



Hilltown Community Health Center

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

BOARD MEETING
April 4, 2019
WORTHINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order
2. Approval of the February 7, 2019 and March 7, 2019 Meeting Minutes (Vote Needed)
3. Finance Committee Report for February and March (Vote Needed)
4. Committee Reports (as needed) (Vote Needed)
 - Executive Committee
 - Quality Improvement
 1. QI/Risk Management Minutes for January and February 2019
 - Fundraising
 - Credentialing/ Privileging-
 1. New Employee:
 - Carlos Coppin, Dental Assistant (Vote Needed)
 2. Recredentialing:
 - Michael Purdy, OD
 - Timothy Gearin, DMD
 - Andrew J. Adams, DDS
 - Alice Rudin, DDS
 - Julie Cowles
 - Marylou Stewart, DDS
 - Ellen Wright
 - Rossie Feldman, LICSW
 - Eleanor Smith
 - Jillian McBride, LICSW
 - Susan Hedges
 - Amanpreet Gill, DMD
 - Elizabeth Coates, MD
 - Brenda Chaloux, FNP
 - Personnel
 - Facilities
 - Recruiting, Orientation, and Nominating (RON)
 - Strategic Planning
 - Corporate Compliance
5. Chief Executive Officer / Senior Manager Reports

6. Old Business

- New Access Point Application Update
- Tentative reschedule date for the July Board Meeting to **Thursday, July 11th**

7. New Business

- 2019 Budget (Vote Needed)
- Policies (Vote Needed)
 - Sliding Fee Scale 2019
 - Credit & Collection Policy
 - Emergency Management Plan
 - Credentialing and Privileging Policy
 - HIPPA Security Management Process (Vote Needed)
 - Access Authorization
 - Access Control Policy
 - Assigned Security Policy
 - Audit Controls Policy
 - Authorization and-or Supervision Policy
 - Business Associates Contracts Policy
 - Contingency Plan Policy
 - Data Backup Plan Policy
 - Device and Media Controls Policy
 - Evaluation Policy
 - Facility Access Controls Policy
 - HIPPA Security Awareness and Training
 - Information Access Management Policy
 - Risk Analysis Policy
 - Sanction Policy
 - Security Incident Response and Reporting Policy
 - Workforce Clearance and Security Policy
 - Workstation Accessible Use Policy
 - HIPPA Privacy Management Policy (Vote Needed)
 - Assigned HIPPA Privacy Officer Policy
 - Clinical Record Documentation, Storage and Archiving Policy
 - Disclosure of Behavioral Health PHI Requiring Patient Consent Policy
 - Disclosure of PHI Requiring Patient Consent Policy
 - HIPPA Documentation Requirements Policy
 - HIPPA Training Requirement Policy
 - Patient's Right to Access, Inspect and-or Copy Policy
 - Physical Safeguards for Patient Privacy Policy
 - Reporting of Alleged Violations Policy
 - Requests for Confidential Communications Policy
 - Safeguarding Patient Information of Deceased Patients Policy
 - Uses and Disclosures of PHI without Patient Consent Policy

8. Executive Session

9. Adjourn

HCHC BOARD OF DIRECTORS MEETING

Date/Time: 02/07/2019 5:30pm

Worthington Health Center

MEMBERS: John Follet, President; Alan Gaitenby; Kathryn Jensen, Clerk, Lee Manchester; Nancy Brenner, Vice President, Matt Bannister; Wendy Long; Seth Gemme

STAFF: Eliza Lake, CEO; Michael Purdy, Risk Manager; Frank Mertes, CFO; Tabitha Griswold, Executive Assistant

ABSENT: Maya Bachman

Guest: Kate Albright-Hanna

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Approval of Minutes 01/03/2019	<p>John Follet called the meeting to order at 5:36pm.</p> <p>John Follet motioned to introduce Kate Albright-Hanna, potential new Board Member. Introductions to Kate Albright-Hanna were made.</p> <p>The minutes from the meeting of January 3, 2019 were reviewed. Wendy Long moved acceptance, Nancy Brenner seconded. The minutes of the monthly meeting of 1/3/2019 were approved by those present.</p>	January 3, 2019 minutes were approved.
Finance Committee	<ul style="list-style-type: none">John Follet summarized the recent Finance Committee as the health center finances are doing "OK", however not making great strides but have stabilized. John Follet stated that the Operating Deficit for the year was approximately \$376k which is only \$20k below the budget for the year. John Follet commended Frank Mertes with creating a budget that anticipated the year's shortfalls.John Follet noted that the bottom line was positive because the money that was fundraised supported it. John	

	<p>Follet noted that the figure of operating days of cash is still low but so is the A/P very low, meaning that there is not a lot of bills hanging over the health center. John Follet wanted to assure the Board that the figure is safer than it might look. Much of the current stability was due to the loan that HCHC received from MassHealth to pay bills in Fall 2018.</p> <ul style="list-style-type: none"> • John Follet reviewed departmental income statements for 2018, and noted that the overall picture shows that the number of visits has increased in dental and Behavioral Health (BH) but the revenue has diminish from years before. This is largely due to certain dental procedures that insurances are no longer paying HCHC to conduct. Revenues in BH were down due to greater proportion of reimbursement being from public payers. In Medical, HCHC had an increase in revenue due to a rate increase from state. Eliza Lake added that State Representatives have filed a dental rate increase for community health centers. She noted that if that were to go through that would be very helpful to HCHC. • John Follet noted that the overall the amount that HCHC has spent for expenses was less than what was budgeted. However, since last year HCHC has spent more because it is a bigger operation, because of the Amherst expansion. John Follet stated that the financial state of the organization is overall stabilized but there are still some challenges in the New Year. • With the recent resignation of a Board Member brought up the conversation of the Vanguard investment account and the Board. The Finance Committee has questioned the Board's role in overseeing the investments. Several Board Members will be attending a MassLeague symposium this weekend and that may be the place to bring that question. Eliza Lake stated that the current policy and procedure does not really speak to the management and use of the investments, however recent uses has not violated the current policy. The Board asks that moving forward clarification on the oversight of the investment needs to be made. 	<p>Finance committee report was approved.</p> <p>Board Members attending Symposium will report back on any relevant information on this matter.</p>
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	<p>Kathryn Jensen moved that the report of the Finance Committee be accepted. Alan Gaitenby seconded the motion. The motion was approved by those present.</p>	
CEO Report	<ul style="list-style-type: none"> • Eliza Lake reported that the Town of Amherst has come to tentative agreement. Frank Mertes sent a proposal for repayment of back owed rent but has not received a response. Eliza Lake reported that the Town has indicated that it is willing to take responsibility for \$110k of the construction costs for their building but requested back rent through June 2017 to be paid. Frank Mertes reported that the proposal states that rent back pay would be repaid in increases by years. Eliza Lake reported that once HCHC knows of the exact amount in repayment then the capital campaign can be continued to make up the shortfall. • Eliza Lake reported on the \$300k MassHealth payback of the 2018 cash advance. After recent conversations with MGH/Partners, they are tentatively willing to help with payback terms by providing HCHC with a loan with a longer term. This plan may include a grant of \$50k. While the repayment to MassHealth could potentially be renegotiated, they would never offer a grant opportunity like Partners. Eliza Lake also reported on CDH willingness to support the HC's legislative priorities. Frank Mertes sent the proposal to Partners but has not received a response. Frank Mertes noted that the proposal was clear that the loan would not be collateralized. • Dr. Beth Coates, MD has asked again for the annual leave she's been taking for the past few years. The process is for the CEO and Board to review and approve or not approve. She's agreed to be flexible as possible in the timing of her leave. The timing for this is not best as the health center will be losing a provider in the spring, but the SBHC providers will be available to help during some of the summer months. A motion to approve the leave request for Dr. Beth Coates for a two month sabbatical was made by 	<p>Leave for Dr. Beth Coates was approved.</p>

	<p>Nancy Brenner. The motion was seconded by Alan Gaitenby. With no further questions or discussion, the motion was approved.</p> <ul style="list-style-type: none">• Dr. Lora Grimes, MD has given notice. Her last day will be in April. As she does not know her start date at her new location, HCHC has offered to hire her back as per diem. There is an MD candidate coming in March to interview. With the leaving of Dr. Grimes, there will only a NP and a part time physician in WHC. There has been a proposal of no Tuesday clinical hours on the table, but management is working to develop a plan that has the minimum of disruption.• Eliza Lake reported on a New Access Point (NAP) grant that was released by HRSA in January 2019. This grant will provide funded health centers with \$650,000 in ongoing annual operational funds; HCHC did not get this type of funding for the Amherst site. In this funding round, HRSA created zip codes that are designated as “hot spots.” They also provided applicants with a spreadsheet to give a “needs” score worth 20 points towards the 100 point scoring on the grant. In MA, because health data shows relatively good health status, we may only get 10 points. Eliza Lake has received an overwhelming amount of agreement in the need for a Health Center in Ware, including people that live there. Eliza Lake feels confident in applying for this grant as the only health center in Hampshire County, having connections with providers in Ware already, and the proximity to Amherst. Frank Mertes found from colleagues that Fitchburg is may be applying for the NAP grant, as well. Eliza Lake presented the map of all the HCs in MA and every HC in W. Mass and where their patients come from. Eliza Lake feels that we would be competitive in this grant. Eliza Lake proposes moving forward with the grant application process that starts in March with the submission of a one-page abstract. The proposal would be for a small medical practice and to be financially conservative. Frank Mertes explained from previous experience that the HC could eventually obtain other grants to expand to include dental services. If the	
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	<p>grant were to be awarded, the HC would have 120 days to open. Eliza Lake stated that further growth is needed for viability and that the HC is more comfortable after learning lessons from Amherst. With unanimous vote by members present to support the pursuit of this opportunity, Eliza Lake will report back in a month. Eliza Lake will submit the first document needed for NAP application, as needed, but will bring the application before the Board prior to submission.</p>	
Executive Committee	John Follet reported that the committee has not met.	
Recruitment, Orientation & Nominating (RON) Committee	<p>Wendy Long reported that with the recent resignation of a Board Member, there is now a vacant position in the RON Committee, as well as the Finance Committee. The Committee continues to search for an Amherst-based Board Member. The prospect of teleconferencing meetings would help with this recruitment. Eliza Lake reported to continue conversations with colleagues of health centers with similar geographical issues.</p> <p>Wendy Long presented potential new Board member, Kate Albright-Hanna, with positive feedback from other Board members, noting her ties to the community, and her strong marketing and fundraising background.</p> <p>Alan Gaitenby moved to approve the acceptance of the new Board member. Nancy Brenner seconded the motion. Kate Albright-Hanna was approved as a Board member by those present.</p>	Nominatio n of Kate Albright- Hanna was approved.
Corporate Compliance Committee	Eliza Lake reported that senior management will meet on this agenda in the upcoming weeks.	
Credentialing / Privileging Committee	<p>John Follet to approve credentialing for Elizabeth Peloquin, an NP student. Michael Purdy reported that she is attending American International College.</p> <p>Nancy Brenner moved the credentialing for Elizabeth Peloquin be accepted. Wendy Long seconded the motion. The credentialing was approved by those present.</p>	Credentiali ng for Elizabeth Peloquin, NP Precepting Student was approved.

