

Medical Team staff will reconcile labs orders on a weekly basis during pre-visit planning or during other dedicated time.

1. The Team MA will reconcile labs during pre-visit planning for patients with upcoming appointments to ensure that they have been done before appointment by calling the patient and reminding them to have the labs done.
2. During other dedicated time the team MA will check all orders that need to be reconciled. The Team MA will call patient once and mail a letter if no response from phone call after 2 weeks reminding patients that are overdue by 1 month to have their labs drawn. This will be documented in a TE.
    a. If patient has had the labs done and we do not have the results, we will request them to be sent to our electronic fax.
    b. If the patient has not gotten the labs drawn as directed or declines the medical team member will create a TE to notify the Provider.
        1. If the Provider agrees the labs are not necessary, the Provider will document and labs should be cancelled by Provider or Team medical staff.
        2. If the Provider believes labs are necessary, they will arrange to contact the patient.
3. When a result returns unsolicited (virtual) and creates a duplicate order, the original order will be deleted by the medical team staff member.

Lab results received via fax or mail will be scanned (if thru mail) and attached to the original order and results will be entered manually for certain orders.

1. The scanning specialist will attach any results received via electronic fax or scanning to the lab order and send to Provider to review.
2. The scanning specialist will manually enter non-interfaced lab results such as lipids, HA1C, urine microalbumin values and forward the labs to Provider to review.
3. When no order exists, the scanner will create a new order and attach the result and forward to the Provider to review.

Manually reconciled lab results will be assigned to the appropriate Provider as designated in the protocol below:

1. Critical lab results will be brought to the attention of the ordering or covering Provider immediately upon receipt.
    a. The Provider will address the lab and the patient will be contacted by health center personnel within 12 hrs.
    b. The patient notification will be documented in the “action” section of the telephone encounter.
    c. If the patient or emergency contact cannot be directly reached, the police should be called to locate the patient to inform them if they need urgent medical attention.
2. All non-critical lab results will be assigned to the PCP, ordering Provider, or covering Provider the day the results are received.
    a. The Provider will arrange for contacting the patient with labs results within 5 business days.
    b. Follow up on abnormal results will be arranged under the direction of the PCP, ordering Provider, or covering Provider.

Anticoagulation lab results will be tracked by nursing in accordance with the PT/INR standing order.

Hilltown Community Health Centers, Inc.

Clinical Policy
Medical Department

SUBJECT: COORDINATING CARE TRANSITIONS
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for coordinating the transition of care for patients recently discharged from the hospital, emergency room or other clinical care facility.

Policy:

1. Providers, RN (care manager), nursing, medical assistants, reception staff will identify patients with a hospital admission and or Emergency Department (ED) visit.
2. RN (care manager), nursing, medical assistants/reception will share clinical information securely with admitting hospital or ED and will continue two-way communication during the patient's hospitalization.
3. RN (care manager), nursing, medical assistants/reception will request patient discharge summaries before follow-up appointment date.
4. A member of the patient's clinical care team will contact and arrange follow-up appointments within 48 hours of discharge from ED or hospital.
5. HCHC will obtain proper consent for release of information and securely exchange information with community partners.

Questions regarding this policy or any related procedure should be directed to the Practice Manager at 413-238-4126.

Originally Drafted: NOV 2012 Reviewed or Revised: MAY 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Procedure:

Providers, RN (care manger), nursing, medical assistants, reception staff will identify patients with a hospital admission and or ED visit.

1. Patients will be identified using methods laid out in the Hospital and ER follow-up policy.
2. When RNs are unavailable, nursing supervisors will receive the notifications.

RN (care manager), nursing, medical assistants/reception will share clinical information securely with admitting hospital or ED and will continue two-way communication during the patient's hospitalization.

If admitting hospital requests medical information at the time of admission and/or during the patient's hospitalization, reception will fax medical summary, (assuring confidential fax). Medical summary may include, but not limited to:

a. Medical history
b. Current medications
c. Allergies

To quickly fax a medical summary, open the patient hub:

d. Click on Medical Summary
e. Click the FAX button
f. Enter recipient information in upper left corner
g. Click the Send Fax button

RN (care manager), nursing, medical assistants/reception will request patient discharge summaries before follow-up appointment date.

1. Requests for discharge summaries will be made when the follow-up appointment is booked, or when the staff receives notice of the ED visit/hospital admission.
2. Requests will be made by fax or telephonic request to the medical records department at the rendering hospital.
3. Nursing staff will annotate both the request and subsequent receipt of the discharge summary using ED/Hospital template.

A member of the patient's clinical care team will contact and arrange follow-up appointments within 48 hours of discharge from ED or hospital.

1. Providers, RN (care manager), and nursing will determine if follow-up appointment can be waived.
2. In the case of a fractured bone, the patient will be scheduled to see orthopedics, and an office visit with primary provider may not be medically necessary at this time.
3. When in doubt, nursing will request advice from the providers.

HCHC will obtain proper consent for release of information and securely exchange information with community partners.

1. All patients sign a release of information form at the time of being registered as a new patient. The release of information form is updated on a yearly basis. The release authorizes all necessary information to be shared with 0186insurance companies, other payers, and medical providers/facilities.
2. The signed release of information form is scanned into patient's EMR record.