Hilltown Community Health Center

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

BOARD MEETING
February 7, 2019
WORTHINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the January 3, 2019 Meeting Minutes (Vote Needed)

3. Introduction of potential new Board Member: Kate Albright-Hanna

4. Finance Committee Report (Vote Needed)

5. Committee Reports (as needed) (Vote Needed)
    - Executive Committee
    - Quality Improvement
        1. QI/Risk Management Minutes for Nov and Dec 2018
    - Fundraising
    - Credentialing/ Privileging
        1. Elizabeth Peloquin, NP (Vote Needed)
    - Personnel
    - Facilities
    - Recruiting, Orientation, and Nominating (RON)
    - Strategic Planning
    - Corporate Compliance

6. Chief Executive Officer / Senior Manager Reports

7. Old Business

8. New Business
    - Policies (Vote Needed)
        - Patient Complaint and Grievance Policy
        - Emergency Transfer of Patients Policy
        - Serious Incident Reports to Department of Public Health (DPH) Policy
        - Voluntary and Involuntary Commitment Policy
    - Annual Disclosure Form

9. Executive Session

10. Adjourn

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 01/03/2019 5:30pm
Huntington Health Center

MEMBERS: John Follet, President; Tim Walter, Treasurer; Alan Gaitenby; Kathryn Jensen, Clerk, Lee Manchester; Nancy Brenner, Vice President, Matt Bannister; Wendy Long
STAFF: Eliza Lake, CEO; Michael Purdy, Risk Manager, Marie Burkhardt, Marketing
ABSENT: Seth Gemme; Maya Bachman; Frank Mertes, CFO
Guest: NONE

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Approval of Minutes 12/06/2018	John Follet called the meeting to order at 5:30pm. The minutes from the meeting of December 6, 2018 were reviewed. **Lee Manchester moved acceptance, Tim Walter seconded. The minutes of the monthly meeting of 12/06/18 were approved by those present.**	December 6, 2018 minutes were approved.
Finance Committee	Tim Walter reported on the Finance Committee's meeting of today. The financial situation continues in the negative, with a current loss of $80K. October saw a high usage, but visits in November were down in all departments. There was discussion about interpretation of low visit numbers, whether due to patient need/motivation or to staff availability. Tim noted the absence of Frank Mertes. HCHC is currently applying for a Non-Compete Continuation Grant for HRSA funds for the second year of a three-year grant. The text of this grant was included in the written materials for members of this board. This grant is an important source of	

	funding, and its expected stability is important in the current context. **Alan Gaitenby moved that the report of the Finance Committee be accepted. Nancy Brenner seconded the motion. The motion was approved by those present.**	Finance committee report was approved.
CEO Report	Eliza reported that she and Frank met with the Amherst Town Administrator, Paul Bockelman, about which party has responsibility for the large construction cost overrun. He was not initially sympathetic, but seemed to understand when he learned that HCHC had specifically been asked to locate there. This matter has yet to be resolved, and there will be a meeting later in the month to continue the conversation. There was also discussion of the rent and its rate of increase. HCHC is currently paying $5/sq ft and expects eventually to pay $12/sq ft. Frank has submitted a proposal to Paul that would reduce the rent as a concession to the high cost of preparing the building for our occupancy. Eliza has been with Natalie Blais and several other recently elected representatives to the State House, and feels that they understand and will champion the legislation important to HCHC. Ms. Lake reported that HCHC will be advertising for new patients for the Amherst site in coordination with the open enrollment period for MassHealth. Eliza reminded members of the Board education opportunity available at a Mass League symposium in Worcester on February 9, 2019.	
Executive Committee	John Follet reported that the Executive Committee has been involved in the annual evaluation of the CEO, the written version of which was included in materials sent to board members. Further discussion of this matter was deferred to the Executive Session at the conclusion of the meeting.	
Recruitment, Orientation & Nominating	Tim Walter reported that a prospective board member is being interviewed in the coming week.	

(RON) Committee		
Corporate Compliance Committee	The agenda of this committee is expecting to receive new attention from the coming Administrative Assistant.	
Credentialing / Privileging Committee	John Follet reported that this committee has not met.	
Facilities Committee	Alan Gaitenby reported that this committee has not met. Eliza Lake reported that one boiler had to be replaced in the lowest level of the Huntington Health Center.	
Personnel Committee	John Follet reported that this committee has not met.	
Strategic Planning	Nancy Brenner reported that this committee has not met.	
Fundraising Committee (ad hoc)	Nancy Brenner expressed support for this new project and said it will be discussed later in the meeting Marie Burkhardt led a discussion of community messaging, a consideration prior to inception of fundraising. There were many ideas about how HCHC should describe itself to the public. The ideas collected will be discussed by the Fundraising Committee and used to develop a proposed messaging campaign.	
Quality Improve-ment/Risk Management Committee	Kathryn Jensen reported that the QI committee meeting continues in its rotating department reports along with Risk Management. Matters of recent concern have been the coding problem in the Medical Department and a back-log of referrals. The latter has been taken care of since the QI meeting, according to Eliza Lake. The coding problem is also getting ongoing attention.	
Committee Reports	After all the committee reports had been reviewed and discussed**, Tim Walter moved the committee reports be accepted. Matt Bannister seconded the motion. The measure was approved by those present.**	Committee reports presented at this meeting were approved.

Old Business	Ms. Lake called the members' attention to the new procedure for delay or closure of sites for inclement weather or any other emergency situation. It has been revised to reduce the incidence of and to mitigate the financial impact to the health center of any such closures.	
New Business Policies Policy	Eliza noted the copy of the Center's application for the Non-compete Continuation Grant, the HRSA grant mentioned earlier, which is due to be submitted next week. **Matt Bannister moved acceptance of the submission. The motion was seconded by Tim Walter and approved by those present.**	Policies Policy was approved.
Employee Credentialing	John Follet presented the final document for Leah King, LCSW: a certificate for CPR. **Nancy Brenner moved to accept the credentials of Leah King. Wendy Long seconded the motion, which was approved by those present.**	Credentialing was approved for Lean King, LCSW.
Executive Session	The annual evaluation of Eliza Lake, CEO, a copy of which had been sent to members, was discussed. **Matt Bannister moved acceptance of the document. Wendy Long seconded the motion, which was approved by those present.**	Annual evaluation of CEO was approved.
Next Meeting	**Tim Walter moved the meeting be adjourned. Alan Gaitenby seconded the motion, which was approved by those present. The meeting was adjourned at 7:20 pm.** The next scheduled meeting will be on February 7, 2019 in Worthington.	