Facilities Committee	Alan Gaitenby reported that this committee has not met. Eliza Lake reported that there has been reconfigured staffing situation in Worthington, integrating providers with support staff in shared workspaces. Frank Mertes reported that water issues are getting better, and there was a frozen pipe during the last deep freeze but it was minor. Eliza Lake reported that there was a minor plumbing issue during DPH visit.	
Personnel Committee	John Follet reported that this committee has not met.	
Strategic Planning	Nancy Brenner reported that this committee has not met. Eliza Lake reported that Senior Management recently reviewed the Action Plan and it will be sent to committee next week.	
Fundraising Committee (ad hoc)	Nancy Brenner reported that this committee met yesterday and talked about messaging brainstorm for our fundraising efforts to evolve for annual meeting, which could be used for first push for fundraising. The Committee took ideas from last month and are working with those phrases. The messaging would be used to both market HCHC to patients (current and potential) and to conduct fundraising in both the Hilltowns and the Valley. The Committee will develop a few possibilities, and will then present them to staff and select community leaders to get feedback.	
Quality Improvement/Risk Management Committee	Kathryn Jensen reported that the QI Committee has two issues of concern, as reported in the materials provided in the packet. First, data collection continues to be a challenge, both in terms of consistent coding by providers and in the ability to collect and analyze the data in the electronic health records. The situation has improved from previous years, but there continues to be challenges that need to be addressed. Second, during the January meeting worrisome understaffing was discussed, particularly at the Worthington Health Center. The sense of the staff present on the Committee is that medical support staff are underpaid. Eliza Lake reported that the health center is currently advertising for four new MAs. Michael Purdy reported that out of the 28 resumes the HC has received for the position, six of those resumes were viable. Frank Mertes has contacted fellow health centers and found that the health center's reimbursement for these positions are right in line with other health centers, the one difference being the hours of operation compared to other sites. Senior Management reports recognizing the issue and working	

	<p>hard to address it. In regards to the understaffing in RNs, Senior Management is recruiting more MAs to support the RNs. Eliza Lake reported that referrals are completely caught up and remaining so. There is a new receptionist with referrals background that starts on Monday, February 11th, to support the behavioral health specific referrals. Eliza Lake reported on the UDS, which the major Federal report is due by Friday, February 15th. Eliza Lake met with EMR Specialist and Clinical Operations Director to use and DRVS to run all the required measures. Eliza Lake reported that most of the measures look to be right in line with previous years. Michael Purdy reported that MAs work with previsit planning is required for the best collection of some quality measures, and since the health center has been understaffed there is a little dip in those numbers. There was a general Board discussion about the data, and they were informed that they will receive the full UDS report at the next Board meeting. Kathryn Jensen was impressed with staff interest in quality of record keeping.</p>	
Committee Reports	<p>After all the committee reports had been reviewed and discussed, Alan Gaitenby moved the committee reports be accepted. Matt Bannister seconded the motion. The measure was approved by those present.</p>	<p>Committee reports presented at this meeting were approved.</p>
Old Business	No old business was discussed.	
New Business DPH Policies	<p>Eliza Lake noted that following a recent unannounced DPH visit, some policies were brought to the attention of Senior Management for required revisions. Some of the new policies were already in place for the School-Based Health Center, but needed to be expanded to the whole organization.</p> <p>Matt Bannister moved acceptance of the submission. The motion was seconded by Kathryn Jensen. Without any further discussion needed, the following policies were approved.</p> <ol style="list-style-type: none"> 1.) Patient Complaint and Grievance Policy 2.) Emergency Transfer of Patients Policy 3.) Serious Incident Reports to the Department of Public Health (DPH) Policy 	<p>All policies were approved.</p>

	4.) Voluntary and Involuntary Commitment Policy.	
Employee Credentialing	There was no employee credentialing to report.	
Executive Session	The recent resignation of a Board Member was discussed.	
Next Meeting	<p>Nancy Brenner moved the meeting be adjourned. John Follet seconded the motion, which was approved by those present. The meeting was adjourned at 7:40 pm.</p> <p>The next scheduled meeting will be on March 7, 2019 at the Huntington Health Center.</p>	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

HCHC BOARD OF DIRECTORS MEETING

Date/Time: 03/07/2019 5:30pm

Worthington Health Center

MEMBERS: John Follet, President; Alan Gaitenby; Kathryn Jensen, Clerk, Lee Manchester; Matt Bannister; Kate Albright-Hanna

STAFF: Eliza Lake, CEO; Michael Purdy, Risk Manager; Frank Mertes, CFO; Tabitha Griswold, Executive Assistant

ABSENT: Maya Bachman; Wendy Long; Nancy Brenner, Vice President, Seth Gemme

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 02/07/2019	<p>John Follet called the meeting to order at 5:38pm.</p> <p>The board requested that minutes include the former board members' identity, as mentioned in the minutes. The former Board member was Tim Walter. His name will be added to the last bullet on the second page.</p> <p>As there was not a quorum of board represented, the items requiring a board vote were not voted upon and will be voted on during the next meeting.</p>	Amendments to be made to February 7, 2019 Board minutes
Finance Committee	<ul style="list-style-type: none">John Follet reported that January figures will be available next month, as is usual practice for the beginning of the new fiscal year. The Finance Department has been closing 2018's books, as well as participating in the annual audit. The April meeting will include the financial report for both January and February.UDS review- John Follet reported that the UDS is comprised of various data collection such as cost, number of patients, etc. This report is compiled and submitted every year around February 15th. John Follet reported that the initial UDS was successfully submitted on February 15th. The	

	<p>report is to support our and other Health Centers' accountability and is a useful tool for identifying needed improvements in coding and billing, as well as possible areas of quality improvement. Overall, the growth in patient numbers has not been large, but there is an anticipation for greater growth this coming year (with Amherst up and running). John Follet noted on the second page in relation to costs, our average cost per patient visit (number of visits divided by costs) tend to be lower than the Massachusetts average but higher than the National Average (which Massachusetts generally is). Frank Mertes, CFO explained that due to such small numbers at HCHC, any disruption in provider availability has a dramatic impact on the numbers. In terms of the clinical measures, we continue to improve our data collection around certain measures, but we are confident that the data submitted was accurate. For instance, the number of pap smears was lower than might be expected for the population of adult women under the age of 65, but HCHC's patient population skews older than the norm for health centers, and therefore our patients only require screening once every five years, instead of once every three. This reduces the overall number of screenings that occur. A positive trend was seen in the depression screenings due to efforts of the Behavioral Health and Medical Department collaborative work.</p> <ul style="list-style-type: none">• An update on the \$300k MassHealth loan is also provided in the CEO report and will be discussed there.• Update on the Town of Amherst lease agreement is still ongoing due to a cancelled meeting with Town Administrator last week.• Frank Mertes requested a discussion with the Board on how the Board wants to use/interprets the function of the budget. Frank Mertes explained different strategies/ scenarios for a budget, including an aspirational budget, one that is strictly a forecast of the year, and one that shows the organization's cash flow needs. The Board discussed the uses of a budget, including how to use it to make staff accountable, how to be flexible given constantly changing conditions (provider mix, grant revenue, etc). The Board emphasized that it wants to see transparency	
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	<p>with numbers and any gap analyses. The Board understood that due to the nature of the small sites of HCHC, little changes make a big impact on the budget. With this guidance from the Board, Frank Mertes will be presented at the next board meeting a realistic budget, and will develop a gap analysis to show what HCHC needs to do to attain break-even.</p> <ul style="list-style-type: none"> • The staffing issue was observed as a statewide issue from fellow Health center senior management staff and hospitals alike. Senior Management has working on a new formula for determining medical provider compensation, which is tied the individual's clinical hours, not their hours of employment. This new system will have an effect on the upcoming budget. Advertising is also a budget variable during the spring 2019 MassHealth plan selection period. Frank Mertes is also working on a new wage scale for Medical Assistants to become slightly more competitive. • The 2019 Fiscal audit went very well. It was commended by the auditors that the financial records were in pristine order. The auditors were able to end their field work early after two days visit to HCHC. There were very few remaining questions from the auditors that are being addressed. 	
CEO Report	<ul style="list-style-type: none"> • Eliza Lake stated that there was not a lot of news to report about HCHC's involvement in C3 other than the current advertising campaign taking place. • Eliza Lake reported on her time spent with local hospitals on the federally- and state-required Community Health Needs Assessment. She has attended four hosted community input forums in Westfield, Northampton, Amherst, and Ware. From this needs assessment each hospital has to come out with their top priorities. Health centers can use this information as a basis of their own needs assessment. This summer HCHC will do another needs assessment. This year there is hope to have the health center do its own little bit of community engagement during the needs assessment process. • Eliza Lake had a meeting with the CEO of Baystate Noble Hospital and our mutual interest in collaboration. The discussion covered the possible use by HCHC of empty space in the hospital building, and other possible collaborations. Noble's service area is bigger than just Westfield, and Noble is 	

	<p>looking to engage with that broader service area. Eliza Lake will be looking at the proposed offer to become the Chair of the Noble Hospital Community Benefits Advisory Committee, gauging the value of her time and potential dual purpose of community engagement.</p> <ul style="list-style-type: none"> • The ironing out of the final license agreement with the Town of Amherst is still in limbo, as noted in the Financial Committee report. • HCHC management is continuing to develop its application for a New Access Point (NAP) in Ware. The overall feedback gathered from community members is of support for a health center in the area. Eliza Lake is still working to gain the support of the Baystate. Baystate is looking to the town's position before granting support. Eliza Lake and Frank Mertes have a meeting scheduled for next week with the town's Select Board to help garner that support. The application, which is due April 11th, will be presented to the Board at its April meeting for approval before we submit. • Mass General Hospital (MGH) is granting \$50,000 as a result of our conversations about HCHC's financial challenges. HCHC should have the check by April 1st. Frank Mertes and Eliza Lake are looking at the various options for repayment of the MassHealth \$300K loan. Overall, they are looking at minimizing cash out the door every month and slowing down the repayment. • In the email to medical providers (which was included in the Board packet), Eliza Lake explained how HCHC management is responding to the current staffing crises in the medical department. • Eliza announced Congressman McGovern's visit to the Amherst site on March 20th at 10:30am. The MassLeague is working to supporting this visit. The visit will be a quick tour of the site, meeting the staff and a talk about the Amherst and Ware expansion. Jo Comerford will be coming on March 15th for a quick tour as well. 	
Executive Committee	John Follet reported that the committee has not met.	
Recruitment, Orientation &	Eliza Lake reported that both she and Marie Burkart, Development Director will be reaching out to two people involved in the banking industry in Amherst. Eliza reported that following a recent speech	

Nominating (RON) Committee	to Applewood someone identified a community member that that may be interested.	
Corporate Compliance Committee	Eliza Lake reported that Senior Management will meet on this agenda in the upcoming weeks.	
Credentialing/ Privileging Committee	Due to the lack of quorum the credentialing of a new employee was unable to be conducted.	
Facilities Committee	Eliza Lake reported that the automatic door openers at the Worthington and Huntington Health Centers have been successfully installed. ADA compliant handles will be installed soon in the Admin area of Worthington.	
Personnel Committee	John Follet reported that this committee has not met.	
Strategic Planning	Eliza Lake reported that the recently reviewed Action Plan has been sent out to the committee. The committee will meet once more this year before needing to update the Strategic Plan in 2020.	
Fundraising Committee (ad hoc)	<p>Matt Bannister reported that the committee met last week in Northampton. There are three phrases/messages/slogans being proposed as the core message for the advertising campaign. Matt Bannister reiterated that these messages are high, overarching themes. “Your Health; Our Mission” seemed to stick out to several members as brief and hard hitting. The Board did not want to lose “community” and “engagement” in HCHCs message. These phrases will be shared with staff and the community.</p> <p>Matt Bannister discussed the mailing portion of the campaign with the difference between saturation mailings and potentially purchasing mailing lists by income and/or age. The cost of the mailings are approximately 30-40 cents per piece. Matt Bannister is working on formatting the letter with a couple different versions. Matt Bannister informed the Board that with the feedback provided, the committee will take the advertising to the next level. The big drive being for the June Annual Meeting. In regards to engaging staff, the best suggestion being to narrow the considerations and rank them as well as ranking each message by best message for patients vs. donors.</p>	Eliza Lake will send an email to staff to engage them on the different phrases.
Quality Improvement/Risk	Kathryn Jensen reported that the QI Committee that the focus of the February QI meeting was on the UDS submission and staffing	

