Hilltown Community Health Center

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BOARD MEETING
AUGUST 31, 2017
HUNTINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the July 27, 2017 Meeting Minutes

3. Welcome new Board member, Maya Bachman

4. Finance Committee Report

5. Chief Executive Officer / Senior Manager Reports

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

6. Old Business

7. New Business
   - Policy Review (Annual)
     1. Corporate Compliance Program
     3. Staff Corporate Compliance Committee
     4. School-Based Health Center Policies

   - Employee Credentialing-New Employee:
     Kimberly Krusell, OD

   - Employee Privileging:
     Frances Huberman, LCSW

8. Adjourn

HCHC BOARD OF DIRECTORS MEETING

Location:
Date/Time: 07/27/2017 5:30pm
Worthington Health Center

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

Agenda Item	Summary of Discussion	Decision/Next Steps	Person Responsible/ Due Date
Approval of Minutes 06/13/2017	John Follet called the meeting to order at 5:30pm. The June 13, 2017 minutes were reviewed by the Board members present. **A motion was made by Lee Manchester to approve the June 13, 2017. The motion was seconded by Wendy Lane Wright. The motion to approve the June 13, 2017 minutes was approved unanimously.**	The June 13, 2017 minutes were approved	
Guest: Maya Bachman	We welcomed Maya Bachman, potential Board member to the meeting. She resides in Holyoke and is a patient of HCHC. She shared with the group that she's been a paralegal for approximately 10 years and works in Springfield where they practice medical malpractice defense. She has a Masters in Public Administration with an emphasis in health care administration. She's very interested in health care administration and how healthcare and community health centers work in rural areas, such as ours. She has as legal office expertise that she can bring to the Board. John asked Maya if it was ok to		

	circulate her resume to the group and she agreed. The Board members present introduced themselves to Maya and welcomed her.		
Finance Committee	John Follet reported for the Finance Committee meeting. The summary sheet was reviewed showing that the health center did not meet revenue targets in almost every area last month. It's felt that one of the reasons for this is because patient scheduling needs to be more efficient. We've been struggling on the revenue side with medical and dental visits, in particular with the net amount per visit and the number of visits. Productivity numbers are being discussed with the providers. They're very willing to understand and want to help address the issue. The June numbers show medical $11,000 under for the month, but dental is $10,000 over budget. The behavioral health department broke even. As a reminder, the first two months of this year were not good. Since then, we've been improving each month, slowly getting into better position. It was noted that we're in a much better position now than this time last year. Matt asked if this is cyclical or structurally how things go? Frank answered his question by saying FQHCs have many requirements and top heavy costs. The hope is for Amherst to help with increasing our revenue. We're currently $25,000 under budget for expenses. Lee stated the number of visits shows we're 955 visits under budget. Is the schedule too tight or are not enough appointment slots		

	available? Some providers take more time with patients than others. Having not enough patients is not an issue. Worthington is doing well. Clinic time and vacation time for providers all play into the issue. We're currently budgeted for 2.2 visits per hour. Some providers are under that number while some are on target. If we were as efficient as possible, would we still be under for visits or would we have had enough visits? Past performance was looked at for budget purposes. Frank feels providers could meet this 2.2 target and there's enough of a demand for patients. Providers have say over the time a visit takes for each patient and this plays into the target of 2.2 patient visits per hour. The ACO we've joined will help us with becoming more efficient with care management of patients and patient-centered medical home (PCMH) activities. We're looking at restructuring clinical management within the health centers as well. It was asked if there's a back log of patients at the Huntington location. Patients seeing Sheri Cheung have a long wait for appointments. Patients are loyal to her. Another provider is out with an injury. All providers are working hard. Is it the structure or lack of patients that needs to be considered? Frank answered that it's the structure that needs to be looked at closer. For this month's dashboard review, there were two areas with issues: Operating days cash (cash on hand) and how long it takes us to pay the bills. There is not many days of		

	cash on hand available presently, but we are paying the bills. Also, the billing department has a lot of write offs due to high deductibles from patients who aren't paying them. We only send patients to the collection agency for delinquent bills over $1000. There have been some additional costs found for the Amherst project. First, there's an issue of electrical utilities that need to be moved/changed. A door needed to be dug out and electric and telephone utilities were buried there under the concrete. Those lines go to a restaurant and parking garage. Who's responsibility to move? The cost to do so is approximately $100,000. There are also $60,000 in costs related to the electrical panel within the building. It was found to be not to code and it serves the entire building. It was asked how these will be fixed? Eliza answered by saying we may need to come up a creative solution for both organizations to solve these issues. A new budget was sent to HRSA with all new costs included, but it's still a little short. Fundraising and the contingency have been reviewed. The budget gap remaining can be filled by several different ways – small mortgage, extra fundraising, Town of Amherst kicks in, and/or find another grant; there are options to consider. There has been some concern by staff stating too much effort and concern is being put into the Amherst project by management. The plan is to make capital improvements in Huntington and Worthington to make each place	Finance committee report was approved	

	look better. Painting, carpet removal, new flooring, etc. are on the list of improvements. The capital fund can be used for these. Quotes to get the work done will be worked on. **A motion was made by Kathryn Jensen to accept the finance report. It was seconded by Alan Gaitenby. With no further discussion needed, the finance committee report was approved.**		
CEO Report	Eliza's report was handed out to members. There was a meeting with the ACO, C3, today. They presented us with their vision on how they'll implement their model of care here. They agreed to let go of idea of having someone working for both us and the Community Health Center of Franklin County. It's been determined that we have 1,600 Medicaid patients according to state calculations. They will hire one person to do both at-risk complex care management and population health management. Our Medicaid number is down because no one dually-eligible is enrolled in this program, which means no elders or anyone with disabilities. The State of MA already has two programs for dual-eligible patients. The state's schedule is now March 1st to implement. The date keeps being pushed back. It was asked if this program is not looking as grand as it once did? It will be a bit messy, and complicated, but it will be ok. In a year or so, we'll know if this will be a continual thing and how many patients we have. C3 will have had time to crunch our data to see where we stand by this time.		

	We're still moving forward with moving the electronic medical record to the cloud with eCW. It's not going to be easy getting our data from CDH as they transition to other platform. C3 will extract our data once we're in the cloud. We've applied for $150,000 in HRSA funding through the AIMS Grant, which is focused on behavioral health and substance use disorders. The Board was given a copy of the application. We plan to purchase a module for Behavioral Health and perhaps a case management module as well. A Community Health Worker will be hired with some of this grant for Amherst, as well as hire a nurse to assist with case management of pain management patients. The Board should vote on our application to apply for this grant. **Alan Gaitenby made a motion to approve the application for applying for the AIMS grant. Lee Manchester seconded the motion. With no further discussion needed, the motion to apply for the AIMS grant was approved unanimously.** Eliza also reported that there will be an active shooter drill in October. It was asked if any there has been any preface for staff prior to this upcoming drill? Yes, a video was shown to staff in April on what to expect. There has been some staff pushback. Its felt statistically, an active shooter scenario is not going to happen in our area. Time should be spent on other things that are more likely. The response has been that we will do most the extreme case scenario drill to cover	AIMS grant was approved	

	all scenarios. If staff can't participate for any reason, including a history of trauma, they will be excused. Cultural sensitivity training will take place this Fall. An email was sent to department managers to inform them. Some staff may question why we're doing this. This training will start with approximately 15 staff members for an all-day training. We'll then develop plans for the rest of staff. Some staff feel we are not a welcoming place for people of color. Some staff are not comfortable with patients who display their feelings boldly. We want this to be a staff-involved process. There was a recent staff meeting where staff asked if they could attend board meetings. There was an incident when a vendor called asking when their billed could be paid, and talked to the wrong department. The call was blown out of proportion in terms of the threat to the organization, as the electric bill had crossed in the mail with the payment. At this meeting, Eliza was asked questions concerning if we were going to close and why the bills were not being paid. A second meeting was scheduled explaining cash flow and prioritizing payroll. Another issue was with payroll and raises inappropriately shared. Staff thought the CEO was being kept in the dark by the CFO, but we believe that the issue has now been put to rest. Communication from management to staff should be better, and will be addressed. There will now be a standing		

	agenda for town meetings which was requested by staff. Our medical malpractice insurance renewal – FTCA insurance – was recently completed. Part of the requirements is that the Board receive an annual (at minimum) Risk Management report. The report reiterates that HCHC has a risk management plan which is part of our Corporate Compliance plan. Risk Management is incorporated into the QI/RM committee functions, and includes clinical quality improvement and assurance, insurance reviews, staff training programs, infection control programs, HIPAA training and enforcement, scope analysis, and risk management strategies. The report presented includes items discussed at QI/RM committee from January to June, 2017, as well as other risk management activities and follow-up actions. We're monitoring for risks on a continuous basis. A Board member asked about the report's statement that QI/RM reports to the Board quarterly, and it was explained that this is a minimum requirement: QI/RM Committee minutes and reports are actually given at least six times a year. It was asked if QI looks at non-clinical risks as well? Yes, they do and will most likely do more of that. There is much interaction between risk management, corporate compliance, QI, HIPAA, emergency preparedness, etc. Part of the challenge is making sure that all of these efforts are integrated and conducted in a seamless manner. Michael Purdy, as the Risk		

	Manager, works with the QI/RM Committee to ensure that this is done. The Board agreed to accept the report when it votes to accept all the Committee reports, including the QI/RM Committee report.		
Executive Committee	There was no report from the Executive Committee this month.		
Recruitment, Orientation & Nominating (RON) Committee	There was no report this month.		
Corporate Compliance Committee	There was no report this month. Corporate Compliance policies and the plan will be up for review next month.		
Facilities Committee	There was no report this month.		
Personnel Committee	Personnel committee minutes were sent out for the past 2 meetings. The employee handbook is still being reviewed. Cell phone and social media policies still need to be reviewed. Matt Bannister said he'd be happy to share the bank's recent social media policy that was created.		
Quality Improvement/Risk Management Committee	Kathryn Jensen reported for QI this month. As a member, she's impressed with the process of reporting on things that go wrong or are not correct and how to correct them. The committee consented to becoming a risk management committee as well as QI. Michael Purdy has been chosen as risk manager. Data capturing is an ongoing issue that needs to be addressed. Is it what's been put into the system, is		

	it the software, is it the person extracting the data? These are all issues that will be addressed through the business optimization process that will start this fall, and through the transition to the cloud in the winter/spring. Poor communications from Noble Hospital radiology dept. is also ongoing. We've had many contacts with them to try to improve the slowness in receiving radiology reports, but nothing has changed. We've been lucky that nothing serious has yet happened to a patient. Baystate Noble contracts radiology services out to another organization and there has not been a willingness to make things better. When do we elevate this the next level for patient safety? Communication between departments works very well at HCHC. QI has been helpful for assisting with the NCQA renewal process. Marie Burkart is doing a fabulous job in gathering all the data and writing the report for submission which is due in September.		
Expansion Committee	Not meeting regularly, but discussions take place. Lee, John and Matt attended the reception for Jim Brassord, who rowed up the coast from Miami to NYC to raise funds for the John P. Musante Health Center. Very heartwarming and thoughtful presentation of his journey.		
Strategic Planning Committee	Action plan finished, but haven't typed it up. Janet will complete.		

Committee Reports	After all the committee reports, including the risk management report had been reviewed and discussed**, Lee Manchester made a motion to accept all committee reports along with the Risk Management report. The motion was seconded by Kathryn Jensen and without further discussion, the reports were approved.**	Committee reports and Risk Management report presented at this meeting were approved.	
Old Business	None		
New Business			
Complementary and Alternative Medicine, Change in Scope	We need to make a change to our scope to include complementary and alternative medicine. It was thought the Board had voted on this previously, but it cannot be found in previous meeting minutes. This is for Form 5A. **Kathryn Jensen made a motion to accept the change in scope to include complementary and alternative medicine for Form 5A. Matt Bannister seconded the motion. Without any further discussion, the motion to include complementary and alternative medicine in our scope was approved.**	Change in scope to include complementary and alternative medicine for Form 5A was approved	
Patient Satisfaction Survey Results, Spring 2017	Results from the Spring, 2017 patient satisfaction surveys were reviewed. It was asked what happens with the results? The QI committee reviews all results and creates a plan to make adjustments for things that need to be addressed. After-hours coverage and confidentiality are things found that need addressing. Eliza would like to compare the medical results to the national benchmark now that we're using the CAHPS survey for the medical department. This will be made part of the process when the surveys are completed.		

	There were three providers who had the majority of responses in the results. These three providers have full case loads. Lee asked if we would interpret the results by saying these 3 doctors are giving the best care? No, they see most patients. Lean projects can be created from these results going forward.		
Policy Review	Policy review presented by John Follett and Eliza Lake: (1) **Care & Management of High Risk Patients – no changes were needed. A motion was made by Lee Manchester to approve the Care & Management of High Risk Patients Policy. Without further discussion, the motion was seconded by Alan Gaitenby and approved.** Grant and Contract Approval, Board Orientation, and Board Member Recruitment and Retention Plan were tabled until next month for review.	The Following policies were approved: 1. Care & Management of High Risk Patients	
Employee Credentialing	The credentialing checklist for the following new employee was brought to this meeting as being recommended for full credentialing by the Credentialing and Privileging Committee: Frances Huberman, LCSW. John reviewed her credentialing checklist with the Board. She's a good addition to our team. She has experience with children and is looking forward to seeing patients. **With a short discussion of the employee, Kathryn Jensen moved to accept the recommendations of the credentialing and privileging committee to approve credentialing for Frances Huberman. Lee Manchester**	Credentials were granted for Frances Huberman, LCSW.	Bridget Rida to notify employee of the granted credentials

	seconded the motion, and with no further discussion, the motion passed unanimously.		
Employee Privileging	Privileging was reviewed and approved for the following employees at the Credentialing and Privileging meeting: 1. Deb Lesko, Hygienist 2. Lora Grimes, MD 3. Serena Torrey, LCSW 4. Suzanne Kresiak, LICSW 5. Randall Fisher, LICSW John explained the Lora Grimes has much experience in acupuncture and would like to offer the service here. We'll need a change in scope if this is offered. This can be used as a chronic pain non –opioid alternative service. She has many hours of training. Serena Torrey would like to offer internal family systems therapy. She attended a course and has 32 hours of internal family systems training. This includes addictions, eating disorders. She also has 60 hours of hypnotherapy training. Suzanne Kresiak has been appropriately trained in animal assisted therapy a rabbit that she brings to work and is asking for privileges in animal assisted therapy. **A motion was made to accept the recommendations of the credentialing and privileging committee to approve privileges as noted for the above providers/clinicians by Kathryn Jensen. The motion was seconded by Lee Manchester. With no further discussion needed, the privileges for Deb Lesko, Lora**	Privileges for the following staff were reviewed by the Board and approved: 1. Deb Lesko, Hygienist 2. Lora Grimes, MD 3. Serena Torrey, LCSW 4. Suzanne Kresiak, LICSW 5. Randall Fisher, LICSW	HR to notify each of the approved privileges HR to ask Suzanne for the training documentation related to animal-assisted therapy

	Grimes, Serena Torrey, Suzanne Kresiak, and Randall Fisher were approved. Eliza informed the group that a condition was placed on our HRSA grant due to the attestation of health form not being in some of the files submitted to HRSA for review. We had to prove we had he form. The corrections were made and Eliza heard this afternoon that the condition will be lifted from our grant.		
Maya Bachman	Maya was excused from the meeting and a brief discussion was held regarding Maya Bachman joining the Board. She's very interested in joining and this Board is interested in having her. A motion was made by to Kathryn to accept Maya Bachman as a new Board member. Wendy Lane Wright seconded the motion and with no further discussion needed, Maya Bachman's appointment to the Board was approved by all present. Maya was asked to return to the meeting and was then asked if she'd be willing to join. She said yes and she's very happy to be voted onto the Board.	Maya Bachman's appointment to the Board was approved	
Adjourn	A motion to adjourn the meeting was made by Lee Manchester and seconded by Alan Gaitenby. The meeting adjourned 7:25pm. The next regular Board meeting is scheduled for August 31, 2017 at 5:30pm at the Huntington Health Center.		

Submitted by,

Janet Laroche, Executive Assistant

Hilltown Community Health Centers, Inc.

Summary of Results for the Month Ended July 31, 2017

SEE STATEMENT OF INCOME STATEMENT FOR DETAIL

Revenue

1. Patient revenue services did not meet budget for the month of July 2017.
    a. Medical - $12,017 and 82 visits under budget.
    b. Dental - $21,508 and 401 visits under budget.
    c. Behavioral Health - $6,758 and 105 visits under budget.
    d. Optometry - $1,867 under budget while being 48 visits over budget. The reimbursement rate was lower than budgeted.
    e. Combined optometry hardware and pharmacy was $4,811 over the budget.
2. Grant and contract revenues were $11,898 under budget, mainly due to timing of grant spending.

Compensation and Related Expenses

1. Wages, taxes and benefits were $38,921 under budget. Primarily due to use of vacation accruals.

Other Operating Expenses

1. Total operating expenses were $5,671 or 4.3% under budget. No significand variances.

Net Operating Surplus (Deficit)

1. The Net operating results approximated the budget, but was $4,550 under budget. The lower than expected patient revenue was offset by lower staff and Other Operating Expenses.

Non-Operating Activities

1. Donations for the month amounted to $88,354. We utilized the HRSA Capital grant for $224,730.

Hilltown CHC
Summary of Net Results By Dept.
July 2017

	Net Results Gain (Deficit)			
	July 2017	**July Budget**	**YTD**	**YTD Budget**
Operating				
Medical	$ (15,153)	$ (19,684)	$ (214,445)	$ (74,254)
Dental	$ (6,256)	$ 959	$ (92,503)	$ 21,759
Pharmacy	$ 9,952	$ 4,590	$ 61,579	$ 32,130
Optometry	$ 4,017	$ 1,742	$ 8,232	$ 12,596
Behavioral Health	$ 2,523	$ 4,752	$ 35,437	$ 44,348
Community	$ (5,784)	$ (5,861)	$ 8,170	$ (50,171)
Admin. & OH	$ (3,388)	$ 4,112	$ (506)	$ (33,914)
Fundraising	$ (6,344)	$ (6,488)	$ (46,953)	$ (46,302)
Net Operating Results	**$ (20,433)**	**$ (15,878)**	**$ (240,989)**	**$ (93,808)**
Non Operating				
Donations	$ 88,354	$ 32,443	$ 236,133	$ 227,101
Capital Project Revenue	$ 224,730	$ 81,968	$ 401,460	$ 573,776
Total	**$ 313,084**	**$ 114,411**	**$ 637,593**	**$ 800,877**
Net	**$ 292,651**	**$ 98,533**	**$ 396,604**	**$ 707,069**

Hilltown CHC
Summary Financial Results And Analytics - Dashboard
July 2017

	Dec 2015	FY 2016	Budgeted FY 2017	Actual Q1 2017	Actual Six Months 2017	Actual 7/31/2017 2018	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures									
Operating Days Cash	17	19	13	12	9	8	Measures the number of days HCHC can cover daily operating cash needs.	> 30-45 Days	Not Meeting Benchmark
Current Ratio	1.45	1.78	1.19	1.49	1.70	1.96	Measures HCHC's ability to meet current obligations.	>1.25	Doing Better than Benchmark
Patient Services AR Days	23	23	25	34	30	30	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	30	50	48	56	68	63	Measures HCHC's ability to pay bills	< 60 Days	Not Meeting Benchmark
Profitability Measures									
Net Operational Margin	-4.7%	-3.2%	-0.3%	-13.1%	-5.9%	-3.5%	Measures HCHC's Financial Health	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	-2.7%	4.7%	14.7%	-9.8%	2.8%	50.6%	Measures HCHC's Financial Health but includes non-operational activities	> 3%	Doing Better than Benchmark
Leverage									
Total Liabilities to Total Net Assets	35.0%	33.0%	24.1%	38.0%	32.1%	27.4%	Measures HCHC's total Liabilities to total Net Assets	< 30%	Doing Better than Benchmark