Respectfully submitted,
Kathryn L. Jensen
Clerk

Hilltown CHC
Dashboard And Summary Financial Results
December 2018

	Actual FY 2017	Actual YTD Mar. 2018	Actual YTD June 2018	Actual YTD Sep. 2018	Actual YTD Oct. 2018	Actual YTD Nov. 2018	Actual YTD Dec. 2018	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures										
Operating Days Cash	7	9	3	1	15	5	9	Measures the number of days HCHC can cover daily operating cash needs.	> 30-45 Days	Not Meeting Benchmark
Current Ratio	1.24	0.78	0.84	0.80	0.94	0.83	0.85	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	33	30	34	39	42	39	36	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	56	94	64	58	30	30	29	Measures HCHC's ability to pay bills	< 45 Days	Doing Better than Benchmark
Profitability Measures										
Net Operational Margin	-3.4%	-10.5%	-5.5%	-5.6%	-4.1%	-4.9%	-4.8%	Measures HCHC's Financial Health	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	9.6%	8.5%	5.6%	2.3%	2.9%	1.5%	1.2%	Measures HCHC's Financial Health but includes non-operational activities	> 3%	Not Meeting Benchmark
Leverage										
Total Liabilities to Total Net Assets	29.2%	33.9%	26.3%	29.1%	33.8%	30.4%	31.0%	Measures HCHC's total Liabilities to total Net Assets	< 30%	Not Meeting Benchmark
Operational Measures										
Medical Visits	18,727	4,371	8,863	13,067	15,109	16,708	18,166			
Net Medical Revenue per Visit	$ 134.56	$ 144.39	$ 144.02	$ 144.38	$ 146.08	$ 143.80	$ 143.59			
Dental Visits	14,880	3,512	7,426	11,454	12,953	14,318	15,537			
Net Dental Revenue per Visit	$ 113.60	$ 109.03	$ 115.98	$ 116.41	$ 116.88	$ 114.52	$ 112.76			
Behavioral Health Visits	3,809	1,002	2,120	3,129	3,586	3,916	4,306			
Net BH Revenue per Visit	$ 95.70	$ 85.29	$ 89.42	$ 91.01	$ 88.72	$ 85.15	$ 87.74			
Optometry Visits	2,329	523	1,124	1,726	1,973	2,156	2,381			
Net Optometry Revenue per Visit	$ 79.61	$ 91.60	$ 85.75	$ 87.29	$ 88.73	$ 87.01	$ 86.40			

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Dec. 2018

	Dec. 2018 Actual	Dec. 2018 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	205,925	238,083	(32,158)	2,608,478	2,806,752	(198,274)	2,519,957	88,521
Visits	1,458	1,721	(263)	18,166	20,304	(2,138)	18,727	(561)
Revenue/Visit	$ 141.24	$ 138.34	$ 2.90	$ 143.59	$ 138.24	$ 5.35	$ 134.56	$ 9.03
Patient Services - Dental	112,365	201,361	(88,996)	1,751,991	2,372,917	(620,926)	1,690,338	61,653
Visits	1,219	1,590	(371)	15,537	19,049	(3,512)	14,880	657
Revenue/Visit	$ 92.18	$ 126.64	$ (34.46)	$ 112.76	$ 124.57	$ (11.81)	$ 113.60	$ (0.84)
Patient Services - Beh. Health	44,342	37,968	6,374	377,787	470,714	(92,927)	364,524	13,263
Visits	390	400	(10)	4,306	4,818	(512)	3,809	497
Revenue/Visit	$ 113.70	$ 94.92	$ 18.78	$ 87.74	$ 97.70	$ (9.96)	$ 95.70	$ (7.97)
Patient Services - Optometry	18,135	23,208	(5,073)	205,723	290,271	(84,548)	185,403	20,320
Visits	225	295	(70)	2,381	3,688	(1,307)	2,329	52
Revenue/Visit	$ 80.60	$ 78.67	$ 1.93	$ 86.40	$ 78.71	$ 7.70	$ 79.61	$ 6.80
Patient Services - Optometry Hardware	6,757	6,841	(84)	83,791	85,000	(1,209)	78,083	5,708
Patient Services - Pharmacy	29,235	12,500	16,735	156,241	150,000	6,241	157,525	(1,284)
Quality & Other Incentives	33,668	33,500	168	49,111	33,500	15,611	118,962	(69,851)
HRSA 330 Grant	134,137	138,962	(4,825)	1,719,762	1,647,379	72,383	1,495,440	224,322
Other Grants & Contracts	47,998	116,391	(68,393)	877,929	972,744	(94,815)	904,409	(26,480)
Int., Dividends Gain /(Loss) Investments	(21,365)	2,500	(23,865)	(19,454)	30,000	(49,454)	96,788	(116,242)
Rental & Misc. Income	2,010	2,425	(415)	35,878	29,123	6,755	31,877	4,001
Total Operating Revenue	613,207	813,739	(200,532)	7,847,237	8,888,400	(1,041,163)	7,643,306	203,931
Compensation and related expenses								
Salaries and wages	438,628	502,520	(63,892)	5,696,977	6,162,999	(466,022)	5,418,103	278,874
Payroll taxes	34,410	38,188	(3,778)	426,074	468,387	(42,313)	402,020	24,054
Fringe benefits	32,347	42,734	(10,387)	460,938	523,857	(62,919)	474,256	(13,318)
Total Compensation & related expenses	505,385	583,442	(78,057)	6,583,989	7,155,243	(571,254)	6,294,379	289,610
No . of week days	21	21	-	261	261	-	260	-
Staff cost per week day	$ 24,066	$ 27,783	$ (3,717)	$ 25,226	$ 27,415	$ (2,189)	$ 24,209	$ 1,017