Management Committee	issues. Both of which are also discussed in Eliza Lake's report, with no further comment.	
Committee Reports	Due to the lack of quorum, committee reports will be voted on next meeting.	
Old Business	<ul style="list-style-type: none"> • New Access Point (NAP) update was discussed in the CEO report. • John Follet reported that he responded to the email from Tim Walter, former treasurer. Response email was viewed by attending members. • John Follet will be reaching out to Maya Bachman, to gauge her continued interest and level of participation. 	
New Business	<p>Due to the lack of quorum, policies were unable to be voted on and will be reviewed for next month's meeting.</p> <p>The July 4th meeting will be moved to the following Thursday, July 11th.</p> <p>Due to the lack of quorum and the short timeline of the United Way grant submission, a vote will be needed prior to the next meeting. An electronic vote request will go out tomorrow.</p>	Eliza Lake will send out the change to the schedule to all members
Employee Credentialing	There was no employee credentialing to report.	
Next Meeting	<p>Lee Manchester moved the meeting be adjourned. Matt Bannister seconded the motion, which was approved by those present.</p> <p>The meeting was adjourned at 7:17 pm.</p> <p>The next scheduled meeting will be on April 4, 2019 at the Worthington Health Center.</p>	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

QI-RISK MANAGEMENT COMMITTEE

Location: Huntington Health Center

Date/Time: 01/15/2019 9:15am

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

ABSENT: NONE

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of December 18, 2018 Minutes Review of November 20, 2018 Minutes	<p>The meeting was called to order by Kathryn Jensen at 9:20 am.</p> <p>The minutes from the December 18, 2018 meeting were reviewed. Franny Huberman motioned for correction to meeting minutes in regards to being noted that Serena Torrey leaving and the interviews taking place were not to replace her because Franny Huberman already stepped into the position, but to replace Franny Huberman. Kathryn Jensen motioned that correction approved. Jon Liebman seconded the motion.</p> <p>The minutes from the November 20, 2018 meeting were reviewed. Kathryn Jensen made a motion to approve the minutes and Jon Liebman seconded the motion. With no discussion needed, the November 20, 2018 minutes were approved unanimously.</p>	<p>December 18, 2018 Minutes were approved unanimously, with correction made.</p> <p>November 20, 2018 Minutes were approved unanimously</p>
Upcoming HRSA Visit	<p>Eliza Lake reported on the preparation for the HRSA operational site visit in November 2019. This visit should be much easier to prepare for than previous visits as a Site Visit Protocol Checklist has been given to Health Centers. Eliza Lake wanted to note that some of these items in the checklist may not be required work for some of the committee members but she wanted to make them aware of it.</p> <p>The Committee reviewed the HRSA Site Protocol Checklist and all of the elements to the Program Requirement related to QI. There was more discussion around the following items:</p> <ul style="list-style-type: none">Eliza Lake will gather information as to what "QI Assessments" HRSA will be looking for, currently the understanding is that the QI Semi Annual report has sufficed. As per past HRSA site visits the patient sample was picked at random by HRSA for review.Incident report tracking and process will reviewed by Michael Purdy, Dawn Flatt and Eliza Lake, and the group will identify any LEAN projects that maybe be indicated by the trends in incidents reported.	<p>Annual review of Incidents to be completed</p>

	<ul style="list-style-type: none"> • Evidence based practice policy will be reviewed to see if it is being utilized and is up to date. • Changes/clarifications to the grievance process are being made currently. • Eliza Lake mentioned that MA League can come out and do a training on the 18 Program Requirements. This training can be for staff, the Board, or some combination of both. <p>Kathryn Jensen was concerned with follow through after QI meetings. Eliza suggested that with the additional of the new Executive Assistant, follow-up can be tracked and monitored by this position more closely, including any identified LEAN projects. Kathryn Jensen found that the third column in the minutes were very helpful in regards to follow up after a meeting.</p> <p>HCHC's Credentialing/Privileging policy will be updated soon to comply with recent changes in the HRSA Compliance Manual. Kathryn Jensen asked if there is deadline for credentialing to be done. Eliza Lake responded that it is to be done in the following month. Eliza will be following up with Bridget Rida, HR on this.</p>	<p>by February meeting</p> <p>Tabitha will develop a HRSA Site Visit Protocol check list for next meeting.</p> <p>Eliza will be report back on the Credentialing/ Privileging process.</p>
Old Business	No old business was discussed.	
Risk Management- Incidents Follow-ups	<p>Michael Purdy reported for risk management. One new incident was reported. A patient with varicella was recently seen. Patient was instructed to enter the Health Center through the side door and into an exam room. The attending Medical Assistant did not take precautions and the MA did have not confirmed varicella immunity. Michael reported that they will be looking back at the vaccination policy. Michael believes that it was never approved by the Board. Jon and Miranda are going to review this policy. An training is being planned at the Medical Provider Meeting on protocol. Department heads will be developing a plan to ensure follow-up on any incidents reported.</p> <p>The Medical Department is under staffed, as well as the Dental Department, with insufficient staffing ratios. There are job postings for Medical Assistants and RNs currently, but there will be a delay in getting them up and running. Meetings with department heads are starting today regarding these issues with the staffing shortage. Jon Liebman stated that there are several hundred patients who are being transitioned to new primary providers, due to Melanie Krupa leaving. Providers have currently increased their hours to accommodate these patients, but that still does not solve the issue of patient follow-up. A new MD is in the interview process. Jon Liebman and Michael Purdy will follow-up with Frank Mertes, CFO regarding the pay rate requested by the interviewee.</p>	Michael will report back next month with a follow up on the incident.

	Jon Liebman reported that there are still issues with the lack of data gathering. Michael Purdy plans on seeing how C3 is going to pulling numbers. He suggested that bench marks could at least be pulled for the time being.	
New Business	No new business reported.	
Patient Satisfaction Survey	Patient Satisfaction survey to be sent out in March. In regards to the HRSA Site Visit planning, the focus is on Medical patients. Eliza Lake is going to locate the Incident Report spread sheet to review with Dawn Flatt and Michael Purdy. Also looking at a more efficient way to distribute survey to patients i.e. tablet or laptop during patient visit.	
Adjourn	Katheryn Jensen moved that the meeting be adjourned, the meeting was adjourned at 10:00am. The next meeting is scheduled for Tuesday, February 19, 2019 at 9:15am at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold
Executive Assistant

QI-RISK MANAGEMENT COMMITTEE

Location: Huntington Health Center

Date/Time: 02/19/2019 9:15am

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

ABSENT: Michael Purdy, CCCSO; Tabitha Griswold, Executive Assistant

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of January 15, 2019 Minutes	<p>The meeting was called to order by Kathryn Jensen at 9:18 am.</p> <p>The minutes from the January 15, 2019 meeting were reviewed. Eliza Lake motioned to approve. Jon Liebman seconded the motion.</p>	January 15, 2019 Minutes were approved unanimously.
Old Business	No old business was discussed.	
Risk Management- Incidents- Infections disease protocol- Staffing	<p>Eliza lake reported that the Executive Assistant with partaking in an ALICE training this week. This will provide good feedback for the Emergency Plan.</p> <p>Eliza reported for risk management. A couple new incidents will be coming. They are currently going through the appropriate channels and will be presented at next month's meeting. An Infectious Disease Training will be presented at provider meeting in February. All training rosters for clinical trainings should be forwarded to Bridget Rida, HR Manager, as she tracks all employees' training.</p> <p>The Medical Department continues to be under staffed; there was a recent resignation of a MA, which has exacerbated the issue. Nursing staff had an interview with a potential RN, but they did not feel this candidate would be a good fit. The rates and geographic location of the Health Center continue to be a barrier to recruitment.</p>	
Dental Department	Mary Lou Stewart reported on the Dashboard metrics in the Dental Department. Through peer review there was identified an issue with updating full mouth series x-rays, which has now been corrected through education of all dentists. Also found through peer review were issues with updated medical history and medications in paper form, which has also been addressed. Dentrix has limited capacity to track the record issues, but an	

	<p>upgrade may address this issue. New scanners are also needed. As has been discussed before, there is no communication between HCHC's electronic health and dental record systems.</p> <p>According to 2018 Quality Measures, sealants numbers are good and very high. However, the numbers show that there is 315 high risk patients and only 61 with 2nd fluoride and 2nd varnish. This number seems to be very low and this is going to be checked into. The general consensus this that these are being performed but maybe not coded correctly.</p> <p>Mary Lou reported that there were two patients with infected teeth, these patients keep wanting antibiotics instead of getting their extractions. The Medical Dept. reported that they see this happen as well, and does not prescribe over the phone either. There can be a termination of the patients, if it is deemed that the provider is endangering patients with inadequate treatment. This could be a legal risk but good documentation would address this risk.</p> <p>Mary Lou also requested that cell phone use by staff be banned. This is something that is being looked into with the updating of the Employee Handbook.</p>	
Community Programs- status report	<p>Kim Savery reported on Community Programs. Kim made an amendment that she incorrectly reported the percentage of patients screened for SDOH. Instead of less than 5% of MassHealth patients screened for SPOH, in the 4th quarter there was actually 228 completed out of 612 patients. Kim reported that a PDSA project has been implemented to increase the screening of MassHealth patients, with a goal of universal screening. HCHC has a 2 year pilot with PRAPARE, the screening tool, and has developed a system through which, if positive answers are generated, then the patients get placed with appropriate staff. C3 requires that 5% patients screened, but that benchmark will rise to 100% fairly soon. C3 has their own tool but it doesn't cover as many SDOH- the staff does not like those questions as much. PDSA project will happen at HHC- MassHealth patients with CPEs will be asked to come in early to do screening with CHWs (w/ motivational interviewing training) and to develop a relationship. CHW's will tell MA when ready and then input responses into eCW. If the patient presents as high risk (3-5 markers) this will be communicated with PCP directly.</p> <p>Kim also reported that Diabetes Prevention Program classes are ending. There is a potential that the health center will be eligible on 3/1/19 for a MassHealth reimbursement (\$990/patient), and we are way above the curve. Eliza will look into the potential for billing for these services.</p>	
UDS	<p>Eliza reported that the initial UDS was successfully submitted on February 15th. In general the numbers look positive. The UDS is a useful tool for identifying needed improvements in coding and billing, as well as possible</p>	

	<p>areas of quality improvement. In the submission of the report, a few questions were raised about a couple of clinical measures, but we are confident that the data submitted was accurate. For instance, the number of pap smears was lower than might be expected for the population of adult women under the age of 65, but HCHC's patient population skews older than the norm, and therefore our patients only require screening once every five years, instead of once every three. This reduces the overall number of screenings that occur. The report will be reviewed by an outside consultant hired by HRSA before the numbers are finalized.</p>	
New Business	There was no new business to report.	
Adjourn	<p>Katheryn Jensen moved that the meeting be adjourned, the meeting was adjourned at 10:00am. The next meeting is scheduled for Tuesday, March 19, 2019 at 9:15am at the Huntington Health Center.</p>	