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Jul. 2017

	Jul. 2017 Actual	Jul. 2017 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Over (Under) Cur. v. PY YTD
OPERATING ACTIVITIES								
Revenue								
Patient Services - Medical	211,983	224,000	(12,017)	1,454,110	1,623,455	(169,345)	1,375,111	78,999
Visits	1,488	1,570	(82)	10,342	11,379	(1,037)	N/A	N/A
Revenue/Visit	$ 142.46	$ 142.68	$ (0.21)	$ 140.60	$ 142.67	$ (2.07)		
Patient Services - Dental	136,378	157,886	(21,508)	1,033,229	1,145,156	(111,927)	949,082	84,147
Visits	1,064	1,474	(410)	8,650	10,691	(2,041)	N/A	N/A
Revenue/Visit	$ 128.17	$ 107.11	$ 21.06	$ 119.45	$ 107.11	$ 12.33		
Patient Services - Beh. Health	25,524	32,282	(6,758)	208,450	232,119	(23,669)	116,788	91,662
Visits	226	331	(105)	2,160	2,380	(220)	N/A	N/A
Revenue/Visit	$ 112.94	$ 97.53	$ 15.41	$ 96.50	$ 97.53	$ (1.02)		
Patient Services - Optometry	13,921	15,788	(1,867)	97,544	113,554	(16,010)	74,470	23,074
Visits	209	161	48	1,309	1,158	151	N/A	N/A
Revenue/Visit	$ 66.61	$ 98.06	$ (31.45)	$ 74.52	$ 98.06	$ (23.54)		
Patient Services - Optometry Hardware	9,432	6,833	2,599	42,039	47,831	(5,792)	47,078	(5,039)
Patient Services - Pharmacy	12,629	10,417	2,212	84,753	72,919	11,834	94,000	(9,247)
Quality & Other Incentives	328	-	328	4,280	-	4,280	23,701	(19,421)
HRSA 330 Grant	119,665	128,875	(9,210)	853,332	902,125	(48,793)	646,730	206,602
Other Grants & Contracts	46,529	49,217	(2,688)	477,837	404,519	73,318	530,154	(52,317)
Int., Dividends Gain /Loss Investments	94	417	(323)	44,581	2,919	41,662	12,732	31,849
Rental & Misc. Income	2,437	2,352	85	17,951	16,464	1,487	18,585	(634)
Total Operating Revenue	578,920	628,067	(49,147)	4,318,106	4,561,061	(242,955)	3,888,431	429,675
Compensation and related expenses								
Salaries and wages	400,134	437,840	(37,706)	3,099,471	3,148,272	(48,801)	2,920,406	179,065
Payroll taxes	28,695	33,318	(4,623)	237,570	239,582	(2,012)	225,521	12,049
Fringe benefits	42,813	39,405	3,408	288,980	283,341	5,639	249,634	39,346
Total Compensation & related expenses	471,642	510,563	(38,921)	3,626,021	3,671,195	(45,174)	3,395,561	230,460
No . of week days	21	21	-	151	151		151	
Staff cost per week day	$ 22,459	$ 24,313	$ (1,853)	$ 24,013	$ 24,313	$ (299)	$ 22,487	$ 1,526

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Jul. 2017

	Jul. 2017 Actual	Jul. 2017 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Over (Under) Cur. v. PY YTD
Other Operating Expenses								
Advertising and marketing	10	2,354	(2,344)	2,407	16,478	(14,071)	5,881	(3,474)
Bad debt	328	-	328	28,843	-	28,843	767	28,076
Computer support	8,296	9,895	(1,599)	52,957	69,265	(16,308)	82,100	(29,143)
Conference and meetings	-	1,584	(1,584)	11,535	11,088	447	15,484	(3,949)
Continuing education	5,874	2,875	2,999	18,618	20,125	(1,507)	10,190	8,428
Contracts and consulting	1,513	4,917	(3,404)	32,882	34,419	(1,537)	51,408	(18,526)
Depreciation and amortization	13,695	14,646	(951)	95,863	102,522	(6,659)	97,392	(1,529)
Dues and membership	3,078	2,621	457	62,105	68,347	(6,242)	17,970	44,135
Equipment leases	1,720	1,609	111	13,498	11,263	2,235	12,133	1,365
Insurance	1,210	1,042	168	8,392	7,294	1,098	7,101	1,291
Interest	1,526	1,551	(25)	10,977	10,857	120	12,481	(1,504)
Legal and accounting	4,663	2,917	1,746	23,547	20,419	3,128	18,002	5,545
Licenses and fees	2,232	4,374	(2,142)	27,381	30,618	(3,237)	26,744	637
Medical & dental lab and supplies	21,044	15,833	5,211	115,406	110,831	4,575	83,394	32,012
Merchant CC Fees	1,349	792	557	8,369	5,544	2,825	5,450	2,919
Office supplies and printing	2,493	3,375	(882)	18,814	23,625	(4,811)	26,356	(7,542)
Postage	2,094	1,288	806	10,517	9,016	1,501	8,599	1,918
Program supplies and materials	18,584	16,833	1,751	116,892	117,831	(939)	108,763	8,129
Pharmacy & Optometry COGS	4,882	9,000	(4,118)	31,793	63,000	(31,207)	36,289	(4,496)
Recruitment	723	708	15	2,478	4,956	(2,478)	1,168	1,310
Rent	3,140	3,238	(98)	21,439	22,666	(1,227)	23,850	(2,411)
Repairs and maintenance	11,674	14,375	(2,701)	92,350	100,625	(8,275)	106,045	(13,695)
Small equipment purchases	-	2,375	(2,375)	6,979	16,625	(9,646)	12,346	(5,367)
Telephone/Internet	9,395	7,722	1,673	63,441	54,054	9,387	47,731	15,710
Travel	4,573	3,958	615	28,212	27,706	506	25,643	2,569
Utilities	3,615	3,500	115	27,379	24,500	2,879	26,053	1,326
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	127,711	133,382	(5,671)	933,074	983,674	(50,600)	869,340	63,734
Net Operating Surplus (Deficit)	**(20,433)**	**(15,878)**	**(4,555)**	**(240,989)**	**(93,808)**	**(147,181)**	**(376,470)**	**135,481**
NON-OPERATING ACTIVITIES								
Donations, Pledges & Contributions	88,354	32,443	55,911	236,133	227,101	9,032	338,118	(101,985)
Loan Forgiveness	-	-	-	-	-	-	30,333	(30,333)
Capital Grants	224,730	81,968	142,762	401,460	573,776	(172,316)	196,879	204,581
Net Non-operating Surplus (Deficit)	**313,084**	**114,411**	**198,673**	**637,593**	**800,877**	**(163,284)**	**565,330**	**72,263**
NET SURPLUS/(DEFICIT)	**292,651**	**98,533**	**194,118**	**396,604**	**707,069**	**(310,465)**	**188,860**	**207,744**

Hilltown Community Health Centers
Balance Sheet - Monthly Trend

	12/31/2016	1/31/2017	2/28/2017	3/31/2017	4/30/2017	5/31/2017	6/30/2017	7/31/2017
Assets								
Current Assets								
Cash - Operating Fund	321,717	219,552	218,737	264,566	222,786	402,994	145,334	151,179
Cash - Restricted	350,559	343,796	319,043	327,319	393,082	424,966	410,286	556,104
Patient Receivables	815,560	776,855	779,047	812,996	816,281	867,340	809,623	782,403
Less Allow. for Doubtful Accounts	(55,491)	(56,503)	(60,352)	(60,673)	(75,644)	(77,171)	(77,991)	(75,684)
Less Allow. for Contractual Allowances	(321,655)	(326,543)	(335,744)	(361,085)	(327,694)	(373,831)	(335,420)	(310,076)
A/R 340B-Pharmacist	13,596	11,367	10,545	12,172	8,577	5,841	11,185	10,182
A/R 340B-State	893	1,012	676	941	420	414	252	239
Contracts & Grants Receivable	111,318	137,950	134,068	124,972	119,372	113,655	116,403	84,304
Prepaid Expenses	25,010	32,616	36,914	18,647	19,310	19,687	77,987	13,039
A/R Pledges Receivable	129,791	127,813	139,875	130,478	149,793	133,596	122,263	106,950
Total Current Assets	1,391,298	1,267,915	1,242,810	1,270,334	1,326,284	1,517,492	1,279,921	1,318,640
Property & Equipment								
Land	204,506	204,506	204,506	204,506	204,506	204,506	204,506	204,506
Buildings	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913
Improvements	872,646	872,646	872,646	872,646	872,646	872,646	872,646	872,646
Equipment	974,504	974,504	974,504	974,504	974,504	974,504	974,504	974,504
Construction in Progress	52,011	90,900	114,025	146,318	153,325	260,249	339,753	521,910
Total Property and Equipment	4,717,580	4,756,469	4,779,594	4,811,887	4,818,894	4,925,817	5,005,322	5,187,479
Less Accumulated Depreciation	(2,031,443)	(2,045,356)	(2,059,269)	(2,072,527)	(2,086,222)	(2,099,916)	(2,113,611)	(2,127,306)
Net Property & Equipment	2,686,137	2,711,113	2,720,324	2,739,360	2,732,672	2,825,901	2,891,710	3,060,173
Other Assets								
Restricted Cash	53,811	53,816	53,820	53,825	53,829	53,834	53,838	53,843
Pharmacy 340B and Optometry Inventory	18,555	18,663	21,100	19,236	19,315	15,253	14,446	14,445
Investments Restricted	5,786	5,786	5,786	6,055	6,055	6,055	6,142	6,142
Investment - Vanguard	419,937	419,937	419,937	448,180	448,180	448,180	463,696	463,696
Total Other Assets	498,089	498,203	500,643	527,296	527,379	523,322	538,122	538,126
Total Assets	**4,575,524**	**4,477,230**	**4,463,778**	**4,536,989**	**4,586,335**	**4,866,714**	**4,709,754**	**4,916,939**

Hilltown Community Health Centers
Balance Sheet - Monthly Trend

	12/31/2016	1/31/2017	2/28/2017	3/31/2017	4/30/2017	5/31/2017	6/30/2017	7/31/2017
Liabilities & Fund Balance								
Current & Long Term Liabilities								
Current Liabilities								
Accounts Payable	229,370	277,509	309,069	321,677	295,346	292,654	312,269	240,466
Notes Payable	1,753	-	-	-	-	-	-	-
Sales Tax Payable	67	22	32	55	21	41	64	35
Accrued Expenses	2,528	8,626	2,040	(10,150)	(5,185)	(10,565)	(5,527)	(488)
Accrued Payroll Expenses	363,288	408,681	405,954	492,878	499,697	581,810	378,692	367,688
Payroll Liabilities	19,074	17,628	15,189	14,309	15,277	16,828	14,397	16,054
Unemployment Escrow	826	826	826	826	826	826	826	826
Deferred Contract Revenue	93,234	55,482	47,378	33,370	71,960	67,601	53,743	46,807
Total Current Liabilities	710,139	768,772	780,488	852,964	877,942	949,195	754,464	671,388
Long Term Liabilities								
Mortgage Payable United Bank	201,737	200,383	199,025	197,612	196,247	194,862	193,490	192,097
Mortgages Payable USDA Huntington	201,165	200,234	199,299	198,253	197,307	196,321	195,363	194,367
Total Long Term Liabilities	402,902	400,617	398,323	395,865	393,554	391,183	388,854	386,464
Total Liabilities	**1,113,041**	**1,169,390**	**1,178,812**	**1,248,830**	**1,271,496**	**1,340,378**	**1,143,318**	**1,057,852**
Fund Balance / Equity								
Fund Balance Prior Years	3,462,483	3,307,841	3,284,966	3,288,160	3,314,839	3,526,337	3,566,436	3,859,087
Total Fund Balance / Equity	3,462,483	3,307,841	3,284,966	3,288,160	3,314,839	3,526,337	3,566,436	3,859,087
Total Liabilities & Fund Balance	**4,575,524**	**4,477,230**	**4,463,778**	**4,536,989**	**4,586,335**	**4,866,714**	**4,709,754**	**4,916,939**

QI COMMITTEE
Location: Huntington Health Center
Date/Time: 07/18/2017 8:15am

TEAM MEMBERS: Cheryl Hopson (chair); Eliza Lake, CEO; Janet Laroche, Admin & Lean Team Leader; Michael Purdy, CCCSO; Kathryn Jensen, Board Representative; Jon Liebman, ANP; Sheri Cheung, Medicine Representative; Serena Torrey, Behavioral Health Representative; Cynthia Magrath, Practice Manager; Marie Burkart, Development Director

ABSENT: Kim Savery, Community Programs Representative; MaryLou Stuart, Dental Representative

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 8:15 am. The minutes from the June 27, 2017 meeting were reviewed. With no discussion needed, Kathryn Jensen made a motion to approve the minutes as written. Cynthia Magrath seconded the motion. The June 27, 2017 minutes were approved unanimously.	The June 27, 2017 minutes were approved.	
Peer Review / Department Reports Behavioral Health Medical	Serena Torrey reported for Behavioral Health and distributed the department's quarterly report. No legal actions were taken during the 2nd quarter of 2017. The patient waitlist presently has approximately 60 people. The department has hired a new clinician who began this week. A clinician's typical case load is 50-60 clients. Referrals continue to be received by the department. The intake coordinator is confirming with people who are placed on the waitlist to be sure they want to remain. It's being made sure that people on the list are in a position to wait for services. It was asked if people on the waitlist are considered an official referral? This needs to be determined. Sheri Cheung reported for the medical department this month. She informed		

	the group that first quarter peer reviews have been completed. All 4 physicians have reviewed 8 charts per provider. It's been determined that diagnostic imaging and labs need quicker follow up; ICD9 vs ICD10 coding is an issue - eCW has a few bugs and details that providers need to be aware of; adequate review of systems is needed. There's been an improvement from the previous quarter. There were two patient complaints - one medication error that needs to be addressed with nursing and a review of processes; One negative posting/rating on Facebook. The patient was not complaining, but venting online. It was asked how to handle this? Should the patient be called? It was determined that the social media posting should be treated as a complaint. Noble Hospital continues to be an issue for diagnostic imaging. There was an incident concerning a patient with an abnormal chest x-ray result which was not received timely. The imaging file does not say where the file came from. Time was spent trying to figure out where the file came from. Also, it took 8 days to receive the previous chest x-ray image from Noble so it could be reviewed. Jon wrote a formal complaint to the QI Director at Noble about this issue. Thankfully, the patient was not injured. Should we consider a call to DPH? A call to the patient's insurance company? We continue to have an issue with collecting data. Briana continues to work on this. Decent data for quality measures is not available and our internal ability to look at data is weak. In November, our renewal application for federal funding for the next 3 years will be due and data will be needed for this.		

	Data is going to be required more and more as things move forward. Senior management needs to discuss further. It's on their next meeting agenda.		
New Business	None		
Old Business			
1422 Grant	Kim Savery submitted her report in advance of this meeting. Things are progressing. Data for this project comes from a very small group of patients that someone pulls for this grant project. Data has to be cleaned once pulled and has been a very laborious process.		Kim will continue to report on this
Patient Satisfaction Survey	Janet Laroche reported on the results from the spring 2017 surveys. The Medical Department used the CAHPs survey for the first time. It contains 52 questions. There were 239 responses. Overall, very positive results were received. Upon reviewing the data things that need improvement include: Weekend, evening and holiday hours need to be communicated better to patients; Better overall communication about labs and imaging results is needed; Better communication between PCPs and specialists was identified; address social determinants of health in a way that patients find helpful. Now that we're using the CAHPs survey, it would be useful to compare our data with the national statistics available. For NCQA, the next step for the medical department surveys is to determine what could be used as an improvement project. It was discussed to use weekend, evening and holiday hour coverage to be communicated better. Reporting lab results to patients needs to be improved. Is there a protocol for providers to follow? Lab results received outside the interface is another issue to work on. It's not completely clear if all these get communicated to patients.		

	Patients are notified by the patient portal and a letter is mailed to patients stating the results. Not all of our patients access the web. Survey results for Dental, Behavioral Health, Eye Care and Community Programs were all good results as well. A couple of these departments are still having difficulty collecting the specified number of completed surveys.		
NCQA-PCMH	Marie Burkart attended the meeting. She's focusing on getting all the pieces needed for the NCQA renewal application. Section PCMH 1 has been sent to consultant for review. Overall, the submission looked good. Section PCMH 6 is being worked on now. Marie has asked if either no-show rates or wait times could be reported on for this section? It was suggested that wait times for an appointment could be pulled out of eCW easily. It was asked if any data has been collected and an improvement plan has been created within the past 12 months on this?		
Risk Management	Risk management will now be incorporated into this meeting. Eliza sent out the draft risk management plan to the group. She reported that much of this plan is already being done and is included in our corporate compliance plan. The risk management plan is required for our FTCA application which is due July 24. It was suggested that it would be useful to have a document that lists all items needed for various requirements and how often they need to be reported upon and to whom. Risk management will be a standing item on the QI meeting agenda going forward.		

HRSA Site Visit Follow-up	Eliza has a project officer meeting today. We still have an outstanding issue with some employee files that were sent in for review. Because of this, a condition has been placed on our funding and could stop us from receiving a renewal of our FTCA coverage. Eliza's been working closely with our project officer and this will hopefully be resolved by July 24 when the FTCA renewal application is due.		
Adjourn	There being no other business, Eliza Lake moved that the meeting be adjourned. After a second by Jon Liebman, the meeting was adjourned at 9:15am. The next meeting is scheduled for **Tuesday, August 15, 2017** at 8:15am at the Huntington Health Center.		

Respectfully submitted,
Janet Laroche

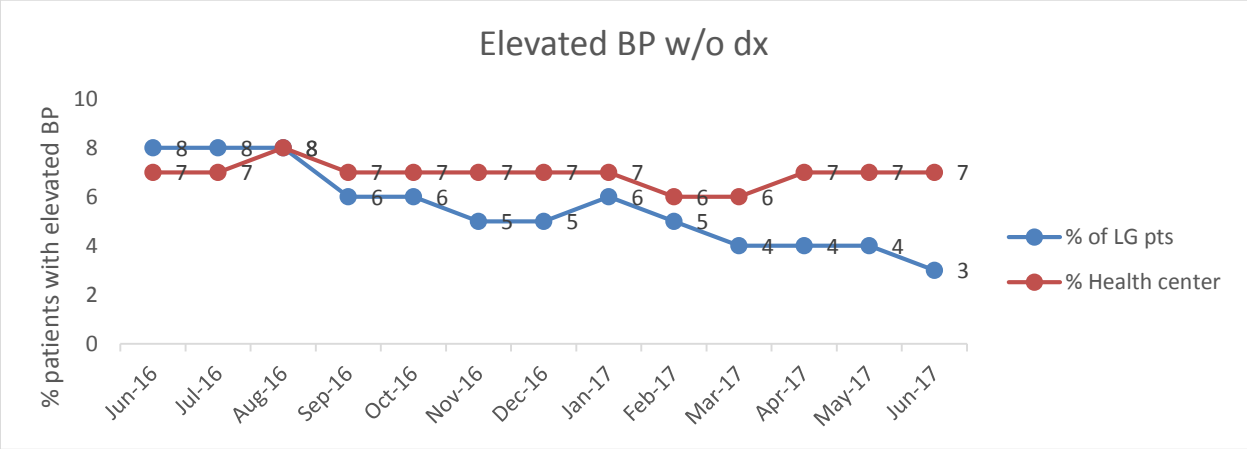
Quality of Care and Health Outcomes and DIsparities Dashboardi
HCHC 330 Grant

Measure	Description	HCHC Stated Goal/Benchmark (with Timeline)	Last Reported (as of 4th quarter 2016)	Current Percentage	Notes
As of: 2nd quarter 2017					
Department Prioritized Measures , Behavioral Health					
Number of Pts Currently Served	183	200.00	196.00	91.5%	
Number of Pts on Waitlist	64	10.00	51.00		
Psychiatric referrals this quarter	3	NA	3.00		
Cases Peer Reviewed this quarter	8	8.00	9.00	100.0%	
Pts Referred for Targeted Intervention this quarter	4	4.00	2.00	100.0%	
Legal Actions Involving BH this quarter	0	NA	0.00		
Urgent Care Visits this quarter	2	NA	2.00		
Crisis Support Given this quarter	0	NA	1.00		
Average Percent No-Shows	24%		21.0%		

HILLTOWN COMMUNITY HEALTH CENTERS, INC.
1422 MONTHLY PROGRESS REPORT
JUNE 2017

HTN: Reduce the number of potentially undiagnosed HTN patients

I. Undiagnosed HTN Registry
List Project(s):* none
Data:
- How many patients from the registry have been diagnosed with HTN: 2
- How many patients have been removed from registry because they were found to not have HTN, if known(R03.0 or other reasons) 15



Challenges/Successes:
The new DRVS report identifies those with a dx of R03.0 (elevated BP without dx) so we know who is already being monitored (and therefore are not "hiding in plain sight"). For our testing provider, it brings her percentage down from 5% to .06% and for the entire health center (including the testing provider) it brings the percentage down to 5%.

II. Pre-visit Planning HTN identification efforts
Project(s):*
Data:
- How many new patients have been diagnosed with HTN as a part of this project, if known?

Challenges/Successes:
Dissemination to stakeholders as requested by medical director. Strong concerns were voiced and Supervisors met to sort out responsibilities for parts of the process. This resulted in a decision to spread the test of the process across the health center all at once. This will certainly result in lots of feedback.

III. HTN Control efforts
Projects: Continuing to finalize an appropriate registry. Finalizing our recommended workflow.
- Current HTN control rate: 71%

Challenges/successes
This process involves fewer team members so the challenge of staff member time is less relevant here.