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Dec. 2018

	Dec. 2018 Actual	Dec. 2018 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	100	783	(683)	4,687	9,500	(4,813)	4,145	542
Bad debt	(1,465)	13,871	(15,336)	58,489	166,551	(108,062)	78,253	(19,764)
Computer support	4,374	16,442	(12,068)	84,529	197,302	(112,773)	108,575	(24,047)
Conference and meetings	185	1,347	(1,162)	4,660	16,252	(11,592)	15,368	(10,708)
Continuing education	5,944	2,795	3,149	24,628	33,463	(8,835)	28,972	(4,344)
Contracts and consulting	3,647	4,768	(1,121)	30,774	57,257	(26,483)	58,983	(28,208)
Depreciation and amortization	22,127	23,541	(1,414)	203,116	278,614	(75,498)	164,337	38,780
Dues and membership	2,739	2,926	(187)	30,754	35,198	(4,444)	83,754	(53,000)
Equipment leases	1,575	2,426	(851)	24,892	29,178	(4,286)	24,178	714
Insurance	2,070	1,489	581	23,556	18,000	5,556	14,472	9,084
Interest	1,291	1,500	(209)	17,970	18,000	(30)	18,611	(641)
Legal and accounting	2,167	3,000	(833)	31,964	36,000	(4,036)	34,044	(2,079)
Licenses and fees	4,140	4,333	(192)	55,190	51,970	3,220	49,637	5,552
Medical & dental lab and supplies	9,121	20,137	(11,016)	134,183	241,666	(107,483)	127,574	6,609
Merchant CC Fees	1,215	1,208	7	17,921	14,551	3,370	13,861	4,061
Office supplies and printing	1,721	2,950	(1,229)	43,172	35,250	7,922	32,700	10,472
Postage	2,050	1,989	61	18,009	22,835	(4,826)	16,819	1,189
Program supplies and materials	15,333	20,755	(5,422)	238,837	249,111	(10,274)	198,373	40,463
Pharmacy & Optometry COGS	3,137	5,040	(1,903)	115,845	60,406	55,439	116,892	(1,046)
Recruitment	-	434	(434)	340	5,120	(4,780)	4,119	(3,780)
Rent	7,123	6,537	586	65,099	78,422	(13,323)	37,192	27,907
Repairs and maintenance	18,016	12,835	5,181	180,895	154,031	26,864	156,024	24,871
Small equipment purchases	2,358	2,807	(449)	10,080	33,750	(23,670)	13,557	(3,477)
Telephone/Internet	12,511	13,326	(815)	141,729	151,890	(10,161)	114,555	27,174
Travel	2,463	3,953	(1,489)	24,079	47,508	(23,429)	46,901	(22,821)
Utilities	6,183	3,913	2,270	54,003	47,000	7,003	46,956	7,047
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	130,126	175,103	(44,978)	1,639,400	2,088,825	(449,425)	1,608,849	30,551
Net Operating Surplus (Deficit)	**(22,304)**	**55,194**	**(77,497)**	**(376,152)**	**(355,668)**	**(20,484)**	**(259,922)**	**(116,230)**
NON-OPERATING ACTIVITIES								
Donations, Pledges & Contributions	8,025	37,913	(29,888)	65,594	305,000	(239,406)	402,687	(337,093)
Loan Forgiveness	-	-	-	-		-	-	-
Capital Grants	-	-	-	404,993	445,912	(40,919)	671,525	(266,532)
Net Non-operating Surplus (Deficit)	**8,025**	**37,913**	**(29,888)**	**470,587**	**750,912**	**(280,325)**	**1,074,212**	**(603,625)**
NET SURPLUS/(DEFICIT)	**(14,279)**	**93,107**	**(107,385)**	**94,435**	**395,244**	**(300,809)**	**814,290**	**(719,855)**

Hilltown CHC
Summary of Net Results By Dept.
Dec. 2018
Net Results Gain (Deficit)

	Dec. 2018	Dec. Budget	Over (Under) Budget	YTD	YTD Budget	Over (Under) Budget	PY YTD	Cur. v. PY YTD
Operating								
Medical	$ 5,225	$ 21,758	$ (16,533)	$ (204,688)	$ (450,930)	$ 246,242	$ (387,127)	$ 182,439
Dental	(38,523)	3,138	(41,661)	(305,495)	(70,204)	(235,291)	(168,980)	$ (136,515)
Behavioral Health	15,937	4,069	11,868	40,817	47,268	(6,451)	28,955	$ 11,862
Optometry	2,732	4,674	(1,942)	(7,292)	63,459	(70,751)	(884)	$ (6,408)
Pharmacy	29,271	9,166	20,105	147,723	110,000	37,723	114,807	$ 32,916
Community	(7,681)	16,077	(23,758)	(28,681)	(1,667)	(27,014)	510	$ (29,191)
Fundraising	(6,187)	(5,606)	(581)	(68,879)	(69,113)	234	(69,823)	$ 944
Admin. & OH	(23,078)	1,918	(24,996)	50,343	15,519	34,824	222,619	$ (172,276)
Net Operating Results	**$ (22,304)**	**$ 55,194**	**$ (77,498)**	**$ (376,152)**	**$ (355,668)**	**$ (20,484)**	**$ (259,923)**	**$ (116,229)**
Non Operating								
Donations	$ 8,025	$ 37,913	$ (29,888)	$ 65,594	$ 305,000	$ (239,406)	$ 402,687	$ (337,093)
Capital Project Revenue	-	-	-	404,993	445,912	(40,919)	671,526	$ (266,533)
Total	**$ 8,025**	**$ 37,913**	**$ (29,888)**	**$ 470,587**	**$ 750,912**	**$ (280,325)**	**$ 1,074,213**	**$ (603,626)**
Net	**$ (14,279)**	**$ 93,107**	**$ (107,386)**	**$ 94,435**	**$ 395,244**	**$ (300,809)**	**$ 814,290**	**$ (719,855)**

Impact of Musante on Net Operating Results above.

	Dec. 2018	YTD
Medical	(33,710)	(138,088)
Dental	(11,383)	(65,449)

Hilltown Community Health Centers
Balance Sheet - Monthly Trend

	12/31/2017	3/31/2018	6/30/2018	9/30/2018	12/31/2018
Assets					
Current Assets					
Cash - Operating Fund	$ 139,487	$ 193,864	$ 59,713	$ 11,682	$ 197,997
Cash - Restricted (Amherst Donations)	238,749	108,789	25,978	25,048	6,152
Patient Receivables	922,130	892,811	1,008,550	1,132,355	945,217
Less Allow. for Doubtful Accounts	(99,215)	(135,875)	(136,698)	(164,027)	(109,786)
Less Allow. for Contractual Allowances	(364,280)	(355,637)	(400,599)	(425,743)	(317,200)
A/R 340B-Pharmacist	17,254	16,255	18,243	29,082	31,147
A/R 340B-State	928	(765)	(4,299)	(4,736)	(4,736)
Contracts & Grants Receivable	167,729	56,863	66,864	92,099	69,673
Prepaid Expenses	4,882	21,493	20,263	22,470	14,866
A/R Pledges Receivable	56,527	37,121	28,991	28,911	28,828
Total Current Assets	1,084,189	834,920	687,006	747,140	862,157
Property & Equipment					
Land	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
Improvements	872,646	872,646	905,848	905,848	911,848
Equipment	964,232	964,232	964,232	964,232	964,232
Construction in Progress (Amherst)	1,382,662	1,857,729	2,012,678	2,125,022	2,257,598
Total Property and Equipment	6,037,958	6,513,025	6,701,176	6,813,520	6,952,096
Less Accumulated Depreciation	(2,185,507)	(2,220,682)	(2,255,859)	(2,322,241)	(2,388,623)
Net Property & Equipment	3,852,452	4,292,343	4,445,317	4,491,279	4,563,473
Other Assets					
Restricted Cash	53,713	53,717	53,732	53,731	53,713
Pharmacy 340B and Optometry Inventory	13,089	13,224	13,544	14,344	14,518
Investments Restricted	6,978	6,978	7,350	7,789	6,661
Investment - Vanguard	514,406	464,406	467,823	377,622	227,889
Total Other Assets	588,186	538,326	542,450	453,486	302,782
Total Assets	**$ 5,524,827**	**$ 5,665,589**	**$ 5,674,773**	**$ 5,691,906**	**$ 5,728,412**
Liabilities & Fund Balance					
Current & Long Term Liabilities					
Current Liabilities					
Accounts Payable	$ 296,786	$ 508,923	$ 359,533	$ 335,288	$ 164,918
Notes Payable	-	-	-	-	300,000
Sales Tax Payable	51	315	59	35	56
Accrued Expenses	80,324	(3,108)	(6,046)	6,846	18,793
Accrued Payroll Expenses	368,564	504,005	397,811	478,758	386,764
Payroll Liabilities	19,499	8,674	12,214	15,276	20,702
Unemployment Escrow	826	826	826	826	826
Line of Credit	-	-	-	50,000	-
Deferred Contract Revenue	107,507	48,531	56,783	43,843	120,296
Total Current Liabilities	873,556	1,068,166	821,179	930,872	1,012,354
Long Term Liabilities					
Mortgage Payable United Bank	185,129	180,782	176,531	172,239	167,900
Mortgages Payable USDA Huntington	189,368	186,406	183,323	180,164	176,949
Total Long Term Liabilities	374,497	367,188	359,854	352,403	344,849
Total Liabilities	**1,248,053**	**1,435,354**	**1,181,033**	**1,283,274**	**1,357,204**
Fund Balance / Equity					
Fund Balance Prior Period	4,276,773	4,230,235	4,493,740	4,408,632	4,371,208
Total Fund Balance / Equity	4,276,773	4,230,235	4,493,740	4,408,632	4,371,208
Total Liabilities & Fund Balance	**$ 5,524,827**	**$ 5,665,589**	**$ 5,674,773**	**$ 5,691,906**	**$ 5,728,412**