Respectfully submitted,
Tabitha Griswold
Executive Assistant

Hilltown CHC
Dashboard And Summary Financial Results
January 2019

	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	Actual YTD Jan. 2019	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures											
Operating Days Cash	7	9	3	1	15	5	9	10	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	0.83	0.76	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	33	30	34	39	42	39	36	37	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	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%	-15.3%	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%	-15.3%	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%	32.6%	36.0%	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	1,726			
Net Medical Revenue per Visit	\$ 134.56	\$ 144.39	\$ 144.02	\$ 144.38	\$ 146.08	\$ 143.80	\$ 143.59	\$ 132.36			
Dental Visits	14,880	3,512	7,426	11,454	12,953	14,318	15,537	1,476			
Net Dental Revenue per Visit	\$ 113.60	\$ 109.03	\$ 115.98	\$ 116.41	\$ 116.88	\$ 114.52	\$ 112.76	\$ 109.32			
Behavioral Health Visits	3,809	1,002	2,120	3,129	3,586	3,916	4,306	427			
Net BH Revenue per Visit	\$ 95.70	\$ 85.29	\$ 89.42	\$ 91.01	\$ 88.72	\$ 85.15	\$ 87.74	\$ 80.11			
Optometry Visits	2,329	523	1,124	1,726	1,973	2,156	2,381	222			
Net Optometry Revenue per Visit	\$ 79.61	\$ 91.60	\$ 85.75	\$ 87.29	\$ 88.73	\$ 87.01	\$ 86.40	\$ 77.49			

Hilltown Community Health Centers
Income Statement - All Departments
Jan. 2019

	Jan. 2019 Actual	YTD Total Actual	YTD PY Actual	Over (Under) Cur. v. PY YTD
OPERATING ACTIVITIES				
Revenue				
Patient Services - Medical	228,445	228,445	221,747	6,698
Visits	1,726	1,726	1,489	237
Revenue/Visit	\$ 132.36	\$ 132.36	\$ 148.92	\$ (16.57)
Patient Services - Dental	161,360	161,360	146,504	14,856
Visits	1,476	1,476	1,252	224
Revenue/Visit	\$ 109.32	\$ 109.32	\$ 117.02	\$ (7.69)
Patient Services - Beh. Health	34,206	34,206	33,308	898
Visits	427	427	330	97
Revenue/Visit	\$ 80.11	\$ 80.11	\$ 100.93	\$ (20.83)
Patient Services - Optometry	17,203	17,203	18,692	(1,489)
Visits	222	222	214	8
Revenue/Visit	\$ 77.49	\$ 77.49	\$ 87.35	\$ (9.85)
Patient Services - Optometry Hardware	10,719	10,719	7,414	3,305
Patient Services - Pharmacy	1,598	1,598	6,094	(4,496)
Quality & Other Incentives	337	337	8,834	(8,497)
HRSA 330 Grant	125,425	125,425	117,253	8,172
Other Grants & Contracts	52,995	52,995	54,391	(1,396)
Int., Dividends Gain /(Loss) Investments	19,514	19,514	82	19,432
Rental & Misc. Income	2,467	2,467	2,427	40
Total Operating Revenue	654,269	654,269	616,746	37,523
Compensation and related expenses				
Salaries and wages	517,837	517,837	500,968	16,869
Payroll taxes	42,348	42,348	37,830	4,518
Fringe benefits	46,356	46,356	37,488	8,868
Total Compensation & related expenses	606,541	606,541	576,286	30,255
No. of week days	23	23	23	-
Staff cost per week day	\$ 26,371	\$ 26,371	\$ 25,056	\$ 1,315

Hilltown Community Health Centers
Income Statement - All Departments
Jan. 2019

	Jan. 2019 Actual	YTD Total Actual	YTD PY Actual	Over (Under) Cur. v. PY YTD
Other Operating Expenses				
Advertising and marketing	804	804	130	674
Bad debt	11,631	11,631	20,240	(8,609)
Computer support	6,806	6,806	7,996	(1,190)
Conference and meetings	65	65	4,780	(4,715)
Continuing education	2,068	2,068	1,112	956
Contracts and consulting	1,105	1,105	1,581	(477)
Depreciation and amortization	27,651	27,651	13,695	13,956
Dues and membership	2,645	2,645	921	1,723
Equipment leases	2,674	2,674	1,726	949
Insurance	2,112	2,112	1,225	886
Interest	1,409	1,409	1,492	(83)
Legal and accounting	2,188	2,188	2,167	21
Licenses and fees	4,622	4,622	1,795	2,827
Medical & dental lab and supplies	9,531	9,531	5,767	3,764
Merchant CC Fees	1,204	1,204	1,373	(169)
Office supplies and printing	3,858	3,858	5,777	(1,919)
Postage	28	28	2,018	(1,990)
Program supplies and materials	19,960	19,960	17,654	2,306
Pharmacy & Optometry COGS	6,571	6,571	7,315	(744)
Recruitment	-	-	-	-
Rent	7,123	7,123	3,140	3,983
Repairs and maintenance	10,755	10,755	10,281	474
Small equipment purchases	949	949	-	949
Telephone/Internet	13,589	13,589	7,171	6,418
Travel	1,496	1,496	1,813	(316)
Utilities	7,081	7,081	6,151	930
Loss on Disposal of Assets	-	-	-	-
Total Other Operating Expenses	147,925	147,925	127,321	20,604
Net Operating Surplus (Deficit)	(100,197)	(100,197)	(86,861)	(13,336)
NON-OPERATING ACTIVITIES				
Donations, Pledges & Contributions			12,765	(12,765)
Loan Forgiveness	-		-	-
Capital Grants	-		(40,918)	40,918
Net Non-operating Surplus (Deficit)	-	-	(28,153)	28,153
NET SURPLUS/(DEFICIT)	(100,197)	(100,197)	(115,014)	14,817

Hilltown CHC
Summary of Net Results By Dept.
Jan. 2019
Net Results Gain (Deficit)

	Jan. 2019	YTD	PY YTD	Cur. v. PY YTD
<u>Operating</u>				
Medical	\$ (59,056)	\$ (59,056)	\$ (42,060)	\$ (16,996)
Dental	(25,540)	(25,540)	(26,186)	\$ 646
Behavioral Health	968	968	(1,798)	\$ 2,766
Optometry	(3,154)	(3,154)	(956)	\$ (2,198)
Pharmacy	2,828	2,828	4,835	\$ (2,007)
Community	(10,920)	(10,920)	(2,117)	\$ (8,803)
Fundraising	(5,113)	(5,113)	(8,744)	\$ 3,631
Admin. & OH	(210)	(210)	(9,835)	\$ 9,625
Net Operating Results	\$ (100,197)	\$ (100,197)	\$ (86,861)	\$ (13,336)
<u>Non Operating</u>				
Donations	\$ -	\$ -	\$ 12,765	\$ (12,765)
Capital Project Revenue	-	-	(40,918)	\$ 40,918
Total	\$ -	\$ -	\$ (28,153)	\$ 28,153
Net	\$ (100,197)	\$ (100,197)	\$ (115,014)	\$ 14,817

Hilltown Community Health Centers
Balance Sheet - Monthly Trend

	12/31/2017	3/31/2018	6/30/2018	9/30/2018	12/31/2018	1/31/2019
Assets						
Current Assets						
Cash - Operating Fund	\$ 139,487	\$ 193,864	\$ 59,713	\$ 11,682	\$ 197,997	\$ 233,851
Cash - Restricted (Amherst Donations)	238,749	108,789	25,978	25,048	6,152	1,051
Patient Receivables	922,130	892,811	1,008,550	1,132,355	945,217	1,032,027
Less Allow. for Doubtful Accounts	(99,215)	(135,875)	(136,698)	(164,027)	(109,786)	(118,366)
Less Allow. for Contractual Allowances	(364,280)	(355,637)	(400,599)	(425,743)	(317,200)	(374,895)
A/R 340B-Pharmacist	17,254	16,255	18,243	29,082	32,188	7,390
A/R 340B-State	928	(765)	(4,299)	(4,736)	1,827	1,827
Contracts & Grants Receivable	167,729	56,863	66,864	92,099	69,673	62,015
Prepaid Expenses	4,882	21,493	20,263	22,470	14,866	16,298
A/R Pledges Receivable	56,527	37,121	28,991	28,911	28,828	26,328
Total Current Assets	1,084,189	834,920	687,006	747,140	869,761	887,526
Property & Equipment						
Land	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
Improvements	872,646	872,646	905,848	905,848	911,848	911,848
Leasehold Improvements	-	-	-	-	1,933,674	1,933,674
Equipment	964,232	964,232	964,232	964,232	1,288,156	1,288,156
Construction in Progress (Amherst)	1,382,662	1,857,729	2,012,678	2,125,022	-	-
Total Property and Equipment	6,037,958	6,513,025	6,701,176	6,813,520	6,952,096	6,952,096
Less Accumulated Depreciation	(2,185,507)	(2,220,682)	(2,255,859)	(2,322,241)	(2,430,365)	(2,458,016)
Net Property & Equipment	3,852,452	4,292,343	4,445,317	4,491,279	4,521,731	4,494,080
Other Assets						
Restricted Cash	53,713	53,717	53,732	53,731	53,713	53,713
Pharmacy 340B and Optometry Inventory	13,089	13,224	13,544	14,344	11,811	12,249
Investments Restricted	6,978	6,978	7,350	7,789	6,661	6,661
Investment - Vanguard	514,406	464,406	467,823	377,622	227,889	247,383
Total Other Assets	588,186	538,326	542,450	453,486	300,074	320,006
Total Assets	\$ 5,524,827	\$ 5,665,589	\$ 5,674,773	\$ 5,691,906	\$ 5,691,566	\$ 5,701,613
Liabilities & Fund Balance						
Current & Long Term Liabilities						
Current Liabilities						
Accounts Payable	\$ 296,786	\$ 508,923	\$ 359,533	\$ 335,288	\$ 164,918	\$ 180,932
Notes Payable	-	-	-	-	300,000	300,000
Sales Tax Payable	51	315	59	35	56	23
Accrued Expenses	80,324	(3,108)	(6,046)	6,846	60,334	61,951
Accrued Payroll Expenses	368,564	504,005	397,811	478,758	386,764	481,414
Payroll Liabilities	19,499	8,674	12,214	15,276	20,702	17,285
Unemployment Escrow	826	826	826	826	826	826
Line of Credit	-	-	-	50,000	-	-
Deferred Contract Revenue	107,507	48,531	56,783	43,843	120,296	124,247
Total Current Liabilities	873,556	1,068,166	821,179	930,872	1,053,896	1,166,677
Long Term Liabilities						
Mortgage Payable United Bank	185,129	180,782	176,531	172,239	167,900	166,455
Mortgages Payable USDA Huntington	189,368	186,406	183,323	180,164	176,837	175,775
Total Long Term Liabilities	374,497	367,188	359,854	352,403	344,737	342,230
Total Liabilities	1,248,053	1,435,354	1,181,033	1,283,274	1,398,633	1,508,907
Fund Balance / Equity						
Fund Balance Prior Period	4,276,773	4,230,235	4,493,740	4,408,632	4,292,933	4,192,706
Total Fund Balance / Equity	4,276,773	4,230,235	4,493,740	4,408,632	4,292,933	4,192,706
Total Liabilities & Fund Balance	\$ 5,524,827	\$ 5,665,589	\$ 5,674,773	\$ 5,691,906	\$ 5,691,566	\$ 5,701,613