Prediabetes: Increase the number of at risk patients who receive prediabetes screening.

I. Prediabetes Registry (diagnosis or elevated A1c in prediabetes range) Project(s):*
Still dealing with first round of inquiries to providers regarding diagnoses for patients with prediabetes labs
Data:
- How many patients from the registry because of elevated labs have been given diagnosis? 26 total

* If you have not started a project for an area, please provide timeline for when your work is expected to begin.

HILLTOWN COMMUNITY HEALTH CENTERS, INC.
1422 MONTHLY PROGRESS REPORT
JUNE 2017

Row Labels	Count of MRN
WHC Prov 1	2
WHC Prov 3	3
WHC Prov 4	7
Grand Total	**12**

In the beginning of May, QI sent a list to each provider of their patients who had labs indicating prediabetes with no diagnosis. There were 41 names on the list. Records for all but these have been corrected (or the provider let me know they don't have the dx so they should come off the list).

- How many patients from the registry have been reached for discussion about DPP? In June received 2 referrals but have not been able to discuss options due to lack of patient response.
Challenges/Successes: A subset of providers expressed strong concerns with the draft letter to go newly diagnosed patients. We continue to await their suggested edits.

II. Pre-visit Planning to identify at risk for prediabetes/diabetes
Project(s):* No change
Data:
- How many new patients were screened for prediabetes?
- How many new patients have been diagnosed as a result of pre-visit planning projects?

Challenges/Successes:

PLEASE SHARE THIS MONTH'S ACTIVITIES INVOLVING CHWS

*Jessica has changed the items under this category to better match your existing reporting (see the CHW Performance Measures from the annual work plan)

1. **Outreach from registry**. Please describe how the CHWs are involved. You can do so in narrative manner or numeral as written below:
Calls attempted from registry this month: 2
Conversations with patients from registry this month: Patients have not responded to outreach.

2. **Number of patients referred to (non-DPP) outside community resources this month: 31**

3. **Number of referrals (1 patient referred to 5 services counts as 5 referrals) to (non-DPP) outside community resources this month: 49**

Please provide a breakdown of each non-DPP referrals (including CDSMP, DSME, Nutrition, Walking Clubs, Cooking or Nutrition classes, or other community program even if offered in the clinic)

Name of Program	Referrals Current Month
Walking Group	**8**
STAVROS	**7**
Hilltown Safety at Home	**4**
Insurance Navigators	**5**
YMCA	**6**
Swim Club	**6**

* If you have not started a project for an area, please provide timeline for when your work is expected to begin.

WestMass Elder Care	**1**
LifePath	**1**
Council on Aging	**6**
Cooley Dickinson Mammogram Dept.	**3**
Christopher Heights Assisted Living	**1**

4. **Number of patients who received support from CHWs on health education and self -management skills to HTN this month: 23**

5. **Number of patients who received support from CHWs on health education and self -management skills to pre-Diabetes this month: 23**

DPP Referrals this month

	June	Cumulative
Number of Patients Referred to DPP (all methods)	0	361
Number patients referred through eReferral	0	11
Number of new enrollments (if known):	0	19
Number of patient with whom DPP discussed	0	70

Pharmacy Pilot

Please provide a brief (1-2 sentences) update on the pharmacy pilot.
Pharmacist consultant presented at Medical Providers meeting and recruited 2 Provider champions to help the referral process – one at each site. Several meetings about strategies for data collection.

* If you have not started a project for an area, please provide timeline for when your work is expected to begin.

Administrative Policy
All Departments

SUBJECT: CORPORATE COMPLIANCE PROGRAM
REFERENCE: U.S. Statutes and Federal and State Regulations

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this Compliance Plan to have a formal documented process for ensuring that board members, officers, employees and individuals affiliated with HCHC comply with current statutes and regulations.

Policy

1. All Board members (officers and directors), employees, agents, and volunteers ("Individuals Affiliated with HCHC") are expected to meet high standards of professional behavior whenever he or she acts on behalf of HCHC.
2. Each Individual Affiliated with HCHC has a personal responsibility for becoming familiar with and complying with the laws, regulations, and policies and procedures related to his or her responsibilities.
3. All Individuals Affiliated with HCHC are required to comply with the Standards of Conduct and Compliance Program by signing and returning the acknowledgement attached to this document.
4. HCHC will ensure that its Corporate Compliance Program will evolve as the laws, and interpretations of the laws, change.

Corporate Compliance Program

I. Compliance Objectives

It is important to note that compliance is not limited to fraud and abuse or patient confidentiality. As a business entity, it is HCHC's objective to comply with all federal and state laws and regulations, as well as to use general good business practices to protect its reputation and avoid or prevent any Conflicts of Interest in its dealings with Individuals Affiliated with HCHC or its business partners.

Violations, whether intentional or unintentional, may result in significant civil or criminal sanctions, or both, for institutions and personnel that do not comply with the law. HCHC is committed to ensuring that it complies with these laws and regulations.

HCHC's Corporate Compliance Program is a comprehensive organizational program that:

- Identifies the federal and state laws and regulations governing the organization and ensures compliance with these mandates.
- Develops and maintains written policies and procedures, Standards of Conduct, and advances quality improvement programs throughout the organization.

- Performs periodic self-audits to monitor its compliance with applicable laws and policies governing the organization.
- Conducts ongoing, relevant, and comprehensive education and training for all Individuals Affiliated with HCHC.
- Guides implementation of corrective action plans to improve HCHC's operations and practices.

II. Elements of HCHC's Corporate Compliance Program

The Compliance Program is a process that has been established to assist Individuals Affiliated with HCHC in understanding and complying with all different areas of business. The Compliance Program consists of the following elements:

A. Appointment of a Compliance Officer

HCHC has appointed the Chief Executive Officer (CEO) as the Compliance Officer. The Compliance Officer will be assisted by the members of the Compliance Committee in the development and maintenance of the Corporate Compliance Plan. The Compliance Officer is assured direct access to HCHC's Board of Directors for the purpose of making reports and recommendations on compliance matters. The Compliance Officer's duties include:

- Taking reports of problems or violations and coordinating corrections;
- Suggesting policies related to compliance to the Board and developing procedures implementing policies approved by the Board;
- Overseeing periodic compliance audits and monitoring compliance activities;
- Training Individuals Affiliated with HCHC in compliance matters;
- Reporting incidents of non-compliant conduct to the CEO and Board, as appropriate; and
- Ensuring that appropriate disciplinary actions or sanctions are applied.

To support the Compliance Officer in meeting his/her responsibilities, HCHC has established a staff-level Compliance Committee composed of the following positions:

- Chief Finance Officer, Compliance Contact
- Chief Clinical & Community Services Officer, Compliance Contact
- Executive Assistant, Compliance Contact

The Compliance Committee will meet at least twice annually or more frequently as needed.

B. Written Standards of Conduct and Policies and Procedures for Promoting Compliance

As part of its efforts to implement an effective Compliance Program, HCHC has established written standards to assist Individuals Affiliated with HCHC in recognizing compliance issues and to guide them to do the right thing. This includes but may not be limited to the following:

1. Annex 1: Standards of Conduct
2. Annex 2: Legal Statutes and Regulations

3. Annex 3: Billing, Claims and Records
4. Annex 4: Procurement and Referrals
5. Annex 5: Audits, Investigation and Organizational Response
6. Annex 6: Risk Management Plan
7. Annex 7: Privileging and Credentialing Program
8. Annex 8: 340-B Pharmacy Program
9. Annex 9: Emergency Operations Plan (in development)

HCHC will continue to develop or revise and implement policies and procedures consistent with the requirements and standards established by the Board of Directors, federal and state law and regulations, relevant reviewing and accrediting organizations (such as the federal Bureau of Primary Health Care) and, as applicable, managed care organizations and commercial health plans. It is HCHC's policy to address identified areas of risk and to promote compliance by developing written policies and procedures that establish guiding principles or courses of action for affected personnel.

C. Education and Training

It is HCHC's policy to develop and offer initial Corporate Compliance training upon hire or engagement. In addition, ongoing and regular educational and training programs will be conducted to ensure all Individuals Affiliated with HCHC are familiar with its Compliance Program and Standards of Conduct as well as HCHC's other policies and procedures.

Specifically, HCHC will ensure that Individuals Affiliated with HCHC understand the fraud and abuse laws and, if applicable to their position, the coding and billing requirements imposed by Medicare, Medicaid, and other applicable government health care programs and commercial health plans.

HCHC communicates this information, along with information regarding its standards, policies, and procedures, to all Individuals Affiliated with HCHC by requiring participation in annual In-service training programs, through distributing information about what is required for HCHC to succeed in its compliance efforts via semi-weekly email reminders, and other training programs as appropriate.

D. Maintaining Open Lines of Communication

HCHC is committed to establishing and maintaining meaningful and open lines of communication between the Compliance Officer, the Compliance Committee, and the Board of Directors as well as between Individuals Affiliated with HCHC and the Compliance Officer.

Reporting suspected compliance infractions is the responsibility of every employee. Reports can be made in person to the Compliance Officer or any of the Compliance Contacts. Employees who feel uncomfortable reporting in this fashion may report suspected infractions by using the **Compliance Hotline at extension 218, or at 413-667-3009 ext. 218**. This line will be monitored

daily. Employees may also send the Compliance Officer written reports, which may be sent through intra-office mail.

Employees making good-faith reports of suspected compliance infractions are offered the protection of the **Whistleblower's Act of 1989**.

Employees having questions about our corporate compliance plan can also make use of the Hotline or, they can feel free to contact any of the Compliance Committee members by phone or through written communication.

E. Monitoring, Audits and Evaluation

As part of its efforts to implement an effective Compliance Program, HCHC strives to:

- Regularly monitor compliance with applicable statutes and regulations through peer review, chart audits, etc.
- Periodically conduct more comprehensive self-audits of its operations to ascertain problems and weaknesses in its operations and to measure the effectiveness of its Compliance Program.
- Contract with outside consultants on an annual or biennial basis to conduct full audits of specific operational or clinical areas, as needed and appropriate.

F. System for Responding to Allegations of Improper and Illegal Activity

To support HCHC's commitment to establishing and maintaining meaningful and open lines of communication, HCHC will take appropriate steps to respond to every report of suspected unethical or non-compliant conduct, as well as to address unreported incidents of suspected unethical or non-compliant conduct. These steps may include conducting investigations, reviewing documentation, implementing or revising policies and procedures, offering training, conducting audits, and imposing disciplinary action.

G. Corrective Action and Disciplinary Standards

HCHC is committed to ensuring that its Compliance Program and Standards of Conduct, and its policies and procedures are adhered to by all Individuals Affiliated with HCHC through consistent enforcement, which may be accomplished by imposing appropriate disciplinary action. It is HCHC's goal that every Individual Affiliated with HCHC understands the consequences of improper or non-compliant activities and that all violators will be treated equally and in compliance with HCHC's discipline policy.

III. Employee and Affiliated Individuals' Responsibilities

Individuals Affiliated with HCHC are expected to comply with HCHC's Corporate Compliance Plan, all Annexes to that plan, and its policies and procedures. Affiliated Individuals are **required** to promptly report suspected violations of the Corporate Compliance Plan, its Annexes, and its policies and procedures or other laws, regulations or policies.

Reporting potential non-compliance and participating in HCHC's compliance activities are elements of the job performance of each Individual Affiliated with HCHC and is a service to HCHC. Reports can be made through standard management channels, beginning with an immediate supervisor. As an alternative, Individuals Affiliated with HCHC also may make such report to the Compliance Officer, any Compliance Contact or through the Compliance Hotline at ext. 218. For Board members, reports should be made directly to the Compliance Officer. All reports may be made confidentially, and even anonymously. Individuals Affiliated with HCHC are expected to cooperate fully in the investigation of any potential non-compliance.

Any Individual Affiliated with HCHC who reports a compliance concern in good faith is protected from retaliation by law. Any Individual Affiliated with HCHC who retaliates against another Individual Affiliated with HCHC for his or her reporting of potential non-compliance or his or her participation in addressing potential non-compliance is subject to discipline. Additionally, any Individual Affiliated with HCHC who makes intentionally false accusations regarding a compliance concern is subject to discipline.

Depending on the severity of the violation, violations of the Corporate Compliance Plan may result in the following:

A. For employees, contractors, agents and volunteers – oral admonishment, written reprimand, reassignment, demotion, suspension, and/or separation, in addition to legal penalties which might apply.

B. For officers and members of the Board of Directors – oral admonishment or removal from the Board in accordance with procedures established in the by-laws.

Questions regarding this policy or any related Annex should be directed to the Compliance Officer at 413-238-4128.

Originally Drafted: OCT 2012 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Directors

Corporate Compliance Program Annexes and Attachments

Click link to go to desired Annex

Annex 1: HCHC Standards of Conduct

In general, HCHC expects that all Individuals Affiliated with HCHC will behave in a professional and courteous manner. In addition, these Standards of Conduct describe specific standards to which individuals are expected to adhere.

A. Confidentiality of Information

Individuals Affiliated with HCHC may acquire confidential or proprietary information by virtue of their positions within, or affiliation with, HCHC. The term "confidential or proprietary information" shall mean any and all information (whether written, oral, or contained electronic media) relating to the governance, business, operation, and financial condition of HCHC and/or any of its vendors or collaboration partners, as well as any and all other information determined to be confidential. All information communicated at executive sessions or other closed sessions of the HCHC's Board of Directors is confidential and proprietary information. HCHC's Board of Directors or its CEO may determine that other information, including information shared in Board and/or committee meetings, is confidential or proprietary on a case-by-case basis. Confidential or proprietary information may not be:

1) Disclosed outside of HCHC without appropriate authorization from the CEO (or in the case of Board members, by the Board President in conjunction with the CEO);
2) Used for personal gain or for the benefit of a third party. Individuals Affiliated with HCHC are expected to exercise reasonable care to avoid the inadvertent disclosure of confidential information and, as applicable, will be bound by (and required to comply with) the confidentiality provisions contained in agreements executed between HCHC and other organizations and/or individuals, as well as HCHC's internal confidentiality policies and procedures.

Individuals Affiliated with HCHC will be required to sign a Confidentiality Agreement and/or Business Associate Agreement, as appropriate, that specifically limits the context in which, and persons to whom, confidential information may be communicated. Officers and members of the Board also have a fiduciary duty to not communicate confidential information about HCHC to anyone who is not also an officer or member of the Board, respectively, absent the explicit authorization of the full Board of Directors.

B. Conflicts of Interest

1) General Prohibition

Individuals Affiliated with HCHC must strive to make decisions fairly and objectively and always act in the best interests of HCHC, without regard to any personal pecuniary benefit or any benefit to a third party, and with undivided allegiance. As HCHC is a federal grantee under the Department of Health and Human Services (DHHS), these standards for managing Conflicts of Interest are also necessary to comply with the Federal Uniform Administrative Requirements set forth at 2 C.F.R. §200.318(c) and DHHS regulations found at 45 C.F.R. §75.327(c). No Individuals Affiliated with HCHC shall participate in HCHC's selection,

award, or administration of any contract or grant, paid in whole or in part with federal funds, when a real or apparent conflict of interest (as defined below) is involved.

2) Definitions

Interest. A person has an "Interest" if he or she has, directly, or indirectly through a family member or business partner:

- a business relationship (*e.g.*, an actual or forthcoming compensation arrangement whether by contract or employment) with: (1) HCHC; (2) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; or (3) an entity that is a competitor or potential competitor of HCHC;
- a financial relationship (*e.g.*, a controlling or material ownership, or investment interest, employment relationship or other relationship that a reasonable person would deem significant) with or a tangible personal benefit from: (1) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; or (2) an entity that is a competitor or potential competitor of HCHC;
- a fiduciary relationship (*e.g.*, Board member or trustee) with: (1) an entity with which HCHC has entered (or is negotiating to enter) a transaction or arrangement; (2) an entity that is a competitor or potential competitor of HCHC; or
- a personal relationship with an individual who has a business, financial or fiduciary relationship as defined above. A personal relationship means a relationship based on family, business partnership, friendship or romance.

Any interest in a company through publicly-traded stocks, bonds or mutual funds available to the general public shall not constitute an Interest, provided the ownership or investment interest is less than one percent of the company's shares.

Conflict of Interest. A "Conflict of Interest" arises whenever the interest of a person competes with or has the potential to compete with the best interests of HCHC.

A conflict of interest is presumed to exist if a person with an interest is involved in any way in the transaction or arrangement in which he or she has such interest.

3) Affirmative Disclosure Requirements

It is the policy of HCHC that all interests shall be fully disclosed by any Individual Affiliated with HCHC regardless of whether a conflict of interest is determined to exist.

Annual Disclosures. HCHC requires that Board members and corporate officers of HCHC disclose in writing: (1) all interests that may create an actual or potential conflict of interest, and (2) where applicable, provide a statement suggesting how such conflict of interest could be avoided or mitigated. In order to facilitate such full disclosure, HCHC requires that Board members, corporate officers and persons seeking to affiliate with HCHC complete the Disclosure Form. Completion of a Disclosure Form does not relieve individuals of the obligation to comply with these Standards of Conduct with regard to disclosure of interests that may occur after the filing of the Disclosure Form (*e.g.*, with respect to a particular transaction).

Supplemental Income. HCHC requires that corporate officers of HCHC, as well as all contracted employees, disclose in writing any specifics of any plans to accept supplemental income outside HCHC employment so that HCHC may determine whether such outside

employment or consultancy conflicts, or has the potential or appearance to conflict, with the interests of HCHC. HCHC's prior approval of such outside employment or consultancy is required.

Continuing Obligation. HCHC requires that all Individuals Affiliated with HCHC and persons seeking to affiliate with HCHC disclose interests that arise after the annual filing of the Disclosure Form.

Recipients of Disclosures.

- Members of, and candidates for membership on, the Board of Directors shall make disclosures to the President of the Board of Directors. If the President has such an interest, he or she must make disclosure to the Vice President, who will, in turn, be responsible for advising the Board.
- The CEO shall make disclosures to the President of the Board who will be responsible for advising the Board of such disclosure.
- All other Individuals Affiliated with HCHC shall make disclosures in writing to the CEO.

4) Determining Whether a Conflict of Interest Exists

In the case of a potentially conflicted person who is either a Board member or the CEO, that person may make a presentation to the Board regarding whether he or she has a conflict of interest, and may respond to related questions from the Board. However, after such presentation, he or she shall leave the meeting during any discussion of, or vote on, whether a conflict of interest exists, and if such conflict of interest is determined by the Board to exist, he or she shall leave the meeting during any discussion of, and voting on, the transaction or arrangement that involves the conflict of interest. For all other potentially conflicted persons who are Individuals Affiliated with HCHC, the CEO shall determine whether a conflict of interest exists.

5) Procedures for Addressing the Conflict of Interest

Procurement. If the conflict of interest involves procurement by HCHC, the process shall be conducted in accordance with Section B of these Standards of Conduct and HCHC's Board-approved Annex 4 to this plan.

Alternative Arrangements. In other instances, the Board shall, as it may deem appropriate, appoint the CEO to investigate alternatives to the proposed transaction or arrangement and make recommendations. After exercising due diligence, the Board or, in the case of Individuals Affiliated with HCHC who are not Board members or the CEO, the CEO shall determine whether HCHC can obtain an equivalent (or more advantageous) transaction or arrangement with reasonable efforts from a person or entity that would not give rise to a conflict of interest.

HCHC's Best Interests. If an alternative transaction or arrangement is not reasonably attainable under circumstances that would not give rise to a conflict of interest, the Board or CEO, as applicable, shall determine (if Board, then by a majority vote of the disinterested Board members) whether, notwithstanding the conflict of interest, the transaction or arrangement is in HCHC's best interest, for its own benefit and whether the transaction is fair and reasonable to HCHC such that it would constitute an "arms-length" transaction (and be consistent with 45 C.F.R. Part 75 standards, as may be amended from time to time).

Pervasive Conflicts of Interest. In circumstances where there are material continuing or pervasive conflicts of interest, an individual may be required by the Board of HCHC or the CEO, as applicable, to withdraw from his or her position with HCHC unless the individual, family member or business associate chooses to disassociate from the outside position that causes the conflict of interest.

6) <u>Violations of the Standards of Managing Conflicts of Interest</u>

If the Board or CEO, as applicable, has reasonable cause to believe that a person has failed to disclose an interest, the person shall be informed of the basis for such belief and afforded an opportunity to explain the alleged failure to disclose. If, after hearing the response of the individual who failed to disclose an interest, and making such further investigation as may be warranted in the circumstances, the Board or CEO determines that the individual has in fact failed to disclose an interest in accordance with these Standards of Conduct, appropriate corrective and/or disciplinary action shall be taken, including removal of the individual from the selection, negotiation, or administration of any contracts or grants to which HCHC is a party, and/or admonishment or removal from the Board in accordance with the then current HCHC By-laws.