QI-RISK MANAGEMENT COMMITTEE

Location: Huntington Health Center
Date/Time: 11/20/2018 9:15am

TEAM MEMBERS: Kathryn Jensen (chair), Board Representative; Jon Liebman, ANP, Medical Director via Zoom; Michael Purdy, CCCSO; Dawn Flatt, Director of Clinical Operations; Seth Gemme, Board Representative; Cynthia Magrath, Practice Manager; Serena Torrey, LICSQ, Director Behavioral Health; Eliza Lake, CEO; MaryLou Stuart, DDS, Dental Director

ABSENT: Sheri Cheung, Medicine Representative; Kim Savery, Director of Community Programs

Agenda Item	Summary of Discussion	Discussion/ Next Steps/ Person Responsible/ Due Date
Review of October 2018 Meeting Minutes	The meeting was called to order by Kathryn Jensen at 9:16am. Approval of October 2018 minutes	October 16, 2018 minutes were approved
Risk Management	Michael Purdy recommended that there be staff training on how to de-escalate situations. Last training was a couple of years ago. Discussion regarding a second opinion for narcotic denials, Jon feels this is not a good idea as it creates a situation of provider vs. provider. The challenge is more related to staff training.	Michael, Serena and Jon will discuss how to handle BH incidents, will report back at next month's meeting
Dental	Mary Lou Stuart reports no dental incidences.	
Peer Review / Department Reports Dental Department and Community Programs	Quality Metrics for Dental: MaryLou reports high risk cleanings reporting is challenging. Reports are in January and July but do not capture those done in the previous calendar year. For example, there were 36 treatment plans but 40 were done (4 are from 2017).	

	Sealants for HRSA are 6-9 year olds but because of the timing there should be more than we have. Should be more coded in 2018. Going in the right direction. Community Programs: Kim is not present, Michael reports there are no updates.	
Technical Assistance (TA) for diabetes from HRSA in October	Eliza reports that there were calls with Gloria Ortiz from HRSA regarding a TA we were invited to be part of. During the second call with Gloria, we were able to review Credentialing and Privileging policy; changes that need to be made to bring it in compliance with new requirements - MAs and CHWs need privileging, and students are covered in a separate policy. Regarding Form 5A: Scope of Services: HCHC needs to remove General Medical Primary Care from Column III, and added to Column II; Case Management needs to be removed from Column III; Diagnostic Testing needs to be added to Column I. The Scope must be kept current for anything to be covered by our FTCA coverage. The Board would have to vote on any of these changes before a Change in Scope application can be submitted. Still waiting on final report from the TA sessions. Risk management will make sure all activities are covered.	
New Business	Eliza announced that the Massachusetts Health Quality Partners (MHQP) has awarded HCHC with an award for excellence in Patient-Provider Communication, which is based on responses by commercially-insured patients who completed a CAHPS patient satisfaction survey. Kathryn: Schedule for new year, we are mandated to have 10 meetings a year. Last year we cancelled one and it threw the schedule off. Jon suggested everyone needs to report in 6-8 meetings. Kathryn has seen	

	it based on quarter. We have one more open meeting.	
Adjourn	This meeting adjourned at 9:55am. The next meeting is scheduled for **Tuesday, December 18, 2018** at 9:15am at the Huntington Health Center.	

Respectfully submitted:
Dawn Flatt, Director of Clinical Operations

QI-RISK MANAGEMENT COMMITTEE

Location: Huntington Health Center
Date/Time: 12/18/2018 9:15am

TEAM MEMBERS: Kathryn Jensen (chair), Board Representative; Jon Liebman, ANP, Medical Director; Michael Purdy, CCCSO; Dawn Flatt, Director of Clinical Operations; Cynthia Magrath, Practice Manager; Serena Torrey, LICSW, Director Behavioral Health; Franny Huberman, LICSW; Eliza Lake, CEO; MaryLou Stuart, DDS, Dental Director; Kim Savery, Director of Community Programs

ABSENT: Sheri Cheung, Medicine Representative; Seth Gemme, Board Representative

Agenda Item	Summary of Discussion	Discussion/ Next Steps/ Person Responsible/ Due Date
Review of October 2018 Meeting Minutes	The meeting was called to order by Kathryn Jensen at 9:15am.	
Risk Management	Michael Purdy reported that Department Heads are working on the disruptive patient and dismissal of patient policies. There was another incident with a disruptive patient, and there needs to be clarity in the staff response. The management of referrals is still an issue, and is one that is receiving the attention it deserves, as it is a risk management issue. The medical department is losing a provider in January, and there is another possible provider being interviewed to deal with the resulting capacity issues. Dave Morrier, MA, recently attended an extensive infection control training, and Michael and Dawn will ensure that the information is disseminated to all appropriate staff.	Michael, Serena and Jon will discuss how to handle BH incidents, will report back at next month's meeting

	Other updates: • HCHC has received a grant from the Mass League to support our Emergency Preparedness efforts. • HCHC's scope of services has been updated so that we ensure that the organization is properly covered by FTCA. • The site visit by HRSA is scheduled for November 2019, and therefore the QI/RM Committee will begin reviewing the relevant Program Requirement in January,	
Peer Review / Department Reports Behavioral Health Department	Quality Metrics for BH: Serena reported that they provided 45 Same Day Visits (SDV) in the third quarter of 2018. The Waitlist has been holding steady, and currently is at 24 patients. The list is getting more accurate through the efforts of receptionists to ensure that those on it are confirmed as being interested in receiving services. Also, having most patients seen first in an SDV ensured that there is a proper intake and that the patient is a willing participant. If people elect not to be put on the waiting list, they can always call and be placed on it at a later date. If they elect to be taken off, the referring provider will be informed. Serena is interviewing for a replacement, given that she is leaving on February 1st. Leah King is currently working 20 hours per week in Huntington, but will be working 20 hours in Amherst. The plan is to return to dedicating 20 hours per week of reception support to the department, once there is sufficient staffing. The HRSA SUD-MH grant funding will be used to support telehealth and teleconferencing capabilities for the department to increase access to coordinated primary and specialty care.	