Hilltown CHC
Dashboard And Summary Financial Results
February 2019

	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	Actual YTD Jan. 2019	Actual YTD Feb. 2019	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures												
Operating Days Cash	7	9	3	1	15	5	9	10	11	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	0.83	0.76	0.72	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	33	30	34	39	42	39	36	37	35	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	29	36	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%	-15.3%	-13.6%	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%	-15.3%	-13.6%	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%	32.6%	36.0%	37.5%	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	1,726	3,115			
Net Medical Revenue per Visit	\$ 134.56	\$ 144.39	\$ 144.02	\$ 144.38	\$ 146.08	\$ 143.80	\$ 143.59	\$ 132.36	\$ 137.66			
Dental Visits	14,880	3,512	7,426	11,454	12,953	14,318	15,537	1,476	2,791			
Net Dental Revenue per Visit	\$ 113.60	\$ 109.03	\$ 115.98	\$ 116.41	\$ 116.88	\$ 114.52	\$ 112.76	\$ 109.32	\$ 111.36			
Behavioral Health Visits	3,809	1,002	2,120	3,129	3,586	3,916	4,306	427	736			
Net BH Revenue per Visit	\$ 95.70	\$ 85.29	\$ 89.42	\$ 91.01	\$ 88.72	\$ 85.15	\$ 87.74	\$ 80.11	\$ 79.70			
Optometry Visits	2,329	523	1,124	1,726	1,973	2,156	2,381	222	395			
Net Optometry Revenue per Visit	\$ 79.61	\$ 91.60	\$ 85.75	\$ 87.29	\$ 88.73	\$ 87.01	\$ 86.40	\$ 77.49	\$ 79.27			

Hilltown Community Health Centers
Income Statement - All Departments
Feb. 2019

	Feb. 2019 Actual	YTD Total Actual	YTD PY Actual	Over (Under) Cur. v. PY YTD
OPERATING ACTIVITIES				
Revenue				
Patient Services - Medical	200,352	428,796	428,570	226
Visits	1,389	3,115	2,914	201
Revenue/Visit	\$ 144.24	\$ 137.66	\$ 147.07	\$ (9.42)
Patient Services - Dental	149,450	310,811	250,788	60,023
Visits	1,315	2,791	2,309	482
Revenue/Visit	\$ 113.65	\$ 111.36	\$ 108.61	\$ 2.75
Patient Services - Beh. Health	24,451	58,657	58,567	90
Visits	312	736	642	94
Revenue/Visit	\$ 78.37	\$ 79.70	\$ 91.23	\$ (11.53)
Patient Services - Optometry	14,110	31,313	29,379	1,934
Visits	173	395	370	25
Revenue/Visit	\$ 81.56	\$ 79.27	\$ 79.40	\$ (0.13)
Patient Services - Optometry Hardware	5,444	16,163	11,359	4,804
Patient Services - Pharmacy	2,119	3,717	14,536	(10,819)
Quality & Other Incentives	304	641	9,126	(8,485)
HRSA 330 Grant	125,833	251,258	234,506	16,752
Other Grants & Contracts	55,342	108,337	117,773	(9,436)
Int., Dividends Gain /(Loss) Investments	7,696	27,210	119	27,091
Rental & Misc. Income	2,476	4,942	4,874	68
Total Operating Revenue	587,577	1,241,845	1,159,597	82,248
Compensation and related expenses				
Salaries and wages	443,412	961,249	931,628	29,621
Payroll taxes	34,077	76,424	70,607	5,817
Fringe benefits	35,767	82,123	74,332	7,791
Total Compensation & related expenses	513,256	1,119,796	1,076,567	43,229
No. of week days	20	43	43	-
Staff cost per week day	\$ 25,663	\$ 26,042	\$ 25,036	\$ 1,005

Hilltown Community Health Centers
Income Statement - All Departments
Feb. 2019

	Feb. 2019 Actual	YTD Total Actual	YTD PY Actual	Over (Under) Cur. v. PY YTD
Other Operating Expenses				
Advertising and marketing	199	1,003	746	257
Bad debt	12,965	24,597	20,611	3,986
Computer support	5,949	12,755	15,855	(3,100)
Conference and meetings	424	489	4,679	(4,190)
Continuing education	1,710	3,778	2,764	1,014
Contracts and consulting	3,999	5,103	4,200	904
Depreciation and amortization	27,651	55,301	27,389	27,912
Dues and membership	2,308	4,952	3,933	1,020
Equipment leases	1,501	4,175	3,459	716
Insurance	2,119	4,230	2,896	1,334
Interest	1,400	2,809	2,986	(177)
Legal and accounting	2,188	4,375	7,803	(3,428)
Licenses and fees	2,761	7,383	9,641	(2,258)
Medical & dental lab and supplies	9,908	19,439	16,716	2,724
Merchant CC Fees	1,794	2,998	2,557	441
Office supplies and printing	1,307	5,165	8,854	(3,689)
Postage	2,068	2,096	4,212	(2,116)
Program supplies and materials	16,591	36,551	32,258	4,293
Pharmacy & Optometry COGS	10,211	16,782	11,204	5,578
Recruitment	-	-	284	(284)
Rent	5,405	12,528	6,280	6,248
Repairs and maintenance	12,142	22,898	22,914	(16)
Small equipment purchases	-	949	1,433	(484)
Telephone/Internet	13,696	27,315	8,626	18,689
Travel	997	2,494	3,239	(745)
Utilities	3,958	11,039	12,124	(1,085)
Loss on Disposal of Assets	-	-	-	-
Total Other Operating Expenses	143,251	291,206	237,663	53,543
Net Operating Surplus (Deficit)	(68,930)	(169,157)	(154,633)	(14,524)
NON-OPERATING ACTIVITIES				
Donations, Pledges & Contributions	430	430	12,848	(12,418)
Loan Forgiveness	-	-		-
Capital Grants	-	-	158,878	(158,878)
Net Non-operating Surplus (Deficit)	430	430	171,726	(171,296)
NET SURPLUS/(DEFICIT)	(68,500)	(168,727)	17,093	(185,820)

Hilltown CHC
Summary of Net Results By Dept.
Feb. 2019
Net Results Gain (Deficit)

	Feb. 2019	YTD	PY YTD	Cur. v. PY YTD
<u>Operating</u>				
Medical	\$ (32,942)	\$ (91,998)	\$ (59,250)	\$ (32,748)
Dental	(16,835)	(42,375)	(70,962)	\$ 28,587
Behavioral Health	(3,533)	(2,565)	(3,507)	\$ 942
Optometry	(9,837)	(12,991)	(8,760)	\$ (4,231)
Pharmacy	246	3,074	11,410	\$ (8,336)
Community	(2,575)	(13,525)	(2,504)	\$ (11,021)
Fundraising	(4,045)	(8,729)	(13,881)	\$ 5,152
Admin. & OH	591	382	(7,179)	\$ 7,561
Net Operating Results	\$ (68,930)	\$ (168,727)	\$ (154,633)	\$ (14,094)
<u>Non Operating</u>				
Donations	\$ 430	\$ 430	\$ 12,848	\$ (12,418)
Capital Project Revenue	-	-	158,878	\$ (158,878)
Total	\$ 430	\$ 430	\$ 171,726	\$ (171,296)
Net	\$ (68,500)	\$ (168,297)	\$ 17,093	\$ (185,390)

Hilltown Community Health Centers
Balance Sheet - Monthly Trend

	12/31/2017	3/31/2018	6/30/2018	9/30/2018	12/31/2018	1/31/2019	2/28/2019
Assets							
Current Assets							
Cash - Operating Fund	\$ 139,487	\$ 193,864	\$ 59,713	\$ 11,682	\$ 197,997	\$ 233,851	\$ 252,962
Cash - Restricted (Amherst Donations)	238,749	108,789	25,978	25,048	6,152	1,051	12,402
Patient Receivables	922,130	892,811	1,008,550	1,132,355	945,217	1,032,027	970,729
Less Allow. for Doubtful Accounts	(99,215)	(135,875)	(136,698)	(164,027)	(109,786)	(118,366)	(128,973)
Less Allow. for Contractual Allowances	(364,280)	(355,637)	(400,599)	(425,743)	(317,200)	(374,895)	(344,593)
A/R 340B-Pharmacist	17,254	16,255	18,243	29,082	32,188	7,390	(1,455)
A/R 340B-State	928	(765)	(4,299)	(4,736)	1,827	1,827	1,827
Contracts & Grants Receivable	167,729	56,863	66,864	92,099	69,673	62,015	65,280
Prepaid Expenses	4,882	21,493	20,263	22,470	14,866	16,298	20,021
A/R Pledges Receivable	56,527	37,121	28,991	28,911	28,828	26,328	15,360
Total Current Assets	1,084,189	834,920	687,006	747,140	869,761	887,526	863,561
Property & Equipment							
Land	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
Improvements	872,646	872,646	905,848	905,848	911,848	911,848	911,848
Leasehold Improvements	-	-	-	-	1,933,674	1,933,674	1,933,674
Equipment	964,232	964,232	964,232	964,232	1,288,156	1,288,156	1,288,156
Construction in Progress (Amherst)	1,382,662	1,857,729	2,012,678	2,125,022	-	-	12,348
Total Property and Equipment	6,037,958	6,513,025	6,701,176	6,813,520	6,952,096	6,952,096	6,964,444
Less Accumulated Depreciation	(2,185,507)	(2,220,682)	(2,255,859)	(2,322,241)	(2,430,365)	(2,458,016)	(2,485,666)
Net Property & Equipment	3,852,452	4,292,343	4,445,317	4,491,279	4,521,731	4,494,080	4,478,778
Other Assets							
Restricted Cash	53,713	53,717	53,732	53,731	53,713	53,713	53,712
Pharmacy 340B and Optometry Inventory	13,089	13,224	13,544	14,344	11,811	12,249	11,909
Investments Restricted	6,978	6,978	7,350	7,789	6,661	6,661	6,661
Investment - Vanguard	514,406	464,406	467,823	377,622	227,889	247,383	255,060
Total Other Assets	588,186	538,326	542,450	453,486	300,074	320,006	327,342
Total Assets	\$ 5,524,827	\$ 5,665,589	\$ 5,674,773	\$ 5,691,906	\$ 5,691,566	\$ 5,701,613	\$ 5,669,681
Liabilities & Fund Balance							
Current & Long Term Liabilities							
Current Liabilities							
Accounts Payable	\$ 296,786	\$ 508,923	\$ 359,533	\$ 335,288	\$ 164,918	\$ 180,932	\$ 225,470
Notes Payable	-	-	-	-	300,000	300,000	300,000
Sales Tax Payable	51	315	59	35	56	23	39
Accrued Expenses	80,324	(3,108)	(6,046)	6,846	60,334	61,951	46,717
Accrued Payroll Expenses	368,564	504,005	397,811	478,758	386,764	481,414	480,774
Payroll Liabilities	19,499	8,674	12,214	15,276	20,702	17,285	15,242
Unemployment Escrow	826	826	826	826	826	826	826
Line of Credit	-	-	-	50,000	-	-	-
Deferred Contract Revenue	107,507	48,531	56,783	43,843	120,296	124,247	136,693
Total Current Liabilities	873,556	1,068,166	821,179	930,872	1,053,896	1,166,677	1,205,760
Long Term Liabilities							
Mortgage Payable United Bank	185,129	180,782	176,531	172,239	167,900	166,455	165,007
Mortgages Payable USDA Huntington	189,368	186,406	183,323	180,164	176,837	175,775	174,707
Total Long Term Liabilities	374,497	367,188	359,854	352,403	344,737	342,230	339,714
Total Liabilities	1,248,053	1,435,354	1,181,033	1,283,274	1,398,633	1,508,907	1,545,474
Fund Balance / Equity							
Fund Balance Prior Period	4,276,773	4,230,235	4,493,740	4,408,632	4,292,933	4,192,706	4,124,206
Total Fund Balance / Equity	4,276,773	4,230,235	4,493,740	4,408,632	4,292,933	4,192,706	4,124,206
Total Liabilities & Fund Balance	\$ 5,524,827	\$ 5,665,589	\$ 5,674,773	\$ 5,691,906	\$ 5,691,566	\$ 5,701,613	\$ 5,669,681

Hilltown Community Health Centers, Inc.