7) <u>Records of Proceedings</u>

The minutes of the Board and all committees with Board-delegated powers and those records as determined by the CEO shall contain:

Conflicts of Interest. The names of the people who disclosed or otherwise were found to have an interest in connection with an actual or potential conflict of interest and the nature of the interest; any action taken to determine whether a conflict of interest was present; and the Board or CEO's decision, as applicable, as to whether a conflict of interest in fact existed.

Management of Conflicts. For transactions where a conflict of interest has been disclosed or otherwise found to exist, the names of the persons who were present for discussions and votes relating to the transaction or arrangement, and the names of the persons who recused themselves; the content of the discussion, including any alternatives to the proposed transaction or arrangement or HCHC's best interest; and a record of any votes taken in connection therewith.

C. Vendors and Procurement Standards

HCHC will conduct all procurement transactions in a manner to provide, to the maximum extent possible, practical, open, and free competition, in accordance with HCHC's Board-approved Annex 4 to this plan will address, among other things, the following principles:

- No Individual Affiliated with HCHC may participate in the selection, award, or administration of a contract supported by federal funds, in whole or in part, if a real or apparent Conflict of Interest (as defined in Section B, 2 above) would be involved.
- HCHC will be sensitive to, and seek to avoid, Organizational Conflicts of Interest. Organizational Conflicts of Interest mean that because of relationships with a parent company, affiliate, or subsidiary organization, HCHC is unable or appears to be unable to be impartial in conducting a procurement action involving a related organization.
- HCHC will be sensitive to, and seek to avoid, non-competitive practices among contractors. In order to ensure objective contractor performance and eliminate unfair competitive advantage, contractors/consultants that develop or draft grant applications, or

contract specifications, requirements, statements of work, invitations for bids and/or requests for proposals shall be excluded from competing for such procurements.

- Awards will be made to the bidder whose bid is responsive to the solicitation and most advantageous to HCHC, in terms of price, quality, and other factors. HCHC retains the right to reject any and all bids or offers when it is in HCHC's interest to do so.

D. Nepotism

Except under extenuating circumstances, as determined by the CEO, HCHC will not hire any individual (or assign, transfer or promote a current employee) who is related to one of its employees or contractors, if in the position being applied for (or assigned, transferred or promoted to), the applicant will supervise, be supervised by, or have a direct reporting relationship with the related employee or contractor. Every applicant for employment or consultancy with HCHC must disclose any and all family, business and personal relationships with any Individual Affiliated with HCHC. Members of the HCHC Board of Directors and their immediate family members are not eligible for employment at HCHC.

E. Gifts

No Individuals Affiliated with HCHC may solicit or accept gifts, gratuities, favors or anything of value from any current or potential patient, vendor or contractor of HCHC, or any current or potential party to a sub-agreement with HCHC. Every Individual Affiliated with HCHC will decline or return any gift and notify the CEO of such gift.

A "gift "is defined as anything of value offered directly by or on behalf of an actual or potential patient, vendor or contractor, except for promotional materials of little or nominal value such as pens, calendars, mugs, and other items intended for wide distribution and not easily resold. Gifts include (but are not limited to): personal gifts, such as sporting goods, household furnishings and liquor; social entertainment or tickets to sporting events; personal loans or privileges to obtain discounted merchandise, and the like.

F. Bribery

HCHC will immediately dismiss, remove and, as applicable, terminate the employment or contract of any Individuals Affiliated with HCHC who offered or accepted a bribe to secure funding or other benefits for or from HCHC.

G. Cooperation and Honest Dealing with Government Officials

No Individuals Affiliated with HCHC will attempt to influence actions or decisions made by government bodies, officials, employees, or contractors, unless specifically authorized to do so consistent with applicable HCHC policy. Individuals Affiliated with HCHC will be cooperative and truthful in their dealings with any governmental inquiries or requests, including audits, surveys, and certification reviews. Except where otherwise approved, Individuals Affiliated with HCHC who are not authorized to speak on behalf of HCHC will not respond to any governmental inquiries or requests, including audits, surveys, and certification reviews, and will promptly report any such inquiries or requests to HCHC's CEO, Compliance Officer or other member of senior management.

H. Political Activities

Individuals Affiliated with HCHC will not participate or intervene in any political campaign in support of or in opposition to any candidate for elected public office while at work during business

hours or when acting in his/her official capacity/position as an Individual Affiliated with HCHC. A political campaign is deemed to begin when an individual announces his or her candidacy for an elective public office, or is proposed by others for an elective public office. Individuals Affiliated with HCHC may not use HCHC's name, logo (or other means of identification as affiliated with HCHC), facility or any resources in connection with political campaign activities.

I. Lobbying

Lobbying is generally defined as a communication (written or oral) that is an attempt to influence (for or against) specific legislation including appropriations. Any lobbying activities proposed to be undertaken by HCHC or by any Individuals Affiliated with HCHC on behalf of HCHC shall require the prior approval of the CEO. Any Individuals Affiliated with HCHC undertaking lobbying activities will work with the CEO, or his or her designee, to ensure that such activities are supported by non-federal resources and that all disclosures and reporting of lobbying activities required by state or federal law are submitted in a timely manner.

Annex 2: Legal Statutes and Regulations

The health care industry is subject to many federal and state laws and regulations that govern all aspects of the delivery of and payment for health care services.

The following list represents the laws and regulations that HCHC incorporates into its Compliance Program. It is not an exhaustive list of all the requirements with which HCHC will comply, but rather describes those laws most relevant to its fraud and abuse compliance activities. The list will be updated as the laws change and HCHC's Compliance Officer will update its policies and procedures to reflect these changes. Additional information regarding some of these laws follows the listing.

- Civil False Claims Act: 31 U.S.C. §§ 3729-3733
- Criminal False Claims Act: 18 U.S.C. § 287
- Anti-Kickback Statute and Regulations: 42 U.S.C. § 1320a-7b(b); 42 C.F.R. § 1001.952
- Civil Monetary Penalties Statute and Regulations: 42 U.S.C. § 1320a-7a; 42 C.F.R. § 1003, et seq.
- Exclusion of Entities from Government Health Care Programs: 42 U.S.C. § 1320a-7
- Health Care Benefit Program False Statements Statute: 18 U.S.C. § 1035
- Health Care Fraud Statute: 18 U.S.C. § 1347
- Theft or Embezzlement in Connection with Health Care: 18 U.S.C. § 669
- Obstruction of Criminal Investigations of Health Care Offenses: 18 U.S.C. § 1518
- Medicaid Managed Care Regulations: 42 C.F.R. § 438, et seq.
- Special Fraud and Abuse Alerts and Advisory Bulletins: www.oig.hhs.gov
- Advisory Opinion Materials: www.oig.hhs.gov
- Office of Inspector General Compliance Program Guidances: www.oig.hhs.gov
- Mandatory Compliance Programs as a Condition of Enrollment in Medicare, Medicaid, and CHIP: 42 U.S.C. § 1320a-7k

A. Fraud and Abuse Laws

1) Civil False Claims (31 U.S.C. §§ 3729-3733)

2) Criminal False Claims (18 U.S.C. § 287 and Mass. Gen. 1. chap. 175H, §2 (private insurance) and Mass. Gen.1. chap. 118E, § 40 (Medicaid))

HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully make or cause to be made any false statement or representation of material fact in any claim or application for benefits under any federal health care program or health care benefit program. In addition, HCHC, HCHC Employees and HCHC Agents shall not, with knowledge and fraudulent intent, retain federal health care program or health care benefit program funds, which have not been properly paid.

Examples of prohibited conduct include, but are not limited to: misrepresenting services that were rendered; falsely certifying that services were medically necessary; "up-coding;" billing

for services not actually rendered; making false statements to governmental agencies about HCHC's compliance with any state or federal rules; making false statements concerning the condition or operation of HCHC programs for which licensure/certification is required; billing federal health programs rates in excess of applicable federal health care program established rates; repeatedly violating the terms of a participating physician agreement; and failing to refund overpayments made by a federal health care program.

B. Anti-Kickback Laws (42 U.S.C. §1320a-7b(b), Mass. Gen. 1. chap. 118E, §41) and Mass. Gen. 1. chap. 175H§ 3 (private insurance)

HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully solicit, offer to pay, assist payer in receiving any remuneration, either directly or indirectly, overtly or covertly, in cash or in kind, in return for:

1) Referring an individual to a person for the furnishing, or arranging for the furnishing, of any item or service for which payment maybe made, in whole or in part, under any federal health care program;

2) Purchasing, leasing, ordering, or arranging for, or recommending the purchasing, leasing, or ordering of any good, facility, service or item for which payment maybe made in whole or in part, under any federal health care program. Remuneration may include not only kickback payments and bribes, but also rebates, refunds, educational grants and other benefits to consumers.

Certain legally permitted practices, such as group purchasing agreements and price reductions to health plans, among others, are excluded from this prohibition.

C. Civil Monetary Penalties Act (42 U.S.C. §1320a-7a)

HCHC, HCHC Employees and HCHC Agents shall not knowingly present a claim to any federal health care program or health care benefit program for an item or service the person knows or should have known, was not provided, was fraudulent, or was not medically necessary. No claim for an item or service shall be submitted that is based on a code that the person knows or should know will result in greater payment than the code the person knows or should know is applicable to the item or service actually provided. HCHC, its Employees and HCHC Agents shall not offer to transfer, or transfer, any remuneration to a beneficiary under a federal or state health care program, that the person knows or should know is likely to influence the beneficiary to order or receive any item or service from a particular provider, practitioner or supplier, for which payment maybe made, in whole or in part, under a federal health care program. Remuneration includes the waiver of coinsurance and deductible amounts, except as otherwise provided, and transfers of items or services for free or for less than fair market value.

D. Ethics in Patient Referrals Act of 1989 (42 U.S.C. §1395nn) ("Stark II")

Physicians (the definition of which also includes psychologists) who have an ownership or compensation relationship with an entity that provides "designated health services" shall not refer a patient in need of designated health services for which payment maybe made under Medicare or Medicaid to such entities unless that ownership or compensation arrangement is specifically permitted under the Stark II laws and regulations.

E. Health Care Fraud (18 U.S.C.§1347)

HCHC, HCHC Employees and HCHC Agents shall not knowingly or willfully execute or attempt to execute, a scheme or artifice to:

1) Defraud any health care benefit program.

2) Obtain, by means of false or fraudulent pretense, representation or promise any of the money or property owned by or under the custody or control of any health care benefit program, in connection with the delivery of, or payment for, health care benefits, items or services.

F. False Statement and False Claims Laws

1) Criminal False Statements Related to Health Care Matters (18 U.S.c. §1035)

HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully make or use any false, fictitious, or fraudulent statements, representations, writings or documents regarding a material fact in connection with the delivery of, or payment for, health care benefits, items or services. HCHC, HCHC Employees and HCHC Agents shall not knowingly and willfully falsify, conceal or cover up a material fact by any trick, scheme or device.

2) Civil False Claims Act (31 U.S.C. §3729(a) and Mass. Gen. L. Chapter 118E, §40)

HCHC, HCHC Employees and HCHC Agents shall not:

a) Knowingly file a false or fraudulent claim for payments to a governmental agency, or health care benefit program;

b) Knowingly use a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or health care benefit program; or

c) Conspire to defraud a governmental agency or health care benefit program by attempting to have a false or fraudulent claim paid.

Examples of false or fraudulent claims include, but are not limited to, double billing, up-coding, unbundling, submitting or processing claims for items or services not provided and submitting or processing claims for items or services not medically necessary.

3) Criminal False Claims Act (18 U.S.C. §§286, 287)

HCHC, HCHC Employees and HCHC Agents shall not conspire to defraud another agency or health care benefit program. Conspiring to defraud a governmental agency or health care benefit program is also prohibited.

G. Other Federal and State Laws

HCHC is subject to a range of other federal and state laws including wire and mail fraud, obstruction of criminal investigations, conspiracy laws and the Federal Racketeering Act, which includes criminal and civil penalties, and State administrative sanctions on providers who violate the rules, regulations and laws governing the Medical Assistance program (130 CMR 450.238).

Annex 3: Billing, Claims and Records

HCHC recognizes that a third party billing agency is an HCHC Agent and HCHC is responsible for ensuring the accuracy of its billing regardless of how the billing is submitted or by whom.

While this Plan does not address every situation that may arise in the billing, coding and documentation requirements for outpatient medical, dental and mental health or substance abuse services, the following are some of the specific risk areas for which HCHC Employees and HCHC Agents will receive training and supervision:

- Billing for items or services not actually rendered.
- Billing for medically unnecessary services.
- Duplicate billing.
- Insufficient documentation to evidence that services were performed and thus supporting reimbursement.
- Billing for services provided by unqualified or unlicensed clinical personnel.
- Untimely and/or forged physician certifications on plans of care.
- Failure to adhere to licensing requirements and Medicare conditions of participation.
- Knowing failure to return overpayments made by health care programs.
- Failure to refund credit balances.

A. Documentation

All services rendered must have substantiating medical documentation. If the appropriate documentation is not provided, the service is not considered rendered.

Medical records may not be erased or altered. Medical records may be amended to correct an error or to complete documentation, but only in accordance with established medical records procedures.

Clinical, administrative or clerical employees and agents involved in the preparation and/or submission of charge or billing data must be trained in coding and documentation practices. Employees and Agents who suspect that inaccurate billing or documentation is occurring should immediately contact a Compliance Contact.

B. Billing and Claims

HCHC bills only for services actually rendered. Services rendered must be documented and completely coded, and billing must comply with the requirements of state and federal laws and guidelines, and conform to all payer contracts and agreements.

C. Records

Federal law requires HCHC to ensure that its books and records are accurate. It is against HCHC policy for any person to knowingly cause HCHC books and records to describe inaccurately the true nature of a business or clinical transaction. The following activities are also unethical and against HCHC policy:

- Making records appear as though payments were made to one person when they were made to another;
- Submitting expense accounts that do not accurately reflect expenses;

- Creating any other records that do not accurately reflect the true nature of the transaction;
- Making false entries in HCHC'S books and records, or in any public record, for any reason
- Altering in any way permanent entries in HCHC'S records;
- Knowing that others are falsifying records and not reporting it.

D. Payments/Receipts

The Employees and Agents of HCHC may not receive or make any payments on behalf of the corporation without fully understanding their purpose. The purpose must be the same as described in the documents supporting the transaction.

E. Retaining Records

Billing data must be retained for periods provided by law and by approved policies of HCHC. Employees and Agents of HCHC may not destroy or dispose of records or files without permission. Laws and regulations provide how long certain records must be kept, particularly when the records involve tax, personnel, health and safety, environmental, contract and corporate issues. It is also important to keep all records that are or maybe involved in any government investigation, audits or legal action. Destroying such records before the matter is closed, or destroying records so that they may not be used in legal proceedings, is illegal.

Annex 4: Procurement and Referrals

HCHC Employees and Agents who work with businesses or providers that supply referrals, products or services, may face a variety of ethical or even legal problems. The following additional guidelines address the boundaries of ethical conduct:

A. Kickbacks and Rebates

These perks can take many forms and are not limited to cash payments or credits. Any time an Employee or Agent of HCHC or a member of his/her family is offered something of value as a result of purchasing any product or service or as a result of consideration of such purchase, the Employee or Agent should question both the ethics and legality of the offer. In general, if an Employee or Agent of HCHC stands to gain personally from an organizational business transaction, that transaction is prohibited, and in many cases, may be illegal.

B. Reciprocity

In some instances, HCHC may purchase goods and services from a supplier who also buys goods and services from HCHC. Any form of pressure for reciprocal business from a supplier is not ethical and maybe illegal. HCHC Employees and Agents should never ask a supplier to buy services from them in return for the opportunity to do business with HCHC.

C. Gifts or Gratuities

In general, HCHC Employees and Agents and members of their immediate families are discouraged from accepting gifts. In the event unsolicited gifts are offered, the following circumstances identify when a gift maybe accepted:

- The gift is primarily an advertisement or promotion of a product/service, or
- The gift is a textbook or another product that will benefit patient care.

The Employees and Agents of HCHC may never accept money from companies or individuals doing business with the Agency. It is also unethical to ask businesses for personal gifts or favors.

D. Entertainment by Businesses

The Employees and Agents of HCHC may accept entertainment offers from outside businesses only if the entertainment is reasonable, helps to strengthen the business relationship, and does not involve significant expenses. It is unethical to encourage or ask for entertainment from any person or company who does business with HCHC. The Employees and Agents of HCHC should avoid any offer that is intended primarily to gain favor or influence.

E. Payments to Agents, Representatives and Consultants

Any agreement with agents, sales representatives or outside consultants must be reasonable in amount, in the value of the service provided, and in comparison to trade practices.

F. Payments to Government Employees

It is illegal to offer any government official or employee a payment of money, gifts, services, entertainment or anything else of value.

G. Other Improper Payments

The use of HCHC's funds or assets for any unlawful or unethical purpose is prohibited. It does not matter if Employees and Agents make the payment directly, indirectly or by a third party agent on behalf of HCHC, such payments are prohibited.

Annex 5: Audits, Investigation and Organizational Response

A. Audits

The Compliance Officer or delegated representative shall supervise all auditing systems. Annual audit procedures will be implemented which are designed primarily to determine accuracy and validity of coding and billing submitted to Medicare / Medicaid, other federal and state health programs and other payers, and detect other instances of potential misconduct by HCHC Employees and Agents as quickly as possible. The Compliance Officer will submit written reports of actual or suspected fraud to the CEO and/or the Corporate Compliance Committee.

A brief report from each auditor will be submitted each time audits occur. Random samplings of records drawn from a cross section of each department will be conducted on an annual basis by the internal auditor in coordination with the Compliance Officer. In addition, attention will be given to reviewing the reasons given for claim denials, to reviewing significant increases in the use of certain procedure codes and to analyze other facts that may suggest inappropriate conduct. The auditor shall pay close attention to at least the following risk areas:

- Written standards and policies and procedures;
- Coding and billing;
- Documentation;
- Reasonable and necessary services; and
- Improper inducements, kickbacks and self-referrals.

The Compliance Officer shall determine the number of charts of all claims to be reviewed in each department.

The auditing process will involve contact with the Billing Manager who supervises billing staff, and, as appropriate, billing staff. The Compliance Officer shall review publications and updates received, including OIG Special Fraud Alerts, to identify failures to comply with any applicable requirements, and review updates received to applicable statutes and regulations including those pertaining to fraud and abuse, COBRA, Medical Record Coding, Medicare/Medicaid billing and anti-trust.

HCHC shall promptly repay any discovered overpayments. HCHC shall establish a reserve account to hold any disputed funds until the results of an internal investigation determine whether the money is an overpayment to be repaid or whether it was properly paid and should be returned to the general fund.

HCHC and HCHC Agents shall retain all billing records for six (6) years.

Any suspected incidents of non-compliance shall be reported for review and action to the Compliance Officer and the Department Director of the department where such suspected noncompliance is occurring. The Compliance Officer will then report such issues to the CEO.

B. Investigation

The purpose of an investigation is to identify situations in which applicable federal or state laws, including the laws, regulations and standards of the Medicare and Medicaid Programs, or the requirements of HCHC's Compliance Program, may not have been followed; to identify individuals who may have knowingly or inadvertently violated the law or HCHC's Compliance Program requirements; to facilitate the correction of any violations or misconduct; to implement

procedures necessary to ensure future compliance; to protect HCHC in the event of civil or criminal enforcement actions; and to preserve and protect HCHC's assets.

1) Control of Investigations

   All reports of alleged non-compliance must be forwarded to the Compliance Officer. Serious or otherwise sensitive matters for investigations will be conducted under the direction of or by HCHC's legal counsel. If the involvement of legal counsel is warranted, the Compliance Officer will be responsible for requesting that legal counsel initiate an investigation, prepare a report of findings for the Compliance Officer and recommend the appropriate actions to be taken. HCHC Employees and Agents are expected to fully cooperate with any investigations undertaken by the Compliance Officer and/or legal counsel.