Medical Department	Jon had shared his dashboard information prior to the meeting. He reported that HCHC does not have sufficient data analysis capability to use the data that is collected well, particularly through the management of patients' care by teams. As he noted before, the data available through the EHR is not reliable and he knows that some measures, including child immunizations and cancer screenings, are not accurate. He continues to work with Briana to address these issues, as the problem is partially that the EHR is not correctly mapped to Azara DRVS. One way to address this issue is through the implementation of a new pre-visit planning process, which involves Medical Assistants making sure that the data is coded in the correct place for the aggregator to collect it. Unfortunately, due to staffing shortages, this work is not happening, and obviously any solution that requires substantially increasing staffing is not financially sustainable. Jon is also reviewing the process of peer review, which has not been as effective as would be ideal. He is focused on a process that first pulls data from charts to identify possible cases, then conducts a more in-depth reading of the chart. He is also making sure that MDs on staff are reviewing both MDs' and NPs' work. There are have been no incident reports since his last report.	
New Business	There was no new business.	
Adjourn	This meeting adjourned at 10:00 am. The next meeting is scheduled for **Tuesday, January 15, 2019** at 9:15am at the Huntington Health Center.	

Respectfully submitted:
Eliza Lake, CEO

Measure	Description	HCHC Stated Goal/Benchmark (2013)	Report September 17 2018 TYTD					Report December 13 2018 TYTD				Notes December
			Percentage	Numerator	Denominator	Exclusions		Percentage	Numerator	Denominator	Exclusions	
HRSA: Quality of Care Measures												
Access to Prenatal Care	Percentage of prenatal care patients who entered treatment during their first trimester(NOTE: IMPORTANT CHANGES FOR 2017) Report captured in UDS Table 6B. This data is for 2018 as UDS reports are captured by YTD and not TYTD)	New Measure requirments	0.0%	0	14	0			0	16	0	We are working on a pvp process to record this information.
Childhood Immunization Status (NQF 0038)	NOTE: This measure changed in 2017: Children who have received age appropriate vaccines prior to their 2nd birthday during measurement year (on or prior to December 31) FROM: Percentage of children with their 3rd birthday during the measurement year or January 1st of the following year who are fully immunized before their 3rd birthday.	85%	50.0%	7	14	0		50.0%	8	16	0	
Cervical Cancer Screening	Percentage of women 21-64 years of age who received one or more tests to screen for cervical cancer **(NQF 0032) UDS CQM)**	80%	54.5%	908	1666	31		36.6%	626	1709	30	I spot checked several records. I found that labs called Cytopathology are being counted in the numerator. I cannot explain the decrease.
Children and Adolescent Weight Screening and Follow-Up	Percentage of patients aged 3 until 17 who had evidence of BMI percentile documentation AND who had documentation of counseling for nutrition AND who had documentation of counseling for physical activity during the measurement year	80%	20.9%	103	494	0		22.1%	116	525	0	Counseling is not being checked off in Preventative Medicine
Adult Weight Screening and Follow-Up	Percentage of patients aged 18 and older who had documentation of a calculated BMI during the most recent visit or within the six months prior to that visit and if the most recent BMI is outside parameters, a follow-up plan is documented	50%	42.1%	1789	4252	23		39.8%	1732	4354	28	Counseling is not being checked off in Preventative Medicine
Tobacco Use Screening and Cessation	Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user	55%	4.7%	161	3415	0		1.2%	44	3527	0	We implemented the Tobacco Smart form and we are working with DRVS to map this data.

Asthma Pharmacological Treatment	Percentage of patients 5 - 64 years of age who were identified as having Persistent Asthma and were appropriately ordered medication during the measurement period.	95%	93.1%	122	131	7		91.0%	122	134	9	
CAD Lipid Therapy	Percentage of patients aged 18 years and older with a diagnosis of Coronary Artery Disease (CAD) who were prescribed a lipid-lowering therapy	70%	86.5%	96	111	172		92.0%	92	100	157	
IVD and Use of Aspirin or other anti-thrombotic therapy	Percentage of patients aged 18 years and older who were discharged alive for acute myocardial infarction (AMI) or coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) in the prior year OR who had a diagnosis of ischemic vascular disease during the measurement year who had documentation of use of aspirin or another antithrombotic	88%	84.5%	197	233	62		90.4%	208	230	66	
Colorectal Cancer Screening	Percentage of patients aged 50 to 75 who had appropriate screening for colorectal cancer	55%	60.4%	1307	2163	22		59.7%	1316	2203	19	
Depression Screening and Follow-up	Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented	50%	33.1%	1108	3352	1118		36.2%	1271	3507	1079	The counseling piece is being addressed in the PVP workflow.
New HIV Cases With Timely Follow Up	Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis(UDS Linkage to Care Custom Score Card)	90%	0.0%	0	0	0		0.0%	0	0	0	
Child Dental Sealant	Percentage of children, age 6–9 years, at moderate to high risk for caries who received a sealant on a first permanent molar during the reporting period	65%	0.0%	0	0.0%	0		0.0%	0	0	0	
HRSA: Health Outcomes and Disparities Measures												
A1C less than 8	Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was less than 8% at the time of the last reading in the measurement year. (June 2018 taken from MU DM Quality Measures)	83%	54.5%	235	431	0		71.4%	328	468	1	
A1C Greater than 9 or untested	Percentage of adult patients 18 to 75 years of age with a diagnosis of Type I or Type II diabetes, whose hemoglobin A1c (HbA1c) was greater than or equal to 9% at the time of the last reading in the measurement year. OR Untested	17%	35.0%	151	431	0		28.6%	134	468	1	