FY 2019 Budget Summary

As discussed at the last Board meeting the executive staff remains committed to look for ways to improve the “bottom line” and to propose additional updates to this initial budget in an effort to reduce losses. Currently there are planned meetings with department managers to review this budget in an effort to close the gaps. The purpose and expected outcomes of these meetings is to generate options that will achieve financial stability. These options will be presented to the Board of Directors by senior management. We will develop viable cost cutting and revenue producing initiatives, along with possible restructures of services and/or operational sites. We will report back to the Board on these efforts in future meetings.

The FY 2019 budget is based on current business conditions, current and anticipated staffing, known and anticipated grants and a reasonable estimate of projected patient visits. It does not include a standard pay increase for staffing, however it does include some planned wage increases due to market pressures, particularly regarding Medical Assistants. This is problematic as there is a reasonable expectation by staff for an annual inflationary wage increase to cover their higher cost of living expenses. Unfortunately, the budget anticipates an operating loss of \$426,842 which is compounded by an actual operating loss in FY 2018 of \$430,010. The budget also projects a cash shortage at various points during the year with a year-end cash deficit of approximately \$87,000.

Budget Summary by Statement:

1. FY 2019 Statement of Activities Budget

Shows budgeted activities compared to actual for FY 2018. It includes Operating and Non-operating financial results for all departments.

Revenue: There is a modest 2.5% revenue increase from the PY mainly due to added revenue for a full year of operations at the Musante Health Center. It also shows a reduction of combined grant revenue of approx. \$46,500 and an increase in Interest/Dividend revenues.

Expenses: Overall there is an increase of \$193,036 from the PY in operating expenses. Most expense categories remain comparative to the PY, however Compensation and Depreciation amount to an increase of approx. \$177,000. The added compensation is mostly the result of a full budgeted year of operations at Musante HC, the added depreciation is also a result of our Musante HC capital investments in the PY.

The non-operating differences are also related to Musante HC.

2. FY 2019 Statement of Activities Budget By Month

Informational – shows same format as FY 2019 Statement of Activities Budget, except gives budget on a monthly basis. This is helpful to identify cash needs during the year and is used to compare against actual monthly results as reported to the Board.

3. FY 2019 Statement of Activities Department Budget

Shows the FY annual budget by each department. Helps identify areas needing attention.

4. Budgeted Balance Sheet – Monthly Trend

Budget based upon known and anticipated payments of debt and vendor balances, changes in accounts receivables, prepaids, accrued expenses and operational losses. Please notice the top line in the trend, Cash-Operating fund, it shows the trend of available cash and in November it becomes \$0, it is at this point that the budget anticipates the use of Line of Credit (LOC). For November and December 2019 there is a cash flow deficit of approx. \$135,000 and \$87,000, respectively. The cash balance is very thin and there is a good chance that the LOC will be utilized in earlier months.

5. FY 2019 Visit Trend

Summary of budgeted and actual PY visits and related net revenue per visit by service groups.

Both Mental Health and Medical visits are down. Mental Health is due reduced provider staffing. The Medical reduction in visits is due to a net reduction in provider staffing and provider placement in an underperforming location.

6. FY 2019 Budgeted hours per week

Shows number of hours and Full Time Equivalents (FTE's) by department and location used in the budget. The budget assumed full staffing levels based upon timely recruitment during the year. It is believed that at these levels we are fully staffed.

Hilltown Community Health Centers, Inc.
FY 2019 Statement of Activities Budget

	Budget FY 2019	Actual FY 2018	\$ Increase (decrease)	% Increase (decrease)
<u>Operating</u>				
Patient Services	\$ 5,386,017	\$ 5,191,616	\$ 194,401	3.7%
HRSA 330 & Other Grant	1,797,422	1,719,762	77,659	4.5%
Other Grants & Contracts	753,754	877,929	(124,175)	-14.1%
Interest Dividends	67,360	4,963	62,397	1257.2%
Quality & Other Incentives	40,396	49,111	(8,715)	-17.7%
Rental & Misc.	30,514	35,876	(5,362)	-14.9%
Total Revenue	8,075,462	7,879,258	196,204	2.5%
<u>Expenses</u>				
Compensation & Related Expenses	6,674,300	6,583,989	90,311	1.4%
Recruitment	1,350	340	1,010	297.5%
Conferences & Meetings	4,539	4,660	(121)	-2.6%
Small Equipment Purchases	5,699	10,080	(4,381)	-43.5%
Advertising & Marketing	13,103	4,687	8,416	179.5%
Interest	16,369	17,858	(1,488)	-8.3%
Merchant CC Fees	18,148	17,921	227	1.3%
Postage	18,846	18,009	837	4.7%
Equipment Leases	25,245	24,892	353	1.4%
Travel	25,294	24,079	1,214	5.0%
Insurance	25,417	23,556	1,861	7.9%
Legal & Accounting	33,250	31,964	1,286	4.0%
Dues & Memberships	36,289	30,754	5,535	18.0%
Contracts & Consultants	39,803	34,149	5,654	16.6%
Office Supplies & Printing	41,023	43,172	(2,149)	-5.0%
Continuing Education	41,600	24,628	16,972	68.9%
Licenses & Fees	53,983	55,530	(1,547)	-2.8%
Utilities	56,039	54,003	2,036	3.8%
Rent	67,908	102,057	(34,149)	-33.5%
Bad Debt	75,347	58,489	16,858	28.8%
Computer Support	78,126	84,529	(6,403)	-7.6%
Pharmacy & Optometry COGS	120,182	119,361	821	0.7%
Medical & Dental Lab & Supplies	140,439	134,183	6,257	4.7%
Repairs & Maintenance	163,192	180,955	(17,763)	-9.8%
Telephone & Internet	164,279	141,729	22,549	15.9%
Program Supplies & Materials	230,726	238,837	(8,111)	-3.4%
Depreciation & Amortization	331,807	244,859	86,948	35.5%
Total Expenses	8,502,304	8,309,268	193,036	2.3%
Net Operating Gain (Loss)	(426,842)	(430,010)	3,169	-0.7%
<u>Non-operating</u>				
HRSA Capital	50,389	367,080	(316,691)	-86.3%
Other Capital Grants	64,845	37,913	26,932	71.0%
Donations	430	41,177	(40,747)	-99.0%
Non-operating Net	115,664	446,170	(330,506)	-74.1%
Total Gain (Loss)	\$ (311,178)	\$ 16,160	\$ (327,338)	-2025.7%

Hilltown Community Health Centers, Inc.
FY 2019 Statement of Activities Budget By Month

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total Budget FY 2019	Total Actual FY 2018
Operating														
Patient Services	\$ 453,531	\$ 395,926	\$ 451,467	\$ 442,552	\$ 458,819	\$ 446,718	\$ 418,177	\$ 456,024	\$ 429,357	\$ 502,064	\$ 476,150	\$ 455,236	\$ 5,386,017	\$ 5,191,616
HRSA 330 & Other Grant	125,425	125,833	126,160	126,160	228,294	168,659	168,659	120,479	186,492	180,302	120,479	120,479	1,797,422	1,719,762
Other Grants & Contracts	52,995	55,342	81,626	81,130	83,712	56,130	48,259	57,773	60,533	62,775	56,739	56,741	753,754	877,929
Interest Dividends	19,514	7,696	2,380	530	2,530	2,530	2,530	2,530	19,530	2,530	2,530	2,530	67,360	4,963
Quality & Other Incentives	337	304	276	17,276	276	276	276	276	276	276	276	20,276	40,396	49,111
Rental & Misc.	2,466	2,476	2,466	2,567	2,567	2,567	2,567	2,567	2,567	2,567	2,567	2,567	30,514	35,876
Total Revenue	654,269	587,577	664,374	670,214	776,198	676,879	640,468	639,648	698,754	750,514	658,740	657,828	8,075,462	7,879,258
Expenses														
Compensation & Related Expenses	606,541	513,255	525,194	551,027	578,644	512,237	579,386	544,980	555,927	593,092	544,980	569,037	6,674,300	6,583,989
Recruitment	-	-	225	225	-	-	225	-	225	-	225	225	1,350	340
Conferences & Meetings	65	424	405	405	405	405	405	405	405	405	405	405	4,539	4,660
Small Equipment Purchases	949	-	175	175	3,175	175	175	175	175	175	175	175	5,699	10,080
Advertising & Marketing	804	199	4,650	4,650	350	350	350	350	350	350	350	350	13,103	4,687
Interest	1,409	1,400	1,392	1,384	1,376	1,368	1,360	1,344	1,352	1,336	1,328	1,320	16,369	17,858
Merchant CC Fees	1,204	1,794	1,515	1,515	1,515	1,515	1,515	1,515	1,515	1,515	1,515	1,515	18,148	17,921
Postage	28	2,068	2,075	2,075	1,575	1,575	1,575	1,575	1,575	1,575	1,575	1,575	18,846	18,009
Equipment Leases	2,674	1,501	2,107	2,107	2,107	2,107	2,107	2,107	2,107	2,107	2,107	2,107	25,245	24,892
Travel	1,496	997	2,280	2,280	2,280	2,280	2,280	2,280	2,280	2,280	2,280	2,280	25,294	24,079
Insurance	2,112	2,119	2,119	2,119	2,119	2,119	2,119	2,119	2,119	2,119	2,119	2,119	25,417	23,556
Legal & Accounting	2,188	2,188	2,888	2,888	2,888	2,888	2,888	2,888	2,888	2,888	2,888	2,888	33,250	31,964
Dues & Memberships	2,645	2,308	3,134	3,134	3,134	3,134	3,134	3,134	3,134	3,134	3,134	3,134	36,289	30,754
Contracts & Consultants	1,105	3,999	3,470	3,470	3,470	3,470	3,470	3,470	3,470	3,470	3,470	3,470	39,803	34,149
Office Supplies & Printing	3,858	1,307	3,586	3,586	3,586	3,586	3,586	3,586	3,586	3,586	3,586	3,586	41,023	43,172
Continuing Education	2,068	1,710	3,401	3,470	3,861	3,870	3,870	3,870	3,870	3,870	3,870	3,870	41,600	24,628
Licenses & Fees	4,622	2,761	4,660	4,660	4,660	4,660	4,660	4,660	4,660	4,660	4,660	4,660	53,983	55,530
Utilities	7,081	3,958	4,500	4,500	4,500	4,500	4,500	4,500	4,500	4,500	4,500	4,500	56,039	54,003
Rent	7,123	5,405	5,538	5,538	5,538	5,538	5,538	5,538	5,538	5,538	5,538	5,538	67,908	102,057
Bad Debt	11,631	12,965	5,075	5,075	5,075	5,075	5,075	5,075	5,075	5,075	5,075	5,075	75,347	58,489
Computer Support	6,806	5,949	6,537	6,537	6,537	6,537	6,537	6,537	6,537	6,537	6,537	6,537	78,126	84,529
Pharmacy & Optometry COGS	6,571	10,211	10,340	10,340	10,340	10,340	10,340	10,340	10,340	10,340	10,340	10,340	120,182	119,361
Medical & Dental Lab & Supplies	9,531	9,908	12,100	12,100	12,100	12,100	12,100	12,100	12,100	12,100	12,100	12,100	140,439	134,183
Repairs & Maintenance	10,755	12,142	14,064	13,974	14,064	14,064	13,934	14,064	14,024	13,974	14,064	14,064	163,192	180,955
Telephone & Internet	13,619	13,696	13,696	13,696	13,696	13,696	13,696	13,696	13,696	13,696	13,696	13,696	164,279	141,729
Program Supplies & Materials	19,960	16,591	19,450	19,450	19,450	19,450	18,975	19,500	19,400	19,500	19,500	19,500	230,726	238,837
Depreciation & Amortization	27,651	27,651	27,651	27,651	27,651	27,651	27,651	27,651	27,651	27,651	27,651	27,651	331,807	244,859
Total Expenses	754,496	656,506	682,226	708,030	734,095	664,689	731,450	697,458	708,498	745,472	697,667	721,716	8,502,304	8,309,268
Net Operating Gain (Loss)	(100,227)	(68,930)	(17,851)	(37,816)	42,103	12,190	(90,982)	(57,810)	(9,745)	5,041	(38,927)	(63,888)	(426,842)	(430,010)
Non-operating														
HRSA Capital	-	-	-	-	50,389	-	-	-	-	-	-	-	50,389	367,080
Other Capital Grants	-	-	12,348	7,452	45,045	-	-	-	-	-	-	-	64,845	37,913
Donations	-	430	-	-	-	-	-	-	-	-	-	-	430	41,177
Non-operating Net	-	430	12,348	7,452	95,434	-	-	-	-	-	-	-	115,664	446,170
Total Gain (Loss)	\$ (100,227)	\$ (68,500)	\$ (5,503)	\$ (30,364)	\$ 137,537	\$ 12,190	\$ (90,982)	\$ (57,810)	\$ (9,745)	\$ 5,041	\$ (38,927)	\$ (63,888)	\$ (311,178)	\$ 16,160