2) Investigative Process

   Upon receipt of information concerning alleged misconduct, the Compliance Officer or his or her designee will:

   a. Complete an Incident Report Form that includes, if known, the name of the employee who made the report, the date of the report and a summary of the Employee or Agent's concern. Anonymity of the reporting individual, if requested, and confidentiality will be maintained, if at all possible.

   b. Notify the CEO of the nature of the alleged improper conduct and if the involvement of legal counsel is warranted, obtain a memorandum from Senior Management authorizing legal counsel to initiate an investigation.

   c. Ensure that the investigation is initiated not more than three business days following the receipt of the information. The investigation shall include, as applicable, at least the following:

      i Interviews of all persons who may have knowledge of the alleged conduct and a review of the applicable laws, regulations and standards to determine whether or not a violation has occurred.

      ii Identification and review of relevant documentation, including, where applicable, representative bills or claims submitted to the Medicare/Medicaid Programs, to determine the specific nature and scope of the violation and its frequency, duration and potential financial magnitude.

      iii Interviews of persons who appeared to play a role in the suspected activity or conduct. The purpose of the interviews is to determine the facts surrounding the conduct and may include, but shall not be limited to:

         - The person's understanding of the applicable laws, rules and standards;
         - Identification of relevant supervisors or managers;
         - Training that the person received; and
         - The extent to which the person may have acted knowingly or with reckless disregard or intentional indifference of applicable laws.

      iv Preparation of a summary report that:

         - Defines the nature of the alleged misconduct;

- Summarizes the investigation process;
- Identifies any person who is believed to have acted deliberately or with reckless disregard or intentional indifference of applicable laws;
- Assesses the nature and extent of potential civil or criminal liability; and
- Where applicable, estimates the extent of any resulting overpayment by the government.

d. For all investigations in which HCHC's legal counsel is not involved, ensure that significant developments are promptly reported so that a determination can be made as to whether HCHC's legal counsel should be contacted.

e. Establish a due date for the summary report or otherwise ensure that the investigation is completed in a reasonable and timely fashion and that the appropriate corrective action is taken, if warranted.

C. Organizational Response

In the event the investigation identifies employee misconduct or suspected criminal activity, HCHC will undertake the following steps:

1) HCHC will, as quickly as possible, cease the offending practice. If the conduct involves the improper submission of claims for payment, HCHC will immediately cease all billing potentially affected by the offending practice.
2) HCHC will consult with legal counsel to determine whether voluntary reporting of the identified misconduct to the appropriate governmental authority is warranted.
3) If applicable, HCHC will calculate and repay any duplicate of improper payments made by a Federal or State government program as a result of the misconduct.
4) Initiate appropriate corrective action, which may include, but is not limited to, reprimand, oral warning, written warning, demotion, suspension and/or termination, If the investigation uncovers what appears to be criminal conduct on the part of an Employee or Agent, appropriate corrective action against the Employee/s and/or Agent/s, who authorized, engaged in or otherwise participated in the offending practice will include, at a minimum, removal of the person from any position of oversight and may include, in addition, suspension, demotion and termination.
5) Promptly undertake appropriate training and education to prevent a recurrence of the misconduct.
6) Conduct a review of applicable HCHC policies and procedures to determine whether revisions or the development of new policies and/or procedures are needed to minimize future risk of noncompliance.
7) Conduct, as appropriate, follow-up monitoring and auditing to ensure effective resolution of the offending practice.

D. Enforcement of Compliance Program

It is HCHC's position that all violations, including failure to report the misconduct of others when required, will be viewed as a serious infraction and that corrective action up to and including termination of employment maybe imposed upon Employees and Agents as a result of such findings. If a supervisor or manager, due to negligence or carelessness, contributes to or perpetrates

misconduct, HCHC will take appropriate corrective action that is commensurate with the seriousness of the violation in question.

A progressive corrective action approach will be used to address all violations, unless the violation is an offense that may warrant immediate termination. Offenses that may warrant such termination include, but are not limited to:

1) Committing intentional violations of local, state and federal laws or regulations governing coding and billing procedures and practices at HCHC.
2) Taking retaliatory actions against an Employee or Agent for reporting a compliance question, issue or matter to the Compliance Contact; or
3) Presenting false or misleading information or data during the course of an auditor investigation conducted by the Compliance Contact or by a government agency.

HCHC, in determining what corrective action is appropriate, will consider whether the individual voluntarily reported the issue and fully cooperated in any investigation and review.

E. Records and Non-Retaliation

Records of suspected misconduct and any subsequent investigation shall be confidentially retained by the Compliance Officer for ***at least 5 years***.

No HCHC Employee or Agent who in good faith reports suspected misconduct shall be retaliated against or otherwise disciplined by HCHC or any HCHC Employee. The Compliance Officer may review personnel records and information periodically to ensure that those who report suspected misconduct are not subject to retaliation or other improper conduct.

In addition, the Compliance Officer has the authority to keep confidential the names of HCHC Employees and Agents who report information. The Compliance Officer does not, however, have the authority to unilaterally extend any protection or immunity from corrective action, prosecution or any other sanction to those Employees or Agents who have engaged in misconduct.

Annex 6: Risk Management Program

Risk management is a systematic process of identifying, evaluating and reducing losses associated with patient, employee or visitor injuries, property loss or damages and other sources of potential legal liability.

A. Responsibility

The Board of Directors is entrusted with the responsibility for the oversight of the Risk Management Program at Hilltown Community Health Center (HCHC) and its satellite facilities. This responsibility is delegated to the CEO and members of the Corporate Compliance Committee, who in turn delegate responsibility for risk management to the Risk Manager and Quality Improvement/Risk Management Committee.

B. Program Scope

The Risk Management Program encompasses review of the areas of actual or potential sources of risk and/or liability involving patients, visitors, staff and property. This incident reporting system is utilized to collect and trend undesirable or adverse occurrences in all areas throughout the facilities. To accomplish this function, the Risk Manager or the CEO's designee is responsible for developing and maintaining a Risk Management Program that meets the basic operational needs of. Those programs include but are not limited to the following:

- Commercial Insurance Analysis
- Training Programs
- Infection Control Risk
- FTCA and Scope Analysis
- HIPAA Privacy & Security Risk
- Employee Safety in the Workplace
- Emergency Planning & Response

C. Commercial Insurance

A risk analysis and review will be conducted annually in conjunction with HCHCs insurance company. The Chief Financial Officer (CFO) will determine coverage requirements and make adjustments as necessary. Among insurances to be reviewed are

- Property Coverage
- General Liability
- Commercial Umbrella
- Worker's Compensation
- Directors and Officers
- Commercial Auto Liability
- Surety Bonds
- Cyber Liability and Data Breach

Determination will be made by Senior Leadership if additional or optional coverages are warranted based on incident reports or claims.

D. Training Programs

In-service training programs will be reviewed as part of the annual risk analysis to determine if requirements are being met. These requirements include but may not be limited to the following:

- Safety Training (fire drills, disaster drills, workplace safety, workplace violence)
- OSHA Training Compliance (infection control, needle stick protocols, hazardous waste disposal, employee injuries and ergonomics)
- Security Programs (electronic door operation, IT security and enhancements)
- Confidentiality Programs (Corporate Compliance, HIPAA Privacy rules)
- Patient Care Programs (Patient complaint process, dealing with difficult patients, aggressive patients)

E. Infection Control

HCHC is committed to providing a safe and healthful work environment for the entire staff. In pursuit of this endeavor, HCHC's policy on "Employee Exposure to Blood or Other Potentially Infectious Material" is a formal documented process to minimize risk of infection when an employee is exposed to a potentially infectious material, in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Blood borne Pathogens."

The clinical staff is responsible for the implementation of the policy and any other policies related to policies that protect employees from exposure and/or risk. They will maintain, review, and update the policies and procedures at least annually and whenever necessary to include new or modified tasks and procedures.

Those employees who are determined as having occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in the policy.

Operations will maintain and provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bag as required.

- The nursing staff will ensure that adequate supplies of the aforementioned equipment are available in the appropriate areas.
- The care team provider will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained.
- The nursing supervisor will be responsible for the training, documentation of training, and making the written policy available to the employees.

All employees will utilize Universal Precautions as identified in CFR 29, Sec 190.1030 when there is a possibility of encountering blood borne pathogens.

F. HIPAA Privacy & Security

The Corporate Compliance Officer fills the role of HIPAA Privacy Officer and Information Security Officer. HCHC will conduct an annual risk analysis as part of its ongoing evaluation of compliance with 45 CFR Sec 164.XXX. The risk analysis will be conducted by the HIPAA

Privacy Officer and Information Security Officer and/or designated employee(s) and documented in accordance with policy and procedure.

HCHC's risk analysis process must include the following:

- Identification and prioritization of the threats and vulnerabilities of HCHC information systems containing EPHI.
- Identification and definition of security measures used to protect the confidentiality, integrity, and availability of HCHC information systems containing EPHI.
- Identification of the likelihood that a given threat will exploit a specific vulnerability on a HCHC information system containing EPHI.
- Identification of the potential impacts to the confidentiality, integrity, and availability of HCHC information systems containing EPHI if a given threat exploits a specific vulnerability.

G. FTCA and Scope Analysis

HCHC's scope of operations will be reviewed and evaluated by senior management on an annual basis. This analysis will be used to determine if services rendered are documented appropriately in Table 5 and are thus protected under the Federal Tort Claims Act (FTCA).

H. Risk Management Strategies

In order to approach the process of Risk Management systematically, HCHC utilizes the following four-step model for Risk Management:

- The identification of risks
- The analysis of the risk identified
- The treatment of risks
- The evaluation of risk treatment strategies

This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort.

1) Risk Identification: Risk Identification is the process through which the Health Center Staff becomes aware of risks in the health care environment that constitute potential loss exposures for the health center The staff will utilize the following information services to identify potential risks:
    - Identification of trends through the incident reporting system
    - Patient, visitor, staff and physician complaint reports
    - Performance improvement functions
    - Peer review activities
    - Informal discussions with management and staff members
2) Risk Analysis: Risk Analysis is the process of determining the potential severity of the loss

associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide management in the selection of an appropriate risk treatment strategy.

3) Risk Treatment: Risk Treatment refers to the range of choices available to management in handling a given risk. Risk Treatment strategies include the following:

   a. Risk acceptance involves assuming the potential loss associated with a given risk and making plans to cover any financial consequence of such losses.

   b. Risk avoidance is a strategy utilized when a given risk poses a particularly serious threat that cannot be effectively reduced, and the conduct or service giving rise to the risk may perhaps be avoided.

   c. Risk reduction or minimization involves various loss control strategies aimed at limiting the potential consequences or frequency of a given risk without totally accepting or avoiding the risk. Strategies may include staff education, policy and procedure revision and other interventions aimed at controlling adverse occurrences without completely eliminating risk activities.

Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.

4) Risk Management Evaluation The final step in the Risk Management process is risk management evaluation, whereby the effectiveness of the techniques employed to identify, analyze and treat risks are assessed and further action taken when warranted. If improvement and/or resolution of the risk is evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement.

I. Annual Appraisal

As part of the Risk Management Program, the scope, organization and effectiveness of Risk Management activities will be reviewed annually. Program revisions will be recommended, approved and implemented as necessary.

Annex 7: Privileging and Credentialing Program

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 CEO, 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, will be determined by a completed HCHC Health Attestation Form from the individual, and is confirmed by both the supervisor and HCHC's designated physician.

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 completed Health Attestation Form, 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 clinician 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				
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
        ii. improvement data.
        iii. 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.

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 CEO 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 CEO 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.

Annex 8: 340-B Pharmacy Program

Hilltown Community Health Centers, Inc. maintains compliance and meet operational needs of 340B program for Hilltown Community Health Centers, Inc. (hereafter The Health Center). The purpose of the policy is to improve access to 340B prescription drugs for Health Center patients and to prevent diversion and duplicative drug discounts of 340B Drugs, which are prohibited under the statue of the law.

HCHC will maintain a 340B Policy and Procedures Manual that will be reviewed at least annually for needed updates and approved each year. This manual will contain procedures related to the 340B program that ensures both access to 340B prescription drugs for Health Center patients and prevents diversion and duplicative drug discounts of 340B Drugs, which are prohibited under the statue of the law. As updates are needed, based on changes in health center policy, the Manual will be updated accordingly.

The Policy Manual will be readily available to all health center employees. The Policy Manual will be part of regular training within 30 days of employment and annually thereafter for all new employees who are involved with:

1) prescribing medications for patients;
2) assisting in distribution of prescriptions;
3) patient registration and;
4) reviewing eligibility reports or finances for the pharmacy program.

1. **Definitions**:
    a. 340B Drug Program: The 340B Drug Pricing Program resulted from enactment of Public Law 102-585, the Veterans Health Care Act of 1992, which is codified as Section 340B of the Public Health Service Act. Section 340B limits the cost of drugs to Federal purchasers and to certain grantees of Federal agencies.

    b. Covered Entities: The statutory name for facilities and programs eligible to purchase discounted drugs through the Public Health Service's 340B drug pricing program. Covered entities include federally qualified health center lookalike programs; certain disproportionate share hospitals owned by, or under contract with, State or local governments; and several categories of facilities or programs funded by Federal grant dollars, including federally qualified health centers, AIDS drug assistance programs, hemophilia treatment centers, STD and TB grant recipients, and family planning clinics

    c. Contracted Pharmacy: An arrangement through which a covered entity may contract with an outside pharmacy to provide comprehensive pharmacy services utilizing medications purchased under 340B. A written contract must be in place between the Covered Entity (the Health Center) and each contracted Pharmacy. The contract is designed to facilitate program participation. The covered entity is responsible to ensure against 340B drug diversion and duplicate discounts, maintain readily auditable records, and meet all other 340B Drug Program requirements. Additional guidelines that govern the operation of contracted pharmacies for 340B participants can be found at**:** Notice Regarding 340B Drug Pricing Program — Contract

Pharmacy Services (PDF - 72.6 KB).

d. 340B Ceiling Price: The maximum price that manufacturers can charge covered entities participating in the Public Health Service's 340B Drug Pricing Program. The 340B discount is calculated using the Medicaid rebate formula and is deducted from the manufacturer's selling price rather than paid as a rebate. Compared to a drug's Average Manufacturer Price (AMP), covered entities receive a minimum discount of 23.1% for brand name drugs (except clotting factor and drugs approved exclusively for pediatric use for which the basic rebate is 17.1% of AMP), and 13% for generic and over-the-counter drugs and are entitled to an additional discount if the price of the drug has increased faster than the rate of inflation. Note that covered entities are free to negotiate discounts that are lower than the maximum allowable statutory price, i.e., sub-ceiling prices.

e. Covered Drug: An FDA-approved prescription drug, an over-the-counter (OTC) drug that is written on a prescription, a biological product that can be dispensed only by a prescription (other than a vaccine) or FDA-approved insulin. The 340B statute requires manufacturers to offer covered outpatient drugs at or below the ceiling price if the drug is a covered outpatient drug and the manufacturer has a pharmaceutical pricing agreement with the Secretary. Drugs that do not meet the definition of covered outpatient drug under §1927(k) of the Social Security Act may not have a 340B price.

f. Office of Pharmacy Affairs: "The 340B Drug Pricing Program was established in response to the passage of Section 340B of U.S. Public Law 102-585, the Veterans Health Care Act of 1992. Section 340B of this law limits the cost of drugs to certain grantees of federal agencies and other entities identified in the statute. Significant savings on pharmaceuticals may be seen by those entities who participate in this program." The program is administered by the Office of Pharmacy Affairs (OPA) of HRSA, under the federal Department of Health and Human Services (HHS).

g. Eligible Patient: An individual is considered a patient of a covered entity (with the exception of State operated or funded AIDS drug assistance programs) only if: (1) the covered entity has established a relationship with the individual, which includes maintaining records of the individual's health care; (2) the individual receives health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the individual's care remains with the covered entity; (3) the individual receives a health care service or range of services for which grant funding or federally-qualified health center look-alike status has been provided. (Disproportionate share hospitals are exempt from this requirement.)

h. 340B Prime Vendor Program: The 340B law requires HHS to create a "prime vendor" program for the entities in the 340B drug discount program. The prime vendor handles price negotiation and drug distribution

responsibilities for those entities that choose to join the prime vendor. A covered entity does not have to join the prime vendor program in order to participate in the 340B program although covered entities are encouraged to join. Apexus Inc. is the current prime vendor. Since the prime vendor has the potential to control a large volume of pharmaceuticals, it can negotiate favorable prices and develop a national distribution system that would not be possible for covered entities to obtain individually.

i. Recertification: Participating organizations/covered entities must recertify their eligibility every year and notify the Office of Pharmacy Affairs whenever there is a change in their eligibility.

2. **Entity eligibility**
   a. Each registered covered entity must be listed in the 340B covered entity database: http://opanet.hrsa.gov/opa/CESearch.aspx . At least annually, or more frequently as needed based on changes at the entity, the entity will review and update information listed in the 340B Covered Entity database. A copy of the health center's covered entity database listing is included in the manual as **Appendix A.**
   b. Scope of grant verification. As part of registration, CHCs must verify that pharmacy services have been included in the CHC scope of services filed with the Bureau of Primary Health Care as part of the HRSA grant description. A copy of the scope of grant verification can be accessed by contacting the Chief Financial Officer in the health center.
   c. Electronic Hand Book (EHB): The OPA now bases all approval of eligible entity sites based on listing in the EHB for HRSA grantees. As such, any site for which eligible patients can access 340B drugs, must first be registered in the EHB, then subsequently registered in the OPA database, prior to accessing 340B drugs.

3. **340B Program Intent**
   a. HRSA has stated that the intent of the 340B program is "To permit covered entities to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."
   b. Savings used consistent with program intent
      i. Provide care and fill prescriptions for patients who are temporarily in an insurance gap.
      ii. Supplement current health center operations in servicing and meeting patient needs.
4. **Program Requirements**
   a. Notify supplier (wholesaler and manufacturer as needed) Once an eligible organization/covered entity has registered and been approved to participate in the 340B Drug Pricing Program, it is the organization's responsibility to notify drug manufacturers and wholesalers that it will now purchase outpatient drugs at 340B prices. The wholesalers and manufacturers verify the organization's enrollment on the 340B website and must sell it drugs at the 340B price and must sell its drugs at or below the maximum price determined under the 340B formula.
   b. Register contract pharmacies

i. The Health Center has chosen to engage in a contract pharmacy arrangement with Williamsburg Pharmacy and Walgreen's for pharmacy services to be delivered to eligible health center patients at:

Williamsburg Pharmacy location:
49 Main Street, Williamsburg, MA

Walgreens locations:
78 Main Street, Westfield
225R King Street, Northampton
60 Springfield Street, Agawam
70 Main Street, Florence
583 James Street, Chicopee

ii. Contracts between the health center and its contract pharmacy vendors must be maintained and valid.

5. **Access to 340B Drugs**: To continue purchasing drugs at the discounted 340B price, participants must:

    a. Register new outpatient facilities and contract pharmacies. Registration Periods
        i. Effective October 1, 2012, additions of contract pharmacy services (as well as new registrations and additions of outpatient facilities) must be submitted
            1. October 1-15 for a start date of January 1
            2. January 1-15 for a start date of April 1
            3. April 1-15 for a start date of July 1
            4. July 1-15 for a start date of October 1

    b. Recertify eligibility every year.
    c. Maintain program integrity and keep accurate records documenting compliance with 340B requirements. Participants are subject to audit by the manufacturer or the federal government, and any participant that fails to comply with these requirements is liable to the manufacturer for refunds of the discounts obtained illegally.
    d. Receive no duplicate discount (Medicaid Exclusion). Medicaid programs typically receive rebates on drugs purchased for patients. Manufacturers typically pay the rebates to Medicaid after the sale of the drug, thereby resulting in a lower drug price for the Medicaid agency. Charging the manufacturer twice via a rebate and a 340B discount on the same drug is specifically prohibited by the 340B legislation.
    e. Agree to not resell, transfer or divert 340B drug to a person who is not a patient by the 340B definition.
    f. Material Breach. In accordance with its recertification statement, the covered entity acknowledges its responsibility to contact HRSA as soon as

reasonably possible if there is any *material breach* by the covered entity of any of the foregoing.

i. For the purposes of reporting non-compliance to HRSA the term material breach is defined by the health center as meeting the following circumstances:
    1. Greater than 10% of claims identified as non-compliant within a given period are non-correctable.
    2. A covered entity must contact HRSA as soon as reasonably possible following any material breach by the covered entity of any 340B program requirement.
ii. For situations that do not meet the "material breach" the health center will take corrective actions, maintain transparency with all stakeholders involved, and keep auditable records.
iii. The Self-Disclosure Tool available on the PVP website can be used to report non-compliance to HRSA: https://docs.340bpvp.com/documents/public/resourcecenter/Establishing_Material_Breach_Threshold.pdf

6. **Patient eligibility:** For the purposes of 340B, the health center further defines an *eligible patient* as follows:
    a. A patient registered for clinical services with an active encounter with an employed or contracted provider including medical and dental within 12 months.
        i. If patient presents to pharmacy and pharmacy determines that patient has not had an active prescription from health center provider within 12 months, the pharmacy will refer patient to health center to get updated appointment before prescription will be filled.

7. **Provider Eligibility:** The health center defines an eligible 340B provider:
    a. A provider with an active employment contract to provide medical services on behalf of the health center.
    b. A provider contracted by the health center to provide care *on behalf* of the health center for which the entity is able to maintain responsibility for the care of the patient.
    c. List of providers: The health center will submit an updated list of all prescriber NPIs with verified employment or contracted status to 340B Pharmacy not less than on a semi-annual basis, upon any change of provider personnel, or as needed.
        i. Any updates or changes are provided once HR notifies payroll. CFO or his/her designee will update pharmacies as needed.