Hypertension	Percentage of patients 18 to 85 years of age with diagnosed hypertension (HTN) whose blood pressure (BP) was less than 140/90 at the time of the last reading. UDS CQM Table	90%	72.3%	984	1361	7		72.9%	951	1305	6	
Birthweight	Percentage of patients born to health center patients whose birthweight was below normal (less than 2500 grams)	N/A	0.0%	0%	0%	0%		0.0%	0%	0%	0%	
HRSA: Other Measures (from 2016 Non-Compete												
Child Health	Reducing the percentage of pediatric patients age 3-18 during measurement years, whose BMI is greater than or equal to the 85th percentile	25.0%										We do not have report or way to capture the change in pedi BMI.
Oral Health	Children with one or more cavity within the last year or have social factors that place them at risk for caries will be reduced	30.0%	NA	NA	NA	NA		NA	NA	NA	NA	Dental Standard
Breast Cancer Screening 40 to 69	Percentage of women 40 - 69 years of age who had a mammogram to screen for breast cancer.	53.2%	44.6%	606	1359	0		40.3%	549	1362	3	
Breast Cancer Screening 50 and older	Percentage of women t0 and older with no mammogram in the years prior or in the measurement year. (This data is reported from Azara MU General Practice CQM)	NA	53.6%	630	1175	3		49.1%	589	1199	2	
Department Prioritized Measures (with reporting entity, as applicable)												

CEO Progress Report to the Board of Directors
Strategic and Programmatic Goals
February 2019

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

Community Care Cooperative (C3) ACO: Senior Management met last week with the C3 management to get a **semi-annual report on HCHC's performance in the ACO**. While I may not report on these in detail in the future, I thought the Board would like to get a sense of the data that C3 is collecting, and how we will use it to finetune our implementation of the model of care. In general, the report was positive:

- Our admissions to hospitals are equal to or lower than C3's targets, which we know is largely a function of geography – patients are less likely to go to the hospital if it's far away. Our readmission rates are high, but we were able to review the specifics, and it is clear that one person can throw the numbers off pretty quickly, and we discussed the need to know about these patients as immediately as possible, so we can intervene to stop the preventable visits to the hospital.
- While 40% of our Emergency Department admissions were classified as non-emergent, PCP treatable, or preventable, this percentage was lower than that of C3 as a whole. This is the number that would be affected by the efforts described above.
- The C3 nurse that works on-site is doing very good work, and we are ahead of the average for the ACO in terms of her success in engaging with patients (although everyone is behind the taget). C3 is considering possible changes to the structure of her job, including sharing staff between HCHC and CHC of Franklin County, and we are monitoring the situation carefully.
- Not surprisingly, we see many more adults, particularly men who were able to enroll in MassHealth because of Medicaid expansion and who tend to be among the long-term unemployed, than the rest of C3. We also have about half as many children, as a percentage.
- These demographics contribute to HCHC running slightly unfavorable in terms of financial performance, but only about $2000. This number is kept low by our election of the lowest risk tier – the number would be much higher were we to have accepted more risk.
- The use of primary care by our patients is 27% higher than the rest of C3, and 30% higher than the target, which shows that we have a strong primary care foundation – good news!
- C3's model of providing reinsurance to mitigate the impact of having patients with very high costs paid off for us – at least one patient had hospital costs in excess of $200,000, and we were not severely impacted due to the reinsurance program.
- We received a lot of information about the individual hospitals at which our patients received care, which will help us determine where we need to expend efforts at improving coordination of care (and possibly steering patients to high-quality, cost-effective services)
- In general, it is clear that costs in Western Mass are lower and controlled better than in the rest of the state.

We are working with the C3 marketing consultants to refine the **outreach and marketing** that will occur in the enrollment period (March-May). We have rejected their proposal for bus ads, which we used last year, and will instead focus on print media and social media advertising. The rest of C3's members are focused on brand recognition and retention of patients – we need to recruit new members. We currently have about 1400 C3 patients, and we are under the goal (and we hoped to be even higher!). We will support the C3 advertising, which is not very specific, with advertising for HCHC as a whole, in the hope of attracting many more patients, especially to the Musante Health Center.

Finally, we have been interviewed by C3 consultants, and heard their presentation of their findings, related to the creation of **shared services** between all C3 members. The greatest focus is on the creation of a shared EHR for all C3 members, with shared data analytics and reporting, as well as other possible shared services, including employee health insurance. We made it clear that this possibility is one of the reasons that joining C3 was appealing. I will obviously keep you updated on any developments in this area. While not a C3 activity, the Mass League is also looking at shared services between health centers, and we were also interviewed this month by their consultant. It will be interesting to see what comes of these parallel efforts, and how health centers navigate the possibilities.

Hospital Engagement:

- I am meeting with Ron Bryant, CEO of **Noble Hospital**, in early March to discuss our collaboration in serving the Noble service area. Ron asked for the meeting, and I believe that my participation on the Noble Community Benefits Advisory Committee has brought HCHC's role in the community into sharper focus for its management.
- As is reported below, Frank and I have been in close communication with Partners HealthCare, a relationship made possible by our connections with Cooley Dickinson.
- **Cooley Dickinson** has created a new process for community organizations to market their services to Cooley patients, and the eligibility guidelines were seemingly written with FQHCs in mind. We have applied to have materials about our dental and behavioral health services available in waiting rooms and distributed to providers throughout the Cooley system, and expect to have our request approved.

EHR Transitions: Due to staffing changes at C3 and resulting communication issues between Cooley (where our EHR is stored on their servers) and the C3 IT people, we are only just being able to focus on the **business optimization** activities that we planned for last year. Frank was able to the get the HRSA funding that will support these activities rolled over into this budget year, and we anticipate the activities being completed by fall.

Goal 2: HCHC Expansion

John P. Musante Health Center (JPMHC):

- We are continuing to focus on **marketing** and outreach in order to attract more patients to the Amherst site, as discussed above.
- Frank and I met with Paul Bockelman, Amherst Town Administrator, and we appear to have reached an agreement on the Town's responsibility for the **cost overruns**. They do not feel that

most of the costs are their responsibility at all, but are willing to concede that the new electrical panel would have needed to be replaced eventually, so they will assume that $47,000 cost. They will also split all the remaining overruns with us, so they are essentially adopting about $111,000 of the almost $175,000 for which we were asking. They are, however, requiring that we make whole our rent payments going back to June 1, 2017, when they were supposed to rise from $5/square foot per year to $12/square foot per year. We had kept our payments at the lower level while we waiting for a response to our repeated requests for an amendment to the license agreement that would have delayed the increase to February 1, 2018. They never responded, and now they say that they will hold us to the letter of the agreement. We agreed that all payments, going both ways, will be represented in an amendment to the payments moving forward. Frank has sent Paul a proposed schedule for rent payments between now and June 2022 – we have not heard anything back. We of course had hoped for an even larger concession, but it could have been worse. This settlement means that we can now determined exactly what the additional capital costs were, and fundraise appropriately.

- We are getting close to finding a **space for our Behavioral Health provider** in Amherst – Paul mentioned a new option during our meeting, which would be even better than the previous ideas, so we are actively pursuing it. Until we have nailed down the space, we cannot apply to the state DPH for a Mental Health Outreach license. We are also working out problems with the spaces identified for the new Navigator – internet connectivity has proven to be problematic.