Hilltown Community Health Centers, Inc.
FY 2019 Statement of Activities Department Budget

	Medical	Oral Health	Mental Health	Optometry	Pharmacy	Community	Administration	Billing	Facility	Budget FY 2019	Actual FY 2018
<u>Operating</u>											
Patient Services	\$ 2,507,227	\$ 2,080,753	\$ 343,843	\$ 290,476	\$ 163,717	\$ -	\$ -	\$ -	\$ -	\$ 5,386,017	\$ 5,191,616
HRSA 330 & Other Grant	90,453	-	52,878	-	-	27,361	1,626,730	-	-	1,797,422	1,719,762
Other Grants & Contracts	150,654	814	20,397	-	23,026	500,512	58,351	-	-	753,754	877,929
Interest Dividends	-	-	-	-	-	-	67,360	-	-	67,360	4,963
Quality & Other Incentives	40,395	-	-	1	-	-	-	-	-	40,396	49,111
Rental & Misc.	-	-	-	-	-	-	10	-	30,504	30,514	35,876
Total Revenue	2,788,729	2,081,567	417,119	290,477	186,743	527,873	1,752,450	-	30,504	8,075,462	7,879,258
<u>Expenses</u>											
Compensation & Related Expenses	2,962,632	1,792,256	369,084	230,901	-	454,534	651,592	170,475	42,826	6,674,300	6,583,989
Recruitment	1,350	-	-	-	-	-	-	-	-	1,350	340
Conferences & Meetings	1,265	1,449	-	-	-	600	1,225	-	-	4,539	4,660
Small Equipment Purchases	3,000	1,000	1,449	-	-	-	-	-	250	5,699	10,080
Advertising & Marketing	6,800	3,800	-	-	-	-	1,075	1,428	-	13,103	4,687
Interest	-	-	-	-	-	-	-	-	16,369	16,369	17,858
Merchant CC Fees	43	3,369	-	-	-	-	-	14,736	-	18,148	17,921
Postage	-	-	-	597	-	-	18,250	-	-	18,846	18,009
Equipment Leases	8,311	2,129	2,416	1,455	-	-	1,627	642	8,666	25,245	24,892
Travel	1,912	1,450	732	-	-	11,142	6,995	-	3,063	25,294	24,079
Insurance	375	-	-	-	-	534	2,989	3,453	18,066	25,417	23,556
Legal & Accounting	-	-	-	-	-	-	33,250	-	-	33,250	31,964
Dues & Memberships	11,326	1,551	-	-	-	-	23,262	150	-	36,289	30,754
Contracts & Consultants	11,706	2,604	-	-	-	14,464	11,029	-	-	39,803	34,149
Office Supplies & Printing	6,382	3,032	815	159	-	10,221	7,805	4,355	8,255	41,023	43,172
Continuing Education	21,869	13,000	2,250	3,000	-	200	1,281	-	-	41,600	24,628
Licenses & Fees	31,648	5,891	315	563	-	284	12,522	-	2,760	53,983	55,530
Utilities	-	-	-	-	-	-	-	-	56,039	56,039	54,003
Rent	-	-	-	-	-	36,000	-	-	31,908	67,908	102,057
Bad Debt	48,044	12,934	8,104	6,264	-	-	-	-	-	75,347	58,489
Computer Support	25,718	6,012	12,979	3,248	-	1,683	19,186	6,619	2,680	78,126	84,529
Pharmacy & Optometry COGS	65,864	174	-	19,063	35,081	-	-	-	-	120,182	119,361
Medical & Dental Lab & Supplies	-	120,743	-	19,696	-	-	-	-	-	140,439	134,183
Repairs & Maintenance	3,746	10,995	360	342	-	1,754	-	-	145,995	163,192	180,955
Telephone & Internet	5,445	5,409	5,445	-	-	22,444	-	6,324	119,212	164,279	141,729
Program Supplies & Materials	52,279	158,370	-	14,887	-	5,190	-	-	-	230,726	238,837
Depreciation & Amortization	6,207	52,971	-	16,894	-	-	8,052	-	247,683	331,807	244,859
Total Expenses	3,275,922	2,199,138	403,950	317,069	35,081	559,049	800,140	208,181	703,773	8,502,304	8,309,268
Net Operating Gain (Loss)	(487,192)	(117,571)	13,169	(26,592)	151,662	(31,177)	952,310	(208,181)	(673,270)	(426,842)	(430,010)
<u>Non-operating</u>											
HRSA Capital	12,416	-	-	37,973	-	-	-	-	-	50,389	367,080
Other Capital Grants	-	45,045	-	-	-	-	-	-	19,800	64,845	37,913
Donations	-	-	-	-	-	-	430	-	-	430	41,177
Non-operating Net	12,416	45,045	-	37,973	-	-	430	-	19,800	115,664	446,170
Total Gain (Loss)	\$ (474,776)	\$ (72,526)	\$ 13,169	\$ 11,381	\$ 151,662	\$ (31,177)	\$ 952,740	\$ (208,181)	\$ (653,470)	\$ (311,178)	\$ 16,160

Hilltown Community Health Centers
FY 2019 Budget Balance Sheet - Monthly Trend

	Actual Dec 2018	Budget Jan 2019	Budget Feb 2019	Budget Mar 2019	Budget Apr 2019	Budget May 2019	Budget Jun 2019	Budget Jul 2019	Budget Aug 2019	Budget Sep 2019	Budget Oct 2019	Budget Nov 2019	Budget Dec 2019
Assets													
Current Assets													
Cash - Operating Fund	\$ 197,997	\$ 233,851	\$ 252,962	\$ 217,075	\$ 216,980	\$ 215,803	\$ 114,913	\$ 112,202	\$ 15,612	\$ 55,738	\$ 109,960	\$ -	\$ -
Cash - Restricted (Amherst Donations)	6,152	1,051	12,402	11,902	11,402	6,402	5,902	5,402	4,902	4,402	3,902	3,402	-
Patient Receivables	945,217	1,032,027	970,729	1,000,000	975,000	1,010,000	950,000	950,000	950,000	950,000	950,000	950,000	950,000
Less Allow. for Doubtful Accounts	(109,786)	(118,366)	(128,973)	(120,000)	(120,000)	(120,000)	(120,000)	(120,000)	(120,000)	(120,000)	(110,000)	(110,000)	(110,000)
Less Allow. for Contractual Allowances	(317,200)	(374,895)	(344,593)	(325,000)	(345,000)	(325,000)	(325,000)	(350,000)	(350,000)	(330,000)	(325,000)	(325,000)	(320,000)
A/R 340B-Pharmacist	32,188	7,390	(1,455)	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000
A/R 340B-State	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827
Contracts & Grants Receivable	69,673	62,015	65,280	65,000	65,000	65,000	65,000	65,000	65,000	65,000	65,000	65,000	65,000
Prepaid Expenses	14,866	16,298	20,021	18,521	17,021	15,521	14,021	12,521	11,021	9,521	8,021	11,521	10,021
A/R Pledges Receivable	28,828	26,328	15,360	15,360	15,360	15,360	15,360	10,360	8,360	8,360	7,500	7,500	7,500
Total Current Assets	869,761	887,526	863,561	889,686	842,590	889,914	727,024	692,313	591,723	649,849	716,211	609,250	609,348
			13,468										
Property & Equipment													
Land	204,506	204,506	204,506	204,506	204,506	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	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913
Improvements	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848	911,848
Leasehold Improvements	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674
Equipment	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156	1,288,156
Construction in Progress/New Additions	-	-	12,348	12,348	19,800	115,234	115,234	115,234	115,234	115,234	115,234	115,234	115,234
Total Property and Equipment	6,952,096	6,952,096	6,964,444	6,964,444	6,971,896	7,067,330	7,067,330	7,067,330	7,067,330	7,067,330	7,067,330	7,067,330	7,067,330
Less Accumulated Depreciation	(2,430,365)	(2,458,016)	(2,485,666)	(2,513,317)	(2,540,967)	(2,568,618)	(2,596,269)	(2,623,919)	(2,651,570)	(2,679,220)	(2,706,871)	(2,734,521)	(2,762,172)
Net Property & Equipment	4,521,731	4,494,080	4,478,778	4,451,127	4,430,929	4,498,712	4,471,062	4,443,411	4,415,760	4,388,110	4,360,459	4,332,809	4,305,158
Other Assets													
Restricted Cash	53,713	53,713	53,712	53,712	53,712	53,712	53,712	53,712	53,712	53,712	53,712	53,712	53,712
Pharmacy 340B and Optometry Inventory	11,811	12,249	11,909	11,909	11,909	11,909	11,909	11,909	11,909	11,909	11,909	11,909	11,909
Investments Restricted	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661	6,661
Investment - Vanguard	227,889	247,383	255,060	257,440	257,970	260,500	263,030	265,560	268,090	287,620	290,150	292,680	295,210
Total Other Assets	300,074	320,006	327,342	329,722	330,252	332,782	335,312	337,842	340,372	359,902	362,432	364,962	367,492
Total Assets	\$ 5,691,566	\$ 5,701,613	\$ 5,669,681	\$ 5,670,535	\$ 5,603,771	\$ 5,721,408	\$ 5,533,398	\$ 5,473,566	\$ 5,347,856	\$ 5,397,861	\$ 5,439,102	\$ 5,307,022	\$ 5,281,999
Liabilities & Fund Balance													
Current & Long Term Liabilities													
Current Liabilities													
Accounts Payable	\$ 164,918	\$ 180,932	\$ 225,470	\$ 225,000	\$ 225,000	\$ 200,000	\$ 225,000	\$ 225,000	\$ 225,000	\$ 225,000	\$ 225,000	\$ 225,000	\$ 225,000
Notes Payable	300,000	300,000	300,000	300,000	280,000	255,000	235,000	215,000	190,000	170,000	145,000	125,000	105,000
Sales Tax Payable	56	23	39	-	-	-	-	-	-	-	-	-	-
Accrued Expenses	60,334	61,951	46,717	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	55,000	60,000
Accrued Payroll Expenses	386,764	481,414	480,774	488,000	476,000	510,500	309,700	365,250	326,750	410,900	476,500	267,550	374,200
Payroll Liabilities	20,702	17,285	15,242	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000	16,000
Unemployment Escrow	826	826	826	826	826	826	826	826	826	826	826	826	826
Line of Credit	-	-	-	-	-	-	-	-	-	-	-	135,196	86,811
Deferred Contract Revenue	120,296	124,247	136,693	134,693	132,693	130,693	128,693	126,693	124,693	122,693	120,693	118,693	116,693
Total Current Liabilities	1,053,896	1,166,677	1,205,760	1,214,519	1,180,519	1,163,019	965,219	998,769	933,269	995,419	1,034,019	943,265	984,530
Long Term Liabilities													
Mortgage Payable United Bank	167,900	166,455	165,007	163,607	162,207	160,807	159,407	158,007	156,607	155,207	153,807	152,407	151,007
Mortgages Payable USDA Huntington	176,837	175,775	174,707	173,707	172,707	171,707	170,707	169,707	168,707	167,707	166,707	165,707	164,707
Total Long Term Liabilities	344,737	342,230	339,714	337,314	334,914	332,514	330,114	327,714	325,314	322,914	320,514	318,114	315,714
Total Liabilities	1,398,633	1,508,907	1,545,474	1,551,832	1,515,432	1,495,532	1,295,332	1,326,482	1,258,582	1,318,332	1,354,532	1,261,379	1,300,244
Fund Balance / Equity													
Fund Balance Prior Period	4,292,933	4,192,706	4,124,206	4,118,703	4,088,339	4,225,876	4,238,066	4,147,084	4,089,273	4,079,529	4,084,570	4,045,643	3,981,755
Total Fund Balance / Equity	4,292,933	4,192,706	4,124,206	4,118,703	4,088,339	4,225,876	4,238,066	4,147,084	4,089,273	4,079,529	4,084,570	4,045,643	3,981,755
Total Liabilities & Fund Balance	\$ 5,691,566	\$ 5,701,613	\$ 5,669,681	\$ 5,670,535	\$ 5,603,771	\$ 5,721,408	\$ 5,533,398	\$ 5,473,566	\$ 5,347,856	\$ 5,397,861	\$ 5,439,102	\$ 5,307,022	\$ 5,281,999
Current Ratio	0.83	0.76	0.72	0.73	0.71	0.77	0.75	0.69	0.63	0.65	0.69	0.65	0.62

Hilltown Community Health Centers, Inc.