8. **Pharmacy eligibility verification**
    a. Prescriptions can be presented to Pharmacy via hard-copy, e-prescribing, phone and fax.
        i. The prescription is reviewed electronically by pharmacy operating system to verify eligibility of provider NPI and address of provider.
    b. Patient Eligibility verification
        i. Pharmacy staff may verify active patient status by determining if

patient has had an eligible 340B prescription from a health center provider within the last 12 months.

c. Terminated Providers
    i. If a health center provider has been terminated, eligible patient prescriptions will be honored for 12 months from date of issue per state law.
    ii. If pharmacy/patient request renewal prescription and the provider is terminated, a health center nurse will task the renewal to a current provider on the floor to ensure it is not refilled under terminated NPI.
d. Sliding fee scale and/or low income voucher process
    i. Patients who do not have prescriptions covered by insurance including Medicaid and HSNO will be eligible for discounted medications if they fall below 200% FPL per Bureau of Primary Health Care (BPHC) requirements.
    ii. Patients will be able to receive medications at the 340B acquisition cost plus contracted administrative fee.
e. Patient Assistance Programs (PAP)
    i. As appropriate, patients may be referred to Needymeds.com for assistance with free medication if they cannot afford them. The health center's Community Health Workers or Navigators may help with process as appropriate based on needs of patient.
    ii. In limited circumstances, the Medical Assistants or Nurses may contact the contracted pharmacies to determine if there is any other assistance available to help defray the cost of the medication.

9. **Patient freedom of choice verification**
    a. Health Center Providers will inform patients of their freedom to choose a provider of pharmacy services.

10. **Contract Pharmacy Processes**:
    a. The health center has contracted with Williamsburg Pharmacy and Walgreen's to facilitate both the design and implementation of the 340B contract pharmacy program. The entity is responsible for 340B compliance. The executed contract with pharmacy programs appear in Appendix B.
    b. Inventory Model
        i. Williamsburg Pharmacy uses a physical inventory model for contract pharmacy services.
        ii. Walgreen's uses virtual replenishment inventory model.
    c. 340B eligible prescriptions may be presented to registered contract pharmacy location via (e-prescribing, hard-copy, fax, or phone).
    d. Ordering and inventory control - Williamsburg
        i. Williamsburg contracted pharmacy staff places 340B orders, on behalf of the health center, based upon previous 340B use.
        ii. The health center retains title to all drugs from the time the supplier fills the order to the time that Williamsburg takes delivery of the drugs.

iii. Pharmacy inventory is protected by a security system. Only pharmacy employees have access to the pharmacy.
iv. Standard pharmacy protocols are followed by Williamsburg staff for all storage, returns, disposal of drugs by pharmacy.
v. Williamsburg Pharmacy provides entity access to monthly data and reporting information to allow the health center ready and consistent access to all pharmacy dispensing data.

e. Ordering and inventory control – Walgreen's
   i. Orders are triggered by full package usage of NDC-11, placed by using online system on daily interval, and communicated to the Health Center. Staff can verify all orders through Walgreens electronic inventory system. The Health Center will review inventory orders monthly for accuracy.
   ii. Contracted pharmacy staff places 340B orders, on behalf of Health Center, based upon 340B eligible use as determined by the eligibility verification system via Walgreens Inc.
   iii. Walgreens Inc. notifies the Health Center if central replenishment warehouse or pharmacy location doesn't receive 11 digits NDC replenishment order within 30 days of original order fulfillment request.
   iv. For un-replenished orders, the Health Center will reimburse contracted Walgreens Inc. stores at a pre-negotiated rate for such drugs as set forth contract with Walgreens Inc.

11. 340B Procurement, inventory management and dispensing for contract pharmacy

a. 340B Procurement and collections
   i. "Ship to bill to" procedure refers to an arrangement whereby the covered entity will purchase the 340B drugs from wholesalers and/or manufacturers who bills the covered entity and the covered entity pays for these purchases. The manufacturer or wholesaler then directs those 340B drugs to be shipped to the contract pharmacy. Therefore the covered entity maintains title of the 340B drugs as required, but the contract pharmacy (ies) receives the drugs and dispenses them to eligible patients.

b. Orders and Payment to Suppliers
   i. The Health Center will purchase 340B priced pharmaceuticals through its contract with wholesaler.
   ii. Current wholesaler services provided by AmerisourceBergen.
   iii. The pharmacy will promptly review the Inventory Receipt when shipments are received and notify the wholesaler of any discrepancies between the quantities ordered and the actual shipment of 340B Drugs received. It will be corrected on the wholesaler invoice.

c. Inventory verification:
   i. Walgreen's: AmerisourceBergen sends invoices for each store every 15 days. Walgreen's sends copy of original packing slips. These are used to reconcile totals from packing slip with AmerisourceBergen statement of invoices.

ii. Williamsburg Pharmacy: Pharmacy uses packing slips (with stickers) to reconcile shipments from wholesaler AmerisourceBergen. Health center receives faxed copies of packing slips upon order by Pharmacy. These are reconciled to make sure all invoices are listed within wholesaler statement, which is sent every 15 days from wholesaler. If any packing slip is missing, pharmacy will send copy.

12. **Rates for services**
    a. The Health Center agrees to reimburse contract pharmacies in accordance with method and rates as stipulated in its contracts.

13. Medication ordering and dispensing for provider administered medications
    a. No 340B medications are used for provider administered medications unless dispensed through the pharmacy

14. Medicaid Billing
    a. As of July 1, 2013, all contract pharmacy locations follow the rules for 340B billing set in the Massachusetts Medicaid Provider Manual established in 130 CMR 406.000 (MA Medicaid billing requirements for MassHealth).
    b. MassHealth will reimburse eligible covered entities registered in the OPA database as carving-in Medicaid for 340B prescriptions at a rate of 340B actual acquisition cost plus the contracted dispensing fee.
    c. Massachusetts Medicaid excludes from its rebate submission all Medicaid Managed Care prescriptions that are filled by a 340B entity that is listed in the Medicaid Exclusion File as using 340B for Medicaid.
    d. Regulations for Massachusetts' state agencies of Office of Medicaid and the Health Care Safety net Program for 340B are set in the following sources:
        http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-pharmacy.pdf
        http://www.mass.gov/eohhs/docs/dhcfp/g/regs/114-3-31.pdf

15. Division of Health Care Finance and Policy billing
    a. In general the Health Safety Net office will pay for reimbursable services listed in its regulations, including pharmacy services at a 340B entity.
    b. A provider is eligible for Health Safety Net payments for drugs provided *to eligible patients* through its 340B pharmacy at the same rate paid by MassHealth only if it provides prescribed drugs to MassHealth members under 114.3 CMR 31.07.

    c. Safety Net providers *may not* be reimbursed for non-eligible patients or non-340B drugs unless it meets the following requirements 1) the claim is submitted by a provider that directly operates both a 340B in-house pharmacy and a retail pharmacy and 2) the claim is for a drug provided to an individual who has not been seen by a provider-based prescriber to obtain a prescription within a clinically appropriate time period. The provider must inform the patient that it may not fill future prescriptions unless the individual becomes a patient of the health center (provider).
        http://www.mass.gov/eohhs/docs/dhcfp/g/regs/114-6-13.pdf

16. **Record-keeping to prevent diversion and duplicate discounts**
    a. The Health Center, with the assistance of the contract pharmacy, has established and maintained a tracking system as described herein, suitable to prevent diversion of 340B Drugs to individuals who are not patients of the Health Center.
    b. The Health Center has established a process for regular comparison of its prescribing records with the contract pharmacies dispensing records to detect potential irregularities and to ensure the efficacy of the tracking systems.
    c. A sample of 10% of prescriptions monthly will be selected at random for verification with 340B requirements.
        i. A copy of the prescription self-audit checklist tool used monthly to verify eligibility can be found in **Appendix B.**
        ii. Copies of monthly self-audit protocol will be kept for 3 years.
    d. Review of Medicaid prescriptions to ensure appropriate billing (carve-in)
        i. For all prescriptions that are billed to Medicaid FFS (MassHealth), claims must be submitted at AAC plus the contracted dispensing fee.
        ii. Medicaid Managed Care
            1. Prescriptions *can* be filled for Patients with payer IDs that include Medicaid Managed Care at contracted usual and customary rate.
            2. These claims must be submitted with NCPDP claim identification code 20 at point of service.
    e. Process for reconciliation or corrective action if error is identified
        i. For any 340B prescription filled with 340B drugs that is subsequently found to be inappropriate the claim will be resubmitted for processing as if it were not a 340B prescription and billed according to usual and customary procedures established by contract pharmacy for non-340B prescriptions.
        ii. Any prescription from a non-health center provider that does not meet approved referral documentation within 60 days will be reversed and credited to the 340B account and filled with non-340B inventory if appropriate.
        iii. If the prescription was filled for a patient who was cash pay or HSNO, for which no insurance can be billed, the pharmacy claim will be reversed, credited to the 340B account and the health center will cover the cost of the non-340B inventory to reconcile the claim.
        iv. Errors will be documented as will reconciliation process.
        v. Any material breach as defined above will be reported to HRSA with corrective action plan

APPENDIX A

Covered Entity Database Listing

Covered Entity Information

340B ID: CH010330

Entity Name: HILLTOWN COMMUNITY HEALTH CENTERS, INC
Sub-Division Name: Worthington Health Center
Address: 58 Old North Rd
Worthington, MA 01098 - 9753

Billing Address:

Comments: 8/8/05 - UPDATED CONTACT INFO, ADDED MEDICAID #

Contract Pharmacies

Name	Address	Address (cont'd}	City	State	Zip	Begin Date	Termination Date	Carve-In Effective Date
WILLIAMSBURG PHARMACY		49 MAIN ST P.O. BOX 397	WILLIAMSBURG	MA	01096	12/07/2006		
WALGREEN EASTERN CO., # NC.	DBA: WALGREENS 02710	78 MAIN ST	WESTFIELD	MA	01085	10/18/2011		
WALGREEN EASTERN CO., # NC.	OBA: WALGREENS 04358	60 SPRINGFIELD ST.	AGAWAM	MA	01001	10/18/2011		
WALGREEN EASTERN CO., # NC.	OBA: WALGREENS 07063	583 JAMES STREET	CHICOPEE	MA	01020-3911	10/18/2011		
WALGREEN EASTERN CO., WALGREENS NC.	DBA: #11602	70 MAIN STREET	FLORENCE	MA	01062	10/18/2011		
WALGREEN EASTERN CO., WALGREENS NC.	OBA: #11998	225R KING ST	NORTHAMPTON	MA	01060	10/18/2011		

340 Program Information

Entity Type: Consolidated Health Center Program
Approval Date: 8/8/2005
Participating: Yes
Participating Start Date: 10/1/1999
Termination Date:
Termination Reason:
Medicaid Number: MA-1302469
NPI Number:
Grant/Provider Number: H80CS00601
Site ID: BPS-HB0-003922
Alternative Methods: No

Covered Entity Signed By Official

Signed:
Title:
Date Signed: 8/1/2005
Phone:

Covered Entity Authorizing Official

Name: Frank Mertes
Title: Chief Financial Officer
Phone: 413-238-4116

Covered Entity Contact Information

Name: Jeff Hagen
Title: Chief Operating Officer
Phone: 413-238-4138

Edit Date: 3/2/2016

Children Entities

Address

3408 ID	Entity Name	Sub-Division Name	Address	(cont'd)	City	State	Start Date	Termination Date
CH01033A	HILLTOWN COMMUNITY HEALTH CENTERS, NC	HUNTINGTON HEALTH CENTER	73 Russell Rd		Huntington	MA	07/01/2007	

Covered Entity Information

340B ID: CH01033A

Entity Name: HILLTOWN COMMUNITY HEALTH CENTERS, INC
Sub-Division Name: HUNTINGTON HEALTH CENTER
Address: 73 Russell Rd
Huntington, MA 01050 - 9777
Billing Address: HILLTOWN COMMUNITY HEALTH CENTERS, INC
58 OLD NORTH RD
WORTHINGTON, MA 01098
Comments:

340 Program Information

Entity Type: Consolidated Health Center Program
Approval Date: 6/5/2007
Participating: Yes
Participating Start Date: 7/1/2007
Termination Date:
Termination Reason:
Medicaid Number: M.l\-1320866
NPI Number:
Grant/Provider Number: H80CS00601
Site ID: BPS-H80-003134
Alternative Methods: No

Edit Date: 3/2/2016

Covered Entity Signed By Official

Signed:
Title:
Date Signed: 3/27/2007
Phone:

Covered Entity Authorizing Official

Name: Frank Mertes
Title: CHIEF FINANCIAL OFFICER
Phone: 413-238-4116

Covered Entity Contact Information

Name: JEFFREY G. HAGEN
Title: CHIEF OPERATIONS OFFICER
Phone: 413-238-4138

APPENDIX B

Monthly

Prescription

Self-Audit Checklist

Monthly Prescription Self-Audit Checklist

No.	DATA	ASSESSMENT CRITERIA	Yes; No
1.	Medicaid ID Number, Provider Number, or NPI for all entity sites billing Medicaid for 340B drugs, and point of contact with state Medicaid agency.	Medicaid billing information in the HRSA 340B Database for all entity sites (1) is accurate and complete, (2) is based on current state policy requirements, and (3) reflects current actual practices by the entity.	
2.	Ensure that all Contract Pharmacies are included in the sample.	Sample includes a minimum of 10% of prescriptions filed by each contracted pharmacy.	
3.	Scope of services for which FQHC status was awarded to the clinic is up to date	Patient received health care services from the entity that are within the scope of the grant, and at a site that is registered on the HRSA 340B Database.	
		HCHC maintains health record of Individual receiving prescription.	
		Individual received health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (referral for consultation) such that responsibility for the care provided remains with the covered entity.	
		Provider-entity relationship is substantiated by contract/employment/other records per clinic site.	
		Prescription was from a provider NPI matching one on the eligible provider list at the time of prescribing.	
4.	Accounting of all inventory at beginning and end of sample period.	HCHC is able to provide an accounting for disposition of all the selected sample.	

Annex 9: Emergency Operations Plan

This plan is current under development.

Attachment 1

CORPORATE COMPLIANCE PLAN

Acknowledgment Form

I**,** the undersigned Employee or Agent of Hilltown Community Health Centers, do hereby acknowledge that I have received a copy of the Compliance Plan, and that I am responsible for reading the contents thereof. I understand that I must comply with the Standards of Conduct set forth in the Plan and all annexes thereto, as they apply to me. I further understand and acknowledge that infraction of the compliance plan, Standards of Conduct and Annexes thereto will result in disciplinary action up to and including termination.

I will cooperate fully with the Compliance Committee and Compliance Contact(s) to the extent necessary or helpful for implementation of the Plan.

_____	_____
Printed name	Position or Title
_____	_____
Signature	Date

Hilltown Community Health Centers, Inc.

Administrative Policy
Corporate Compliance

SUBJECT: STAFF COMPLIANE COMMITTEE - CHARGES TO MEMBERS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for members of the Staff Compliance Committee to serve and to support the work of the Compliance Officer in implementing HCHC's Compliance Program.

Policy:

1. Authority. The Staff Compliance Committee is comprised of members of Hilltown Community Health Centers, Inc. ("Health Center's") senior management who are representative of Health Center's major departments, such as billing, clinical, human resources, and operations. Members of the Compliance Committee serve to support the work of the Compliance Officer in implementing Health Center's Compliance Program.

2. Duties. As part of their duties, members of the Staff Compliance Committee advise the Compliance Officer and assist in the implementation of the Compliance Program. The Staff Compliance Committee meets regularly (at least quarterly). As directed by the Compliance Officer, and with due consideration for their other job responsibilities, the Staff Compliance Committee's functions include:

- **Compliance work plan.** The Staff Compliance Committee will assist the Compliance Officer in developing and implementing an annual compliance work plan.

- **Developing strategy.** The Staff Compliance Committee will analyze and, as needed, develop new methods for promoting compliance and identifying potential violations and for soliciting, evaluating, and responding to complaints and reports of alleged non-compliance.

- **Identifying areas of risk**. The Staff Compliance Committee will assist the Compliance Officer in assessing HCHC's operations to determine areas of risk and, if necessary, will identify measures to address such areas of risk. In addition, the staff-level Compliance Committee will analyze issues affecting HCHCs (and the health care industry) generally and the legal requirements with which HCHC must comply.

- **Policies and procedures; training and educational materials.** The Staff Compliance Committee will assist in developing, maintaining, implementing, and disseminating Board-approved policies and procedures that address areas of risk and that promote compliance with HCHC's Compliance Program, all applicable laws (including, as applicable, the laws authorizing and implementing Medicaid, Medicare, and other federal and state health care programs, and the requirements under Section 330 of the Public Health Service Act), and requirements imposed by commercial health plans.

- **Monitoring audits and investigations.** The Staff Compliance Committee will monitor the results of internal and external audits and investigations for the purpose of identifying or responding to potential risk areas and will recommend and assist in implementing appropriate corrective and preventive action.

Questions regarding this policy or any related procedure should be directed to the Compliance Officer at 413-238-4128.

Originally Drafted: FEB 2016 Reviewed or Revised: JUL 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.

School-Based Health Center

SUBJECT: ACCIDENT/INCIDENT REPORTS IN-HOUSE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for filing accident/incident reports at the School-Based Health Center (SBHC).

Policy:

The SBHC will file accident/incident reports on the following situations:

- Injury to a client or visitor on the SBHC premises.
- Injury to a staff member either on the SBHC premises or while performing a function for the SBHC outside of the premises.
- Errors made to a client by a staff member while receiving treatment - such as medication error, procedure error, treatment error.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The staff member either involved or responsible for the treatment error or witnessing an accident or receiving an injury shall be responsible for filling out the incident sheet within 24 hours of notification of said accident/incident. (All Staff)

2. The incident sheet shall be sent immediately to the staff's supervisor and if it involves an injury to a client due to the building or grounds a copy shall be sent to the Chief Executive Officer. If the injury involves hospitalization or death of a client, the Chief Executive Officer shall be notified immediately. (Director)

3. All copies of accident/incident reports shall be review yearly at the quality assurance meeting. (All Staff)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: APPOINTMENTS FOR BEHAVIORAL HEALTH
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for behavioral health appointments at the School-Based Health Center (SBHC).

Policy:

Behavioral health appointments will be scheduled by the Social Worker for his/her clients.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: AUG 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The Social Worker will obtain consent for treatment for those students receiving behavior health services not previously obtained. (Social Worker)

2. All attempts will be made to obtain consent specific to behavioral health prior to treatment beginning. If a general consent is on file, one meeting can be held prior to gaining specific consent. (Social Worker)

3. Registration forms will be completed during initial appointment. (Social Worker)

4. A student 18 years of age, or older or an emancipated minor, may sign their own consent. (Social Worker)

5. Passes will be given out for scheduled appointments. (Medical Assistant)

6. Appointments will be made with the least disruption possible to the students' academic schedule. (Social Worker)

7. If a student fails to show for appointment, contact will be made with the student to encourage participation in appointment and/or to ascertain why appointment was missed. (Social Worker)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: APPOINTMENTS FOR STUDENTS ILL AT HOME
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for seeing students at the School-Based Health Center (SBHC) who are ill at home.

Policy:

Students may be seen at the SBHC if they are ill at home and require medical care.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Students, or parents, may call the SBHC if the student is at home and ill and request an appointment.

2. If the student is at least 18 years old, he/she may make own appointment and come in by him/herself. (Medical Assistant)

3. If student is under age 18, the student must be accompanied by an adult for the medical appointment. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: BEHAVIORAL HEALTH RECORD
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for keeping behavioral health records at the School-Based Health Center (SBHC).

Policy:

An accurate and confidential record will be kept for each student seen for behavioral health services.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The behavioral health staff will create and maintain each students' record. (Social Worker)

2. Each page will have two (2) forms of patient identifications: name and date of birth.

3. The record is kept in a locked file in a locked room at the SBHC. (Social Worker)

4. The record is available to staff of the SBHC only. (All staff)

5. Students, family members, and school personnel are able to obtain information with a release of information signed by the parent/ guardian. (Social Worker)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: CARE TO UNEMANCIPATED MINOR NOT ACCOMPANIED BY A PARENT OR GUARDIAN
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for providing care to an unemancipated minor without parent/guardian consent at the School-Based Health Center (SBHC).

Policy:

The Clinician provides appropriate treatment as defined by Massachusetts General Laws, Chapter 112, Section 12F to an unemancipated minor without parental/guardian consent. If the criteria is not met, parental/guardian consent is obtained prior to delivering care.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Upon initial contact with a patient seeking services, the age of the patient is ascertained and the necessity for obtaining consent is determined.

2. When parental consent is not necessary, the Clinician assesses the patient to determine whether examination and/or treatment is necessary.