Diversity and Inclusion Efforts: The DRIVE Committee, which was formed to address this effort, is reviewing a number of trainings and other materials in order to ensure that we are providing cultural sensitivity/humility **training** to all staff. We are also working with the graphic designer to create a graphic representation of our commitment to inclusion and equity. I hope to have the training completed this spring, and have it coincide with the installation of the new designs in the waiting rooms. HCHC is also signed up to participate in the Northampton Pride march in May – Board members will of course be welcome to join us!

School-Based Health Center Expansion: We received word yesterday that HCHC was awarded $51,034 to **expand optometry services** to our Gateway clinic. The funding will support the purchase of equipment and some minor renovations. The staff at both HCHC and Gateway are very excited about this development!

New Access Point Funding Opportunity: While I want to spend the bulk of the CEO Report time discussing this tomorrow, here is some basic information (which I only just shared with the Executive Committee this week) about a New Access Point (NAP) funding opportunity that we are seriously considering:

- Despite being told that they wouldn't do it again, HRSA announced recently that they are accepting applications for New Access Points, and that they have changed the methodology to pinpoint funding to specific areas. We were not surprised to see that in Massachusetts, the Ware area is highlighted as being in great need of a community health center. The grant would provide $120k for renovation/equipment, and then $650K/year for operating costs. This would essentially cover the costs of any staff we would need for a small medical practice (and medical care is a required service).

- As you may remember, even those applications that are not funded in this round will be kept in the hopper for any funding that may come available in the next year or so.
- We have been told that, at a minimum, the CHC in Fitchburg is planning on submitting an application for Ware. Caring CHC may also do so. We think that we would have a leg up because we have the closest site (Amherst), are the only existing health center in Hampshire County, and already have relationships with people in town.
- It will be a difficult application to pull together - Ware is a tricky, prickly town, and we would need to find a site (at least for the application) and pull together lots of info and support letters. The application is easier than in the past, however. It is due in April.
- We feel that we have no real choice about applying, as we will lose the opportunity to expand if someone else gets the grant. But we want to make sure that the Board understands our reasoning and supports this effort. I will present the data that supports our decision-making at the meeting.

I have begun to reach out to community partners in Ware about this project, and have a meeting scheduled with the Town Administrator on Monday. While we do not need community permission to submit an application, we would obviously like to be able to show their support for the project in our application.

Goal 3: Improved Organizational Infrastructure

Financial Stability:

- Frank and I had another meeting with the staff at Partners about our financial situation and the looming **payback to MassHealth**, which would begin in April. Partners included the Cooley CEO and Community Relations staff member on this call, and asked us something we hadn't expected: would HCHC be interested in a loan from Partners that would wipe out our liability to MassHealth and which would have a much longer time horizon than the year that we currently have for the payback? We were of course interested, and Frank developed proposals that account for the loan being either interest-free (which is most likely) or with low interest, with a payback of five years. This would reduce our payments from $5700/week for a year to $5000/month for five years. Partners also said that they would let us know by the end of last week whether they could also give us a $50,000 grant to lower the amount of the total loan – we proposed that we would reduce the monthly payment, not the term. We have not heard back yet about the grant. Obviously, this would be a huge help, and while we were considering trying to negotiate better terms with MassHealth, they would not have reduced the amount due, and we assume that there would be a chance of future grants, as well.
- Senior Management has been having weekly meetings with department managers about our **ongoing poor financial performance**. We have agreed to hire four additional Medical Assistants, which will enable better care coordination, pre-visit planning, and reduce the burden on the existing nursing staff and therefore reduce the need for additional nurses. We have completely addressed the issues in the referrals department, and now are turning our attention to the Dental Department, which has been the most consistent contributor to our losses.
- Very unfortunately, in addition to Physician Assistant Melanuie Kirouac leaving in late December, **Dr. Lora Grimes** gave notice in January and will be leaving in April. This will put an

enormous amount of stress on the Worthington site, and we are developing plans for staffing given that the likelihood of replacing her in the next six months is small. Our discussion includes the reduction of hours of medical services in Worthington. We will come to the Board with any changes that require your vote as soon as possible.

- **Dr. Beth Coates** has again requested a two-month leave, most likely during August and September. As you will remember, her contract states that she can request this leave annually (after she completed 10 years of service for HCHC), and that it must be approved by the CEO and Board. This will be enormously disruptive, but as has been true in previous years, she has stated that this leave is a condition of her continued work for HCHC. I therefore recommend that the Board approve her request, with the recommendation that she work with management to make the timing as least disruptive as possible.

Other Reports

HRSA has asked us to move the dates for our **Operational Site Visit** to the week of November 19th. Tabitha has developed a workplan, based on the OSV Checklist from HRSA, that we will be using this year to ensure our complete compliance with all Program Requirements. We will also ensure that the League is available for Board training, should you be interested.

State and National Outlook:

- Our new Legislative delegation has already signed onto a number of important pieces of legislation that would benefit community health centers. In particular, Senator Comerford and Representative Blais were the lead sponsors of a bill that would increase dental rates for CHCs. Representative Domb also co-sponsored all of the priority bills for the Mass League, whose primary focus is on the Health Center Transformation Fund, as it was last year. I am going into Boston next week and will be sitting down with Senator Comerford's Legislative Director, who had previously been at Health Care for All in Boston for 15 years. The League have delayed the event for new Legislators that was also scheduled for next week, but they have asked me to be on a panel to discuss the workforce challenges faced by health centers in the state.
- Nationally, health center funding needs to be reauthorized again this year – we have only been able to get two-year authorizations for the last four years. The push on Capitol Hill this year will again be to make the funding more stable by making a five-year commitment. I will go to DC in late March to make this argument, and will let you know in April what the reception was to this idea. Luckily, health centers were unaffected by the recent government shutdown, and we will not be affected by another shutdown next week, should Congress and the White House create another one. This does not mean, however, that there isn't a real impact on the well-being of our patients, given the impact to the housing and food security programs upon which they rely.

Hilltown Community Health Centers, Inc.

Behavioral Health Policy
Clinical

SUBJECT: VOLUNTARY AND INVOLUNTARY COMMITMENT
REGULATORY REFERENCE: None

Purpose:

When a patient needs more intensive psychiatric care, he/she will be referred for inpatient treatment. Some patients voluntarily seek this care upon advice of a health care provider, while others must be involuntarily committed for care. This policy outlines reasons for admission and the process to follow.

Policy:

Involuntary or voluntary commitment to an inpatient psychiatric facility or to an inpatient unit of an acute care hospital may be warranted under the following conditions:

1. There is substantial risk of harm to the person himself as manifested by evidence of threats of or attempts of serious bodily harm.
2. There is substantial risk of physical harm to other persons as manifested by evidence of homicidal or other violent behavior or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them.
3. There is a very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he/she is unable to protect himself/herself in the community and that reasonable provision for his/her protection is not available in the community.