3. Information pertaining to treatment is confidential and released only upon written consent of the minor or proper judicial order.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: CHLAMYDIA SCREENING; GONORRHEA SCREENING
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for Chlamydia and Gonorrhea screenings at the School-Based Health Center (SBHC).

Policy:

Chlamydia tests are provided by the MDPH State Laboratory Institute.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: JAN 2005 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The protocol for collection and transport of urine specimens describes the procedure. See the following protocols for Specimen Collection and Specimen Transport.

2. The testing will be offered to any adolescent who is sexually active and desires testing. Testing is confidential and will not be reported to PCP or parent, as mandated by state law. An interview of the student will be conducted to determine information for behavioral data required on the requisition and for counseling purposes. All tested will be followed up in 10 days.

3. Test reports are received by phone or mail. Positive results are called in to the authorized persons at the SBHC (Nurse Practitioner). For positive results it is proposed to have Zithromax, 500 mg. (2 tabs) and Doxycycline 100 mg. (14 tabs) Partners should also be referred for testing and treatment to SBHC, if students at Gateway Regional School District (GRSD), or to STD Clinic or PCP. The infected student will be presented with the following options for referral:

    1. To PCP for other evaluations of STD.

    2. To Planned Parenthood or Tapestry for evaluation.

    3. To either STD clinic, state-affiliated, at Pittsfield or Springfield

If the student is symptomatic of the disease, a referral will be made for further evaluation.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: COLLABORATIVE CARE OF CHILDREN WITH SPECIAL HEALTH NEEDS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the continuity of care for children with special health care needs.

Policy:

The School-Based Health Center (SBHC) will provide a continuity of care for children with special health care needs in the school setting and is ensured by communication with all who provide services.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2004 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. A history of the special health condition is taken at the time of the office visit. Collaboration with the school nurse maybe needed. A phone call to the parent will be made to update the information.

2. After an evaluation of the health condition, follow-up information is provided to the parent by phone or letter. A copy of the D&T is sent home, and a form letter and a copy of the notes from the appointment at the SBHC is mailed or faxed to the primary care provider for continuity of care.

   There may also be communication with the student's aide or teacher as appropriate.

3. Releases of information will be on file. (Provider)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: COMPLAINT PROCEDURE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process handling complaints at the School-Based Health Center (SBHC).

Policy:

The SBHC adheres and follows the PATIENT COMPLAINT AND GRIEVANCE PROCEDURE of the HCHC Inc. that was approved by the Board of Directors on March 31, 2016.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

If any patient or family member has a complaint or grievance with staff or services received at the SBHC, which cannot be resolved by the parties directly involved, the party will be advised of the procedure. (All Staff)

The grievance procedure will be posted in a conspicuous place. (Medical Assistant).

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: CONFIDENTIAL VISITS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for confidential visits at the School-Based Health Center (SBHC).

Policy:

There are health circumstances that arise that mandate no information on a minor child be shared with parents/guardian or school personnel without child's permission. These are related to pregnancy, STD's and mental health issues.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: JUN 2001 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Appointment is scheduled with patient. (Medical Assistant)

2. Provider should determine if patient wishes visit to be confidential and record in patient's electronic chart.

3. Once patient's office visit is established within the resource schedule the word confidential must be added in the billing notes as well at the end of the office notes. (Provider)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: CONFIDENTIALITY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for maintaining patient confidentiality at the School-Based Health Center (SBHC).

Policy:

SBHC employees have the responsibility to respect the doctrine of confidentiality as mandated by Massachusetts State Laws and not divulge any information contained in the records to which they have access unless releases of information are in place.

1. The SBHC maintains an electronic medical record for each patient of the SBHC.

2. SBHC consent form specifically states that the parent or guardian consents to the exchange of health information between SBHC staff and school staff.

3. SBHC consent form authorizes release of information necessary for third party billing.

4. Confidentiality may be broken at the discretion of the clinician if the patient's life is at risk or he/she may be at risk to harm others.

5. All SBHC staff are responsible to ensure that confidentiality is maintained.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: EMERGENCY TRANSFER OF PATIENTS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the timely and appropriate transfer of School-Based Health Center (SBHC) patients who require urgent or emergency care.

Policy:

The SBHC will assure the timely and appropriate transfer of patients who require urgent or emergency care beyond the scope of School-Based Health Center abilities and resources.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 1999 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. For patients who are medically stable, where time is not critical, such as a probable broken wrist, laceration requiring suturing but with bleeding controlled or moderate abdominal pain which could be appendicitis but not sign of rupture:

a) The patient (or parent if a minor) may be given the option to transport the patient to the emergency room by private vehicle if that can be accomplished within a reasonable time frame given the circumstances. In any event, an attempt to call the parent or guardian will be made prior to calling an ambulance. It is the role of the provider on site at the time, in consultation with medical backup if needed, to determine whether a particular patient requires emergency transfer. The local Huntington ambulance will be called to transport such patients as needed to the emergency room of the patient's or parent's choice: Noble or Cooley-Dickinson. (Medical Staff).

2. For patients critically ill or injured such as an uncontrolled asthma attack, chest pain thought to be due to MI, uncontrolled bleeding, symptoms of stroke, major trauma, acute allergic reaction, or any other condition immediately threatening to life or limb, 911 will be called immediately to arrange transport to the nearest hospital emergency room (generally Noble Hospital). If a longer transport period is not thought to be dangerous by the ambulance personnel and the provider on the scene, transport to Cooley-Dickinson, and/or meeting up with a paramedic team from Northampton may also be options. (Medical Staff)

   An attempt will be made to contact a parent or guardian simultaneously or as soon as possible. The phone calls should be made by administrative personnel where possible, to allow medical providers to assist the patient. (Medical Assistant)

3. Letters of agreement from Cooley-Dickinson Hospital and Noble Hospital agreeing to accept emergency transfers from our facility on a 24 hr/day and 7 day/week basis will be kept on file. (Medical Director)

4. Documentation of permissions, allergies, and medications will be faxed to the receiving facility. (Medical Staff)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: EMPLOYEE HEALTH FOR COMMUNICABLE DISEASES
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for employee health at the School-Based Health Center (SBHC).

Policy:

The SBHC will work to prevent transmission of significant communicable diseases among employees and from employees to patients. This policy is meant to include significant diseases such as infectious bacterial gastroenteritis such as shigella or salmonella, respiratory diseases such as tuberculosis, influenza or legionella, or chickenpox, skin diseases such as impetigo or ringworm, and infestations such as lice or scabies.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: FEB 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

All new and existing employees will sign a statement certifying that they are free from communicable disease and that they will notify their supervisor or the medical director if they contract or have been in contact with a communicable disease that could be communicated in the usual course of their job function. The person responsible for hiring any new employee will also be responsible for seeing that the paperwork is complete. (Personnel)

The medical director will be notified immediately of any communicable disease, by an employee and will make a decision based on medical judgment and appropriate DPH regulations about whether the employee may remain on the job, and if so, with what, if any, restrictions. (Director)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: FILING SUSPICION OF CHILD NEGLECT/ABUSE WITH THE DEPARTMENT OF CHILD AND FAMILY SERVICES

REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to provide guidelines for filing suspicion of child neglect or abuse.

Policy:

Whenever a case of child abuse or neglect is suspected, the clinician will file a report with the Department of Child and Family Services (DCF).

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The Clinician will file a telephone report as soon as possible but within 24 hours. (All Clinical Staff)

2. The Clinician will file a follow-up report in writing within forty-eight (48) hours. (All Clinical Staff)

3. Whenever possible, the Clinician will discuss the allegations with the parent/ guardian. (All Clinical Staff)

4. The incident will be reported to the appropriate school personnel as soon as possible. (All Clinical Staff)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: HAZARDOUS WASTE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for disposing and removing hazardous waste from the School-Based Health Center (SBHC).

Policy:

Hazardous and infectious waste will be disposed of and removed from the SBHC in a manner that safeguards safety of patients and staff.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. A hazardous waste disposal unit will be in the exam room. Labeled biohazard, it is a red plastic bag in a metal can. All non-sharp biohazard/contaminated waste is disposed of in this container. (Provider and Medical Assistant)

2. As needed, the waste will be transported to HHC to be picked up by a designated waste facility for disposal. The bags will be sealed and double bagged prior to transport. (Medical Assistant)

3. All sharps, syringes and needles are disposed of in appropriate container designed for this purpose. The container is kept on a locked shelf in the exam room. (Medical Assistant)

4. Prior to each school vacation or on an as needed basis, the container will be transported to HHC to be picked up by a designated facility for disposal. (Medical Assistant)

5. The manifest records received by HHC will be copied and kept on file at the SBHC for 3 years. HHC will notify DPH and SBHC if copies of disposal manifest are not returned to HHC within 30 days. (HHC Staff)

See Form: Regulated Medical Waste and Medical Waste Tracking Form

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: INFECTION CONTROL/SAFETY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for infection control and safety measures at the School-Based Health Center (SBHC).

Policy:

Infection control standards are in effect and uniform for the protection of patients and staff.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. General cleaning of the SBHC space is done daily; this includes sweeping of floor, emptying trash, cleaning toilet and sink. (School Maintenance)

2. Routine care of exam table includes paper change and washing with Cavicide Solution between each patient. Counter tops, any hard surface and all tools within the exam room are treated in the same manner. (Medical Assistant)

3. If exposure to body fluids occurs cleaning of floor, exam table with Cavicide Solution is done immediately. (Medical Assistant)

4. Disinfecting of instruments occurs after each use by soaking for 20 minutes in Cavicide Solution. (Medical Assistant)

5. All staff use appropriate hand-washing techniques and universal precautions. (All Staff)

6. Staff will wear protective equipment if necessary. (Nurse Practitioner/Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: LABORATORY TESTS DONE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for laboratory tests performed at the School-Based Health Center (SBHC).

Policy:

The SBHC is able to do limited laboratory testing on site.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: JUN 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
President, HCHC Board of Director

Procedure:

1. Urine Dipstick
    - Will use sterile cups even if routine specimen. If suspect UTI, use clean catch procedure and sterile container collect specimen in bathroom, place on shelf.
    - Use procedure following Semins urine Strips.
    - Do control test one time daily when dipstick is used.
    - Document in lab/controls black note notebook found in exam room cabinet.
    - Check expiration date on each container.
    - See clean-catch Urine Procedure.

2. Rapid Streps
    - See procedure.
    - Use Swabs provided in the in house rapid kit.
    - Test positive and negative controls with each new box.
    - Document internal control on lab slip and notebook.
    - Use procedure following.

3. Urine Pregnancy tests: HCG
    - Document internal control on lab slip and notebook.
    - Follow procedure
    - See Directions

4. Hemo Point H2:
    - See intended use, set up, and procedure
    - Remove sample tube from the refrigerator and bring to room temperature (15-30C) if arterial or venous blood
    - Activate Hgb limit mode ON with the Hct mode ON
    - Select patient type
    - Follow enclosed directions for test
    - Record results in lab/controls notebook
    - External controls are done with each test

Record results on lab slips. (Nurse Practitioner/Medical Assistant)
Record tests in notebook. (Medical Assistant)
Record controls in notebook. (Nurse Practitioner)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: LABORATORY TESTS REFERRED OUT
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for laboratory tests transported from the School-Based Health Center (SBHC) to an outside lab.

Policy:

Since the SBHC only does limited laboratory testing on site, it refers patients to other lab facilities when necessary.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

For labs ordered to be done at other facility: Blood and or Radiology for non HCHC patients and HCHC patients alike:

- Print out the electronic lab slip for patient to take to any BRL site for blood work (Medical Assistant or Provider)
- Print out electronic Radiology slips for patient to take with them to which ever hospital they prefer (Medical Assistant or Nurse Practitioner)

The electronic lab slip for the patient will have the following information:

- Diagnosis
- Patient's Name, Birthdate
- HCHC information
- Physician electronic signature
- Procedures to be completed

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: LABORATORY TESTS TRANSPORTED TO OUTSIDE LAB AT HUNTINGTON HEALTH CENTER (HHC) OR WORTHINGTON HEALTH CENTER (WHC)
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for laboratory tests transported from the School-Based Health Center (SBHC) to an outside lab.

Policy:

The SBHC collects some specimens on site and Baystate Reference Lab (BRL) comes every day to pick them up.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Lab Specimens (throat cultures, urine, clean catch cultures) (Medical Assistant)

2. Preparations- Label specimen accurately, bag in Biohazard bag with corresponding lap slip (Medical Assistant)

3. Storage- Anything that is to be refrigerated right after collection will be driven over to the HHC. Anything that can wait until SBHC closes for the day will be transported to the HHC then. (Medical Assistant)

4. Prepare electronic lab slip for BRL with the following information: (Provider or Medical Assistant).
   - Date/Time collected
   - Diagnosis/collected by
   - Patient's name
   - Date of Birth
   - HCHC information
   - Physician's electronic signature

5. Procedures to be completed will be on the lab slip (Provider)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: MEDICAL APPOINTMENTS FOR COMMMUNITY PATIENTS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for seeing community patients for medical appointments at the School-Based Health Center (SBHC).

Policy:

1. Ordinary appointments for patients from the Gateway Community (non-students) will be made in the hours when students are not using the SBHC.

2. Any citizen from the Gateway community may make an appointment for medical services. (Medical Assistant)

3. Prior to receiving services, consent to treatment must be on file. If patient is under 18, a parent /guardian must sign for treatment. (Medical Assistant)

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: MEDICAL RECORD POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for medical records at the School-Based Health Center (SBHC).

Policy:

A complete and accurate Medical Record shall be kept for each patient of the SBHC.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Prior to the patient's first visit, a record will be created in E-Clinical Works (eCW) using one or more of the following:
    - Power school website provided by Gateway Regional School District (GRSD)
    - A completed SBHC enrollment form filled out by the patient (if over 18years of age or legally emancipated) or the patients guardian/parent. It is then scanned into the eCW.
    - Information relayed over the phone from the patients guardian/parent accompanied by a detailed telephone encounter in the patients chart. (Medical Assistant)

2. All incoming verbal information/paper work will be scanned into the patients chart or manually typed into eCW via telephone encounter or within the office visit itself.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: MEDICATION PRESCRIBING POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for dispensing medications at the School-Based Health Center (SBHC).

Policy:

If medications are required for patients a prescription will be electronically prescribed and sent to the pharmacy of choice or written and given to the patient.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAR 1999 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: MISSED BEHAVIORAL HEALTH APPOINTMENTS POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for missed behavioral health appointments at the School-Based Health Center (SBHC).

Policy:

It is the responsibility of the clinician to locate students who are late for appointments and to take appropriate steps to follow up with students who have missed appointments.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. If the student is enrolled in the middle school, his/ her daily schedule is available through the secure school scheduling program Powerschool. Schedules can also be obtained from the guidance counselors or the middle school secretaries. Classroom teachers may be reached by using the middle school phone in the SBHC.

2. If the student is enrolled in the high school, his/her daily schedule is on Powerschool. Schedules can also be obtained from the guidance counselors or from the file at the high school office. Classrooms may be reached on the school phone. The high school secretary will call the appropriate classroom when needed.

3. On those occasions when the student is found to be on the school grounds but unreachable by telephone, the clinician may seek him/her out in person, but only if not in violation of the students' confidentiality. (Clinician)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: NON-MEDICAL EMERGENCY PLAN/CRISIS FIRE SAFETY PLAN

REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the School-Based Health Center (SBHC) to participate in the Emergency /Crisis Plan of the Gateway Regional School District (GRSD).

Policy:

The staff of the SBHC will adhere to and participate in the Emergency /Crisis Plan developed by the Gateway Regional Schools.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

All SBHC staff are responsible for this plan.

1. Upon discovering of fire or smoke in the SBHC, all persons should be evacuated from the Center.
2. The fire alarm should be activated or 911 dialed.
3. Handicapped and non-ambulatory patients shall be helped out of SBHC office and out of school building by appropriate SBHC staff.
4. All staff will make sure doors are closed and main door is locked.
5. The building should be evacuated per the Gateway plan
6. All staff will exit thru main SBHC door and exit school building thru front door.
7. Fire extinguishers are located in exam room and central work space.
8. If appropriate, Chief Executive Officer and DPH will be notified.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: NOTIFICATION OF PRIMARY CARE PROVIDERS POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for notifying providers of patients of the School-Based Health Center (SBHC) of a visit.

Policy:

The standard notification letter will be sent to PCP's (even if telephone contact was made at the time of the visit) under the certain circumstances.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAR 1999 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

The Nurse Practitioner will generate a letter with the following information as it applies:

- If a prescription medication was given.
- If a diagnosis of strep throat, UTI or pregnancy is made. (information regarding pregnancy can only be given with the patient's permission).
- If follow-up with the PCP was recommended during the visit (adults with their permission)
- If the patient was seen for a change in chronic condition normally followed by the PCP (like asthma, hypertension, diabetes).
- If an annual or sports physical was done.
- If immunizations were given.
- If lab work was ordered.
- If the SBHC provider is concerned about issues like recurrent illnesses, frequent absences, etc.
- If student has been referred to outside physician.

Examples of visits not sent would be minor bruises, strains, sprains or viral illnesses treatable with over-the-counter medications.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: OFF-HOUR COVERAGE POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for medical care coverage during off hours of the School-Based Health Center (SBHC).

Policy:

HCHC requires that timely and appropriate medical care is assured for SBHC patients when it is not open.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Patients will be given the number for the Huntington Health Center (HHC), which has someone answering the phones 24 hr/day.

2. Patients who have another primary care provider are encouraged to rely on their primary care provider for off hour calls and services. (Staff)

3. Other patients and those experiencing symptoms in need of urgent attention will be directed to go to the nearest emergency room.

4. An answering machine provides the hours of operation of the SBHC and disseminates the above information. (Medical Assistant)

5. Patients seen at the SBHC who are sick and may need follow-up or care when the SBHC is closed, will be given the above information by the provider seeing them. (Nurse Practitioner/Doctor)

6. This information may be given over the phone or in person to those inquiring at any time a provider is unavailable but the office is open. (Staff)

7. The School Nurse will be made aware of this procedure so she may use it when advising SBHC patients who present themselves to her for care, when the SBHC is closed.

8. A posting in the SBHC states what patients should do if the SBHC is closed. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: PARTICIPATION IN SCHOOL EVENTS POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the School-Based Health Center (SBHC) to assist and participate in school events.

Policy:

The staff of the SBHC will be available as a resource to schools to enhance existing health curriculums and provide presentations.

1. Staff of the SBHC will meet with the Health Coordinator and Health Teachers to assess needs, (Program Director/ Provider or Nurse Practitioner/ Social Worker)

2. Staff will participate in classrooms on health and medical issues as requested by or arranged by school staff. (Provider/Nurse Practitioner/ Social Worker)

3. Staff will follow the schools' regulations concerning approval of content of presentations. (Provider/Nurse Practitioner/ Social Worker)

4. The Program Director or staff designee serves on the schools' Health Advisory Board. (Program Director).

5. In addition, staff may participate in special events, such as health fairs. (Provider/Nurse Practitioner/ Social Worker/ Program Director)

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____

John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: PATIENT'S ADMISSION CRITERIA/CONSENT TO CARE POLICY
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for enrolling students in the School-Based Health Center (SBHC) regardless of insurance status and ability to pay.

Policy:

All students enrolled in the Gateway Regional Middle & High Schools are eligible to be enrolled in the SBHC regardless of their insurance status or ability to pay for services.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Consent forms are given prior to an initial visit to all students at the Gateway schools for parental permission. (Medical Assistant)
2. Registration and HIPPA forms are given to students at initial visit.
3. Enrollment is complete when completed consent, registration and HIPPA forms have been returned to the SBHC. (Medical Assistant, Provider/Nurse Practitioner, Social Worker)
4. Staff may respond for any student in an emergency situation. (All Staff)
5. If a non-enrolled student requests treatment, a telephone permission from a parent/guardian may be obtained only one time within a school year and must be followed by a signed consent form. (Medical Assistant/Nurse Practitioner)
6. Any student who is 18 years of age or older may sign his/her consent form. (Medical Assistant, Nurse Practitioner, Social Worker)
7. A minor who is authorized by law to provide his/her own consent (under Massachusetts Minor Consent Status) may sign own form and receive services. (Medical Assistant, Nurse Practitioner, Social Worker)
8. The signed consent form is kept on file and is valid until the parent/guardian notifies the SBHC in writing that the consent is withdrawn. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: PATIENTS SEEN BY THE SBHC AND EITHER THE HUNTINGTON HEALTH CENTER OR WORTHINGTON HEALTH CENTER
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for communicating between HCHC sites for patients of the School-Based Health Center (SBHC).

Policy:

The SBHC communicates in a timely manner with HHC or WHC for those patients who have medical care at both sites.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAR 1999 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

All HCHC patients that receive care at SBHC:

- All notes will be saved in the patient's Electronic chart in eClinical Works (eCW).
- The WHC and HHC will have access to the patient's chart at any time to review.
- As appropriate and necessary the provider will call medical staff of HCHC to relay information. (Medical Provider/Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SELECTION OF PERSONNEL AND LICENSURE/TRAINING
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for selection of School-Based Health Center (SBHC) personnel and their licensure and training.