A. Involuntary commitment

1. A medical or authorized Behavioral Health provider must complete an Application for temporary hospitalization. Ideally, this will be an LICSW; however, if the noted discipline is unavailable, any licensed physician may complete the application.
2. The provider handling the admission calls for assistance from the local Police Department/ State Police in transporting the patient to the appropriate facility, if physical restraint is needed or there is a potential threat of physical resistance.
3. A call is then made to 911 and a request for transfer by the police department or ambulance is made.
4. The medical or authorized Behavioral Health provider gives the original copy of the Application for Temporary Hospitalization to the ambulance attendant to give to the staff at the inpatient facility; gives the second copy to medical reception staff for inclusion in the patient's medical record; and gives the third copy to the police for their files.
5. The behavioral health clinician initiates contact with the staff of the local crisis team in Westfield (413-568-6386) to coordinate care.

B. Voluntary Commitment

1. The criteria for voluntary commitment are the same as that for involuntary commitment. In the case of voluntary commitment, however, the request for hospitalization comes from the patient at the recommendation of the clinician.
2. The patient's provider calls the local psychiatric crisis team to notify them of the patient's need for voluntary commitment and to arrange for a meeting with the crisis team representative either at the health care center, the crisis team office, the patient's home, or the local emergency room.
3. The patient is transported either by ambulance or by a family member or friend if this may happen safely.
4. The medical provider or behavioral health clinician initiates contact with the staff of the inpatient facility to coordinate care.

Questions regarding this policy or any related procedure should be directed to the Behavioral Health Director at 413-667-3009.

Originally Drafted: JAN 2019 Reviewed or Revised: JAN 2019

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:

In the case of involuntary commitment, if a patient arrives to clinic and is acutely at risk of serious physical harm as evidenced by suicidal ideations, or threats of ending or harming himself/herself, or is at serious risk of carrying out physical harm to other persons through homicidal ideations, or violent tendencies, a Section 12 should be filed. Section 12 must be filed by: A Physician, Nurse Practitioner, LICSW, or Psychologist. The original section 12 and a copy should be made available to the paramedic. A copy should also be sent to reception for scanning. The local hospital should be notified and made aware that the patient needs to be transported to the ER via section 12.

In the case of voluntary commitment, a patient who is acutely at risk (suicidal/homicidal) should not be sent to the hospital via family member unless determine by the evaluating clinician that it is safe for the client to travel safely with a family member as this could present as a huge liability. Please use your professional and clinical judgment in determining whether police should be notified to escort the patient, particularly if the client is at imminent danger or at serious risk, and is choosing not to comply with further evaluation.

Responsibilities:

Licensed Clinician: Completes the Application for Temporary Hospitalization; calls Psychiatric crisis team ; calls local Police if assistance is needed; distributes copies of Application to accepting facility, patient's medical record and to police.

Behavioral Health clinician: Consults with local crisis team regarding need for hospitalization.

Hilltown Community Health Centers, Inc.

Administrative Policy
All Departments

SUBJECT: PATIENT COMPLAINT AND GRIEVANCE POLICY
REGULATORY REFERENCE: Department of Public Health

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for managing patient complaints and grievances.

Policy:

1. Patient complaints can be taken by any employee and will be directed to the Practice Manager within 24 hours.
2. The manager or director receiving the complaint will make telephonic contact with the complainant within two days of receiving the complaint.
3. In cases where a provider is the subject of a complaint, the complaint will be forwarded to the Medical Director or to the department's clinical director for investigation.
4. The manager or director will have no more than 10 days to document the complaint, conduct an investigation, respond to the patient and file the investigation.

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

Originally Drafted: DEC 2004 Reviewed or Revised: JAN 2019

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. The employee initially receiving the complaint will attempt to contact the Practice Manager within 24 hours.
    a. If available, the Practice Manager will contact the complainant and document the complaint on the HCHC Patient Complaint form.
    b. If unavailable, the employee will document the complaint on the HCHC Patient Complaint form, ensuring that the complainant's contact information is documented.
    c. If the complainant is unwilling to have the employee document the complaint and insists on speaking with a manager, the employee will take the complainant's contact information and relay it to the Practice Manager.
    d. If the complainant is unwilling to have the employee document the complaint or speak to a Manager, the employee will take the complainant's contact information, if possible, and relay it to the Practice Manager and will also send the patient a copy of the HCHC Patient Complaint form with a request that they fill it out themselves.
2. Once a complaint is received, the Practice Manager will make contact with the complainant, either in person or via telephone.
3. If the complaint has not been documented, the Practice Manager will document the complaint and inform the complainant that an investigation will be conducted.
4. The Practice Manager has ten business days to investigate the complaint and respond in writing to the patient with a copy of the response sent to the Executive Assistant for filing.
5. If a patient remains unsatisfied with the proposed resolution, the complaint will be forwarded to the appropriate executive officer for resolution.
    a. Billing related complaints to the Chief Financial and Administrative Officer
    b. Operations & staff related complaints to the Chief Financial and Administrative Officer
    c. Provider related complaints to the Chief Clinical & Community Services Officer
6. Complaints not resolved at the executive officer level will be forwarded to the Chief Executive Officer
7. A record of all complaints will be maintained on file by Executive Assistant and will be reported to Quality Improvement/Risk Management Committee and the Board of Directors at least quarterly.
8. All complaints will be tracked on an annual basis for trend analysis by the Quality Improvement/Risk Management Committee.

Hilltown Community Health Centers, Inc.

Clinical Policy
All Departments

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 patients who require urgent or emergency care.

Policy:

HCHC will assure the timely and appropriate transfer of patients who require urgent or emergency care beyond the scope of Health Center abilities and resources.

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

Originally Drafted: SEP 1999 Reviewed or Revised: AUG 2018

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. 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. If a minor, 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 ambulance will be called to transport such patients as needed to the nearest emergency room. (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. (Medical Staff) If a minor, an attempt will be made to contact a parent or guardian simultaneously or as soon as possible.

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

Hilltown Community Health Centers, Inc.

Administrative Policy
All Departments

SUBJECT: SERIOUS INCIDENT REPORTS TO DEPARTMENT OF PUBLIC HEALTH (DPH)
REGULATORY REFERENCE: Department of Public Health regulation 140.307, 140.611

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 Health Center (SBHC).

Policy:

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

- fire
- suicide
- serious criminal acts
- pending or actual strike action by its employees
- unanticipated death
- full or partial evacuation for any reason
- serious incidents and accidents

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

Originally Drafted: OCT 2000 Reviewed or Revised: JAN 2019

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. 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. (CEO)

Hilltown Community Health Center

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

Annual Disclosure Statement

Pursuant to the health center's conflict of interest policy), I _____hereby make the following disclosures
(print name)

1. The following are all of my connections with groups doing business with HCHC:

Name and address of group **Nature of connection**

_____
_____
_____
_____

2. I am a member of the board of the following for-profit and charitable organizations:

Name and address of organization(s)

_____
_____
_____

3. During the 1-year period preceding the date of this statement, I have received the following amounts from HCHC, as a vendor of goods or on account of services rendered:

Nature of goods sold or services rendered **Amount**

_____
_____
_____

_____ _____
Date Signature