Policy:

Professional staff of SBHC shall be selected in accordance with the qualifications of each position as set forth in the job description.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. The qualifications of each applicant will be reviewed (Chief Executive Officer and/or Program Director)

2. If appropriate, the certification of licensure will be presented at the initial interview. (Chief Executive Officer and /or Program Director)

3. The team of the SBHC will be involved in the interviewing and selection process whenever possible. (Team)

4. Three references for each applicant will be checked if possible. (Chief Executive Officer and/or Program Director)

5. All licensed staff must comply with state licensing requirements regarding Continuing Education according to each specific licensure. (Chief Executive Officer and/or Program Director)

6. All SBHC medical staff are trained in CPR and First Aid and lab procedures (certification is on file). (Program Director)

7. See all job descriptions resumes in personnel section.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: PREVENTATIVE MAINTENANCE OF MEDICAL EQUIPMENT
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for maintaining medical equipment of the School-Based Health Center (SBHC).

Policy:

The SBHC has a maintenance program to insure all equipment is in safe working order.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. A maintenance check will be performed at a minimum one time a year, by appropriate agent, on all mechanical and electronic equipment. (Medical Assistant)

2. It will be checked to insure it is properly grounded and calibrated with manufacturer's recommendations. Generally, Mass Surgical Supply will calibrate equipment.

   This includes:
   - Sphygmomanometer (blood pressure machine)
   - Oxygen Tank
   - Scale
   - Wall Transformer
   - Exam Table
   - Thermometer
   - Nebulizer
   - Pulse Oximeter

3. A sticker will fixed to equipment. (Calibrating Agent)

4. A copy of invoice will be kept on file. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: PROVISION OF EMERGENCY CARE AND EMERGENCY EQUIPMENT
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for limited emergency care and emergency equipment at the School-Based Health Center (SBHC).

Policy:

Because of rapid availability of emergency transport, the limited space, level of skill of the personnel at SBHC, and the nature of the mission at SBHC, the extent of emergency capability should be, and is, strictly limited to the provision of competent first aid, CPR, and the use of simple, basic emergency equipment.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

Medical providers at SBHC will all be CPR certified, and a copy of that up-to-date certification kept on file. Basic knowledge of first aid for non-cardiorespiratory emergencies is also expected as part of the providers training for their position. (All Medical Staff)

In case of any life-threatening emergency, the provider will call 911 or request a staff member to call 911 while any first aid is being given. (Medical Staff)

Emergency equipment commensurate with our mission will be kept at the SBHC readily available and in good working order. An annual review of this equipment will be undertaken by a medical provider at SBHC, and a written notation made of this review. (Medical Staff)

Emergency equipment on hand will include:

- an epi-pen kit
- a nebullizer unit with albuterol
- sterile gauze bandages and tourniquet
- oxygen with mask and nasal cannula
- CPR mouth shield
- injectable benadryl and epinephrine
- chewable aspirin
- automatic defibrillator/ambu mask

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: QUALITY IMPROVEMENT PROGRAM
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the School-Based Health Center (SBHC) to have a Quality Improvement Program.

Policy:

The SBHC has an ongoing quality improvement program which identifies aspects of care or areas of need that are inadequately addressed with the current practice. It will plan and implement changes to address the deficits and reassess, after the change, to verify its effectiveness.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. At the beginning of each school year the Medical Director with other staff will choose an area (or areas) of focus for quality improvement that year.

2. The focus shall be chosen based on their experience in providing care, patient input or complaints, on chart review or on discrepancies between current practice and practice guidelines, or as requested by the Department of Public Health or other funding/licensing agencies.

3. Each plan will be developed and will include an assessment of the current need/deficit, a plan for improvement, and a method of assessing the impact of changes made. Each plan will be continued in the following years. (Medical Director with other staff)

4. The new proposed plan will be submitted to the Health Center Quality Improvement Committee for approval. (Director)

5. The quality improvement plans from previous years, will be reviewed on at least an annual basis at the beginning of each school year; a summary of the previous year's findings will be documented and placed in the QI section of the SBHC policy and procedure manual. The monitoring of the current plan's progress will be incorporated into the SBHC team meetings. (Director)

6. The current school year's plan will be approved by the Director of the SBHC and a follow-up report given to him/her. It will then be submitted to the Board of Directors. (Director)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: REFERRAL OF PATIENTS TO EMERGENCY SERVICES
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for School-Based Health Center (SBHC) patients with unstable and serious life threatening conditions to be immediately referred to the Emergency Services.

Policy:

1. The provider will assess patients and refer to emergency services when appropriate and follow all procedures in this policy.
2. The procedures followed will be documented appropriately in the patient's medical record.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 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. Assess the Patient immediately. (Provider)

   a. If the complaint or condition requires emergency medical attention, 911 is contacted. (Provider)

   b. If patient is a minor, the parent/guardian is contacted. (Provider)

2. In the event of a psychiatric emergency and the patient is assessed to be a danger to self or others, either the appropriate crisis team is contacted, or if danger is imminent, the local police department. (Social Worker/Provider)

   All Steps taken are recorded in patient's chart. (Provider/Social Worker)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: REFERRALS FOR BEHAVIORAL HEALTH SERVICES
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for referrals for behavioral health services at the School-Based Health Center (SBHC).

Policy:

HCHC has developed a process for referrals made to the SBHC for behavioral health treatment.

Referrals may be made for behavioral health treatment to the SBHC by the guidance staff, the school nurse, the SBHC's Provider/Nurse Practitioner or a student may self refer.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. If a student self-refers, the social worker, with the student's consent, will notify appropriate guidance counselor. School Administration and parents can refer. (Social Worker)

2. The person making the referral will use the appropriate form. (Social Worker)

3. The referral source will contact the parent/ guardian if appropriate prior to making the referral to gain permission. (Social Worker)

4. The Social Worker will contact the family, send a consent form and registration form to them. (Social Worker)

5. The staff will insure that the information necessary to complete a referral is obtained. (Social Worker)

6. The staff will set up the initial appointments as soon as possible after the consent form has been received.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: REPORTABLE DISEASES AND CONDITIONS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for dealing with reportable diseases and conditions at the School-Based Health Center (SBHC).

Policy:

The SBHC will comply with laws and regulations relating to reportable diseases and conditions.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

The SBHC will comply with Department of Public Health (DPH) regulations requiring reporting of certain communicable diseases in our patient population.

A copy of the list of currently reportable disease will be kept with the policy manual, and copies of reporting forms kept with an additional copy of the list in a file folder easily accessible to the providers.

The medical director will be responsible for keeping the file updated and will review any cases reported and serve as a resource for providers if questions arise on reportability.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: RETENTION OF PATIENT FILES
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the School-Based Health Center's (SBHC) patient files.

Policy:

The SBHC patient files will be kept securely for the 30 years required.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: SEP 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. At the beginning of each school year, all records of graduated students will be removed from the files of current patients. (Medical Assistant)

2. These files will be moved and stored in the closed files storage at the SBHC. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SELECTION OF PERSONNEL AND LICENSURE/TRAINING
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for selection of School-Based Health Center (SBHC) personnel and their licensure and training.

Policy:

Professional staff of SBHC shall be selected in accordance with the qualifications of each position as set forth in the job description.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 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 Director

Procedure:

1. The qualifications of each applicant will be reviewed (Chief Executive Officer and/or Program Director)

2. If appropriate, the certification of licensure will be presented at the initial interview. (Chief Executive Officer and/or Program Director)

3. The team of the SBHC will be involved in the interviewing and selection process whenever possible. (Team)

4. Three references for each applicant will be checked if possible. (Chief Executive Officer and/or Program Director)

5. All licensed staff must comply with state licensing requirements regarding Continuing Education according to each specific licensure. (Chief Executive Officer and/or Program Director)

6. All SBHC medical staff are trained in CPR and First Aid and lab procedures (certification is on file). (Program Director)

7. See all job descriptions resumes in personnel section.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SELF-ADMINISTERED PEDIATRIC SYMPTOM CHECKLIST
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for administering and tracking the Pediatric Symptom Checklist at the School-Based Health Center (SBHC).

Policy:

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. The youth self-report can be administered to adolescents ages 11 and up and will be given to each patient on the initial visit yearly.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: DEC 2002 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. A checklist will be given to each student during the patient's first visit to the SBHC each year. (Nurse Practitioner)

2. Items rated "never" are scored 0; items rated "sometimes" are scored 1; and items rated "often" are scored 2. The total score is calculated by the Practitioner by adding up scores for the 35 items. A positive score of 30 or higher suggests the need for further evaluation. Items left blank are ignored. However, if 4 or more items are left blank, the questionnaire is considered invalid. (Nurse Practitioner)

3. It will be scored during the patient's appointment whenever possible to allow further exploration of problems and issues when indicated. If time is not available, and a score of 30 is received, a follow-up appointment is recommended to be made as soon as possible. (Nurse Practitioner)

4. If the patient scores 30, the practitioner will:

    - Schedule additional visits with the patient.
    - Make appropriate referrals.
    - Contact the parents and/or send a letter to the PCP at her discretion.

5. The date the PSC is given and the patient's score will be recorded in his/her chart with narrative indicating impressions, referrals, follow-up, etc. (Nurse Practitioner)

6. A copy of the PSC will be stamped "Confidential" and placed in the patient's chart; the original will be kept in a separate locked file. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SERIOUS INCIDENT REPORTS TO DEPARTMENT OF PUBLIC HEALTH (DPH)
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for reporting serious incidents to DPH that occur at the School-Based Health Center (SBHC).

Policy:

The SBHC will file a written report with DPH of any serious incident occurring on the SBHC premises. These incidents are:

- fire
- suicide
- serious criminal acts
- pending or actual strike action by its employees

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: OCT 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. If the above incidents occur, immediately the Chief Executive Officer will be notified. (All Staff)

2. Immediately following the DPH will be notified by telephone. (All Staff)

3. A written report will be sent to DPH within one (1) week. (Director)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SERVICES FOR SCHOOL STAFF
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the staff of the Gateway Schools to be seen at the School-Based Health Center (SBHC).

Policy:

1. The school staff are able to make appointments for treatment at the SBHC.
2. The school staff will be required to complete the necessary paperwork prior to the appointment.
3. All efforts will be made to give school staff an appointment at a time that will be the least disruptive to their school schedule.
4. Information about the medical appointment will be conveyed to the staff person's primary care physician.
5. The staff person's insurance company will be billed for services.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: SERVICES PROVIDED/REFERRED
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the School-Based Health Center (SBHC) to provide a range of medical, nutritional and behavioral health services, including referrals for those services not provided on site.

Policy:

On site medical services consist of:

- physical exams
- diagnosis and treatment of acute and chronic illnesses
- diagnosis of acute and chronic injuries
- anticipatory guidance appropriate for students' ages
- individual preventative health education
- immunizations
- basic lab tests
- prescriptions
- diagnosis of pregnancy referral to Obstetrician / Gynecologist (Nurse Practitioner)
- STD testing

On site behavioral health services consists of:

- psychosocial assessments and diagnostic evaluations.
- individual therapy
- group therapy
- family assessment and therapy
  (Responsibility - Social Worker)

Services referred might include:

- reproductive care
- treatment of STD's
- diagnosis and treatment of HIV
- X-ray
- specialty care

- psychiatric medications (Social Worker)
  (Responsibility -Nurse Practitioner)

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 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.

School-Based Health Center

SUBJECT: SMOKING
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for no smoking in the School-Based Health Center (SBHC).

Policy:

There will be no smoking allowed in the SBHC facility or on the school grounds.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

The SBHC abides by and enforces the smoking policy of its host, the Gateway Regional Schools; No smoking is allowed in the school or on its grounds.

1. If a patient is observed smoking in or around the school, he/she will be asked to extinguish the material immediately and remove it. (SBHC Staff)

2. The student(s) will be told that when this occurs, he/she will be reported to the appropriate school authority (SBHC Staff)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: STAFFING/COVERAGE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the appropriate staff to be on site of the School-Based Health Center (SBHC).

Policy:

HCHC requires that a Nurse Practitioner or Doctor and Medical Assistant will be on site each day that the SBHC is open.

1. A Nurse Practitioner will be available each day that the SBHC is in operation. (Nurse Practitioner)

2. If the Nurse Practitioner is unavailable, he/she will attempt to secure as much coverage as possible for the time absent.

3. The Medical Assistant will be available each day that the SBHC is in operation (Medical Assistant)

4. If the Medical Assistant is unavailable, the Program Director will attempt to secure staffing to cover the time absent. (Medical Assistant)

5. The Medical Director for the SBHC is a physician employed by HCHC; and is on site at the SBHC an average of 2 hours per week and available by telephone during other hours of operation. (Program Physician)

6. If the Medical Director is unavailable, an alternative physician from HCHC will respond. (Program Physician)

7. Other staff may be added as the need arises and the appropriations become available.

8. The Program Director and Social Worker complete the SBHC staff.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: STORAGE AND DISPOSAL OF EMERGENCY MEDICATIONS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for storage and disposal of emergency medications at the School-Based Health Center (SBHC).

Policy:

The SBHC will store only those medications needed for an emergency situation.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: JUN 2003 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. All medications will be stored in their original containers. (Provider)

2. A log will be kept in red notebook in exam room. It will be updated as medications are received, dispensed, or disposed. (Provider and Medical Assistant)

3. Log will contain the following information for each medication (see sample log)
    - Name of medication
    - Date sample received
    - Lot number
    - Amount stored
    - Expiration date

    When a medication is in need of disposal, the log will state:
    - Medication
    - Date disposed
    - Amount
    - Method
    - Witness

Expired medications will be taken to one of the HCHC health centers, for disposal in a biohazard receptacle according to requirements.

The log will be reviewed quarterly for accuracy in September, December, March and June. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: STUDENT MEDICAL APPOINTMENTS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to provide guidelines for scheduling medical appointments for students.

Policy:

The appointments for students are made with the least possible disruption to their academic schedule.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 2000 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. Appointments may be scheduled by a student, his/her parent or guardian, or by the School Nurse. (Medical Assistant)

2. The appointments may be scheduled in person or over the telephone. (Medical Assistant)

3. Urgent appointments will be scheduled on the same day whenever possible. (Medical Assistant)

4. Non-urgent appointments will be scheduled as soon as possible with the least disruption to the student's schedules. (Medical Assistant)

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: STUDENTS IN BEHAVIORAL HEALTH CRISIS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for seeing a student who is experiencing a mental health crisis.

Policy:

The staff of the School-based Health Center (SBHC) may see a student who is not a registered participant of the SBHC, and who is experiencing a mental health crisis, if requested by school staff.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: MAY 2005 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. If a student is perceived by school staff to be experiencing a mental health crisis, school staff may request a one-time consultation/evaluation by the center's behavioral health staff.

2. This will be considered a consult on the part of the SBHC staff to the school and will not indicate availability for ongoing treatment until the student if age 18, or parent, register as a member of the SBHC and also sign request for behavioral health treatment.

3. This is the responsibility of the behavioral health clinicians.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: TREATMENT OF MINORS
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to provide guidelines for providers and staff regarding the care and treatment to minors at the School-Based Health Center (SBHC).

Policy:

It is the policy of HCHC to provide treatment to all minors in accordance with the Massachusetts General Laws.

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: JUL 2008 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

Consent to Treatment of Minors:

I. A minor **can** provide consent to treatment at the time of care (therefore neither parental consent nor parental notification of treatment would be indicated if the following criteria is met) if;

- The minor is considered an emancipated minor (*Emancipated minor* means a person under 18 years of age who is married or who is determined by a court of competent jurisdiction to be legally able to care for himself or herself.)
- The minor is recognized as a mature minor by the physician (if the physician determines that the minor can give informed consent to the treatment and it is in the minor's best interest not to notify his or her parents.) *The provider must document support for their determination in the medical record including whether a minor's parents or legal guardians will be involved in their care and how that will be incorporated.
- The minor is married, widowed, divorced (treatment would include abortion)
- The minor is the parent of a child *
- She is pregnant or believes herself to be pregnant*
- The minor is living separate and apart from their parent or legal guardian and is managing
- their own financial affairs
- It is an emergency situation where delay in treatment would endanger life, limb or the mental well-being of the patient.

II. If a minor **cannot** consent to treatment as indicated above, consent may be obtained using the Preauthorization to Treat Minors Consent Form (See Appendix B) :

- From the parent or legal guardian at the time of registration
- In the form of written permission from the parent or legal guardian and presented by another adult (for example, a grandparent) who accompanies the minor to the health center.
- In the form of written permission from the legal guardian and presented by the minor in the absence of another adult (at the discretion of the provider).

* Minors may not consent to abortion unless they are married, divorced or widowed without parental consent. Please see appendix A for more details.

III. Consent:

- Obtaining written consent from parent or legal guardian is preferable. However, telephone consent may be obtained if necessary.
- Telephone consent may be obtained from the legal guardian with verification by an employee who is present and hears the phone conversation.
- Documentation of telephone consent should include the name and phone number of the guardian as well as the name of the staff that verified consent must be entered into the progress note on the date obtained.

IV. Medical Records Documentation & Release:

A. Documentation:

1. Consent to treatment forms will be placed in the patient's chart.
2. Once a provider determines that a minor may consent to treatment support for this decision should be documented in the progress note including whether a minor's parents or legal guardian will be involved in their care, to what degree and how they will be incorporated.

B. Release of Information:

1. If the minor consents to treatment as described above, their medical records shall **not** be released without prior written consent of the minor or a judicial order.
2. If the provider determines that the condition of the minor is life threatening they shall notify the parents or legal guardian and inform the minor of this action.

V. Billing Considerations:

- Minors who are able to give consent to treatment and who are financially independent will be responsible for the charge of the visit and should be informed of this at the time of check in.
- Minors who are able to give consent to treatment (and are emancipated), but are **not** financially independent should be enrolled in Mass Health via the Health Connector.
- If the minor is considered to be a "mature minor" the provider should write **CONFIDENTIAL** on the encounter form. This will alert the reception staff to create a separate billing account for this patient with the letter "C" after the account number which will flag the billing department to bill the services to the Free Care Pool.
- Providers will alert the lab technician when they have a **CONFIDENTIAL** lab order and consult with the minor regarding who the responsible party will be for payment of the lab services. This should be communicated on all lab forms sent to the Cooley Dickinson Hospital laboratory (blue patient information form and lab order form).

- The minor should be informed that if they have commercial insurance through a parent or guardian, the insurance company may send the explanation of services or a record of the visit to their parent or guardian's home.

Hilltown Community Health Centers, Inc.

School-Based Health Center

SUBJECT: TRIAGE
REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for triaging student appointments the School-Based Health Center (SBHC).

Policy:

The SBHC has a protocol for triaging student appointments:

1. Students with life threatening or serious illness are referred immediately to the emergency room or their primary care doctor as appropriate. (Provider)

2. Students who are registered at the SBHC (or their parents) requesting routine follow-up or well-care appointments will have appointments made as the schedule allows. (Medical Assistant)

Questions regarding this policy or any related procedure should be directed to the School-Based Programs Manager at 413-667-0142.

Originally Drafted: APR 1999 Reviewed or Revised: AUG 2017

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Director

Procedure:

1. When a parent calls regarding a sick child:

a) If child is not in school, an urgent appointment may be scheduled at the SBHC if the parent accompanies a child under 18.

b) If child is in school, the child will be screened by the school nurse to see if an appointment is indicated, an appointment is made on the nurse's recommendation if space is available. An appointment will also be scheduled, space allowing, if the parent specifies that they do not wish the school nurse to screen the child. (School Nurse; Medical Assistant)

2. When a sick child walks in requesting to be seen:

a) The school nurse will triage all students to determine whether an appointment is desirable or necessary taking into account:
    1) the nature, severity and duration of symptoms.
    2) her knowledge of the student's history, recent illness, and
    3) the student's pattern of absences and use or misuse of the school health facilities in relation to missing class time*

*In order to make it easier to keep track of students who have problematic patterns of absenteeism or loss of class time due to health concerns, the school nurse may keep a confidential list of these students as she becomes aware of them through her own observations or by teachers of guidance counselors, and share information with SBHC personnel. (School Nurse)

3. Any sick student who requires evaluation and cannot be accommodated in a reasonable time frame at the SBHC, due to lack of space in the schedule, is referred to their primary care provider, walk-in center, or emergency room as appropriate. (Medical Assistant)

4. Students not already registered at the SBHC can be seen only if a parent/guardian can be reached to give verbal permission, and a registration form is subsequently filled out. A student will be seen one time only per school year with verbal permission. (Medical Assistant)

5. School staff and adult community members can request appointments and will be accommodated as the schedule allows. If no timely appointment is available, they are referred to their PCP or other source of care as appropriate. (Medical Assistant)