FY 2019 - Visits

Visits	2019 Budget	Actual FY 2018	Actual FY 2017
Mental Health	3,934	4,306	3,809
Medical	17,510	18,166	18,727
Optometry Sum	2,395	2,381	2,329
Dental	18,249	15,537	14,880
Grand Total	23,839	24,853	24,865

Net Revenue Per Visit

Mental Health	\$ 87.40	\$ 87.74	\$ 95.70
Medical	\$ 143.19	\$ 143.59	\$ 134.56
Optometry	\$ 87.28	\$ 86.40	\$ 79.61
Dental	\$ 114.02	\$ 112.76	\$ 113.60

Hilltown Community Health Centers, Inc.
Hrs. per wk. in FY 2019 Budget

	01-01	01-02	01-03	02-01	02-02	02-03	02-04	03-01	03-02	03-03	04-01	04-02	05-06	Admin & Support	Total Hrs.	Total FTE
Position	WHC Med	WHC Den	WHC BH	HHC Med	HHC Den	HHC BH	HHC Opt	SBHC Med	SBHC Den	SBHC BH	MHC Med	MHC Den	Community			
<u>Nurses</u>																
Total wkly hrs.	147.00	-	-	116.00	-	-	-	-	-	-	75.50	-	28.00	-	366.50	9.77
FTE's	3.92	-	-	3.09	-	-	-	-	-	-	2.01	-	0.75	-	9.77	
<u>Medical Assistants</u>																
Total wkly hrs.	138.92	-	-	267.00	-	-	43.66	32.18	13.38	-	122.62	-	-	-	617.75	16.47
FTE's	3.70	-	-	7.12	-	-	1.16	0.86	0.36	-	3.27	-	-	-	16.47	
<u>Receptionist</u>																
Total wkly hrs.	95.93	104.10	18.33	176.20	69.58	30.63	13.13	-	-	-	60.00	60.00	-	-	627.88	16.74
FTE's	2.56	2.78	0.49	4.70	1.86	0.82	0.35	-	-	-	1.60	1.60	-	-	16.74	
<u>Referral Specialist</u>																
Total wkly hrs.	32.00	-	12.50	29.00	-	12.50	-	-	-	-	-	-	-	-	86.00	2.29
FTE's	0.85	-	0.33	0.77	-	0.33	-	-	-	-	-	-	-	-	2.29	
<u>Dental Assistants</u>																
Total wkly hrs.	-	103.00	-	-	119.10	-	-	10.60	22.40	10.60	-	67.30	-	-	333.00	8.88
FTE's	-	2.75	-	-	3.18	-	-	0.28	0.60	0.28	-	1.79	-	-	8.88	
<u>Medical Providers</u>																
Total wkly hrs.	92.15	-	-	148.95	-	-	-	26.90	-	-	98.20	-	-	2.30	368.50	9.83
FTE's	2.46	-	-	3.97	-	-	-	0.72	-	-	2.62	-	-	0.06	9.83	
<u>Dental Providers</u>																
Total wkly hrs.	-	148.95	-	-	192.40	-	-	-	16.70	-	-	91.20	-	-	449.25	11.98
FTE's	-	3.97	-	-	5.13	-	-	-	0.45	-	-	2.43	-	-	11.98	

Hilltown Community Health Centers, Inc.
Hrs. per wk. in FY 2019 Budget

	01-01	01-02	01-03	02-01	02-02	02-03	02-04	03-01	03-02	03-03	04-01	04-02	05-06	Admin & Support	Total Hrs.	Total FTE
Position	WHC Med	WHC Den	WHC BH	HHC Med	HHC Den	HHC BH	HHC Opt	SBHC Med	SBHC Den	SBHC BH	MHC Med	MHC Den	Community			
<u><i>Optometry Providers</i></u>																
Total wkly hrs.	0.38	0.38	0.38	0.38	0.38	0.38	44.00	-	-	-	0.38	0.38	1.50	3.00	51.50	1.37
FTE's	0.01	0.01	0.01	0.01	0.01	0.01	1.17	-	-	-	0.01	0.01	0.04	0.08	1.37	
<u><i>Mental Health Providers</i></u>																
Total wkly hrs.	-	-	61.25	-	-	100.50	-	-	-	38.25	-	-	-	-	200.00	5.33
FTE's	-	-	1.63	-	-	2.68	-	-	-	1.02	-	-	-	-	5.33	
<u><i>Community</i></u>																
Total wkly hrs.	-	-	-	-	-	-	-	-	-	-	-	-	322.50	-	322.50	8.60
FTE's	-	-	-	-	-	-	-	-	-	-	-	-	8.60	-	8.60	
<u><i>Other Positions</i></u>																
Total wkly hrs.	30.00	3.75	0.75	49.75	3.75	0.75	0.38	5.75	0.38	0.38	20.25	3.75	0.38	485.00	605.00	16.13
FTE's	0.80	0.10	0.02	1.33	0.10	0.02	0.01	0.15	0.01	0.01	0.54	0.10	0.01	12.93	16.13	
Grand Total wkly hrs.	536	360	93	787	385	145	101	75	53	49	377	223	352	490	4,028	
FTE's	14.30	9.60	2.49	20.99	10.27	3.86	2.70	2.01	1.41	1.31	10.05	5.94	9.40	13.07	107.41	



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

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

Community Care Cooperative (C3) ACO: Frank, Jon Liebman, and I attended a day-long retreat for the C3 Board and Finance Committee, which was quite interesting. After time devoted to reviewing the successes and challenges of the last year, and a conversation with Don Berwick (member of the Health Policy Commission and former gubernatorial candidate) about the state of health care, we discussed the following:

- A project currently underway to develop a possible shared electronic health record (also called a population health system) that could result in greater data analysis capacity, comprehensive reporting, shared records, shared best practices, integrated shared services, etc, among the members of C3. Most likely, this would mean an opportunity for all members to shift their practices to Epic, which is the same system that many hospitals (including Cooley Dickinson) are currently using. C3 hired a consulting firm to develop a proposal, and they are conducting interviews and meetings to understand every health center's needs and interest. Jon and I met with the consultants in January and Frank is meeting with them again soon. There are many questions about this possibility, and the main one is, of course, the cost; any switch would cause disruption to the providers, and the system itself could be very expensive. C3 has suggested that if we do this soon, they can help mitigate the cost through the federal DSRIP funding, but it is not clear if that would mean we would get less to cover our current C3 implementation costs. The consultants did present some numbers, but the test case was much larger than us, so we don't have enough information to know whether we would be interested. In theory, it all sounds great – in practice, we're waiting to see.
- Most of the members of C3 have identified the barrier to developing high performing care teams, which is an identified goal of the model of care, as the high turnover rate in Medical Assistants. As you know, this has been a real challenge for HCHC, particularly in the last year, and we are not alone. The root cause of this systemic issue is the low rate of pay that all the health centers are paying – on average, CHCs in the state are paying \$.25 to \$.50 per hour less than the private medical offices or hospitals. I know from conversations with local hospitals that they have been forced to raise their rates because of MA turnover, and they are raising them to rates that we find nearly impossible to match. The C3 group discussed two strategies to address this: creating competitive MA wages and a tiered/ladder system from New MA to Senior MA; and developing a clear and robust performance appraisal process. They presented a case study of a health center who did this in Connecticut, which seemed to be successful, but our colleagues all questioned whether CHCs in Connecticut are paid the same low rates as we are in Massachusetts. I was glad to see this conversation happening, and that C3 has identified this as a priority to help CHCs address this huge challenge.

Hospital Engagement: As I mentioned last month, I was asked to be the Chair of the **Baystate Noble Hospital** Community Benefits Advisory Council, and after much consideration I accepted. So far, nothing has really happened, but I will be meeting with the CEO and staff members for the CBAC soon, and look forward to helping develop a plan for increasing Noble's engagement with the larger community, including the Hilltowns.

We finalized the paperwork for the \$50,000 grant that Mass General Hospital is giving us as a result of **Cooley Dickinson** expressing its support for us and our mission. Frank will be speaking with MGH next week about the next phase of their support – guaranteeing a loan for the remaining \$250,000 that MassHealth will be removing from our payments for the next year. We are very grateful for their support, but we are also leery of taking out more debt, so Frank is exploring all the possible options for mitigating the impact of this payback

Goal 2: HCHC Expansion

John P. Musante Health Center (JPMHC):

- After another cancelled meeting with Paul Bockelman, the Amherst Town Administrator, we finally received word that he is accepting Frank's proposal for a restructured lease payment schedule. We do not have a signed amendment to our lease yet, but we are glad that things are moving forward, albeit slowly. As a reminder, the new payments will take reflect the Town assuming responsibility for ~\$110,000 of the additional cost of the changes to the electrical system in the building, but HCHC must make good on the months of increased rent that we did not send them due to our being in negotiations. We will also be able to ramp up to our final rent payment rate somewhat more slowly, which will help with cash flow.
- We have submitted the paperwork to the state to be able to provide behavioral health services in Amherst, but are pulling together the last pieces of documentation that they require. We hope to hear from them soon.
- We are conducting a survey of JPMHC patients to better understand how they heard about the new site, and overwhelmingly (especially among the Spanish speaking patients), the answer has been word of mouth. This is extremely helpful information, but also creates a challenge – how do we increase the numbers of people who hear about us this way? We are working with staff to answer this question, but have also placed ads in the Gazette, Advocate, and Amherst Bulletin and on Facebook to ensure that we are reaching as many people as possible.
- The numbers of Amherst patients continue to rise, but it is still slow. We found out in March that despite what we had been led to believe, the MassHealth Plan Selection Period that started March 1st may not give us the boost we had hoped – MassHealth announced at the beginning of the month that it would not be sending letters to its enrollees to let them know that they can change their ACO/PCP without an approved reason. Instead, they are assuming that everyone who was assigned or chose an ACO will know that for three months starting on their anniversary with that ACO, they can change. I have spoken at length with both the League and C3 about this problem, and no one can come up with a satisfactory way to address it – we don't know which people in the community are currently in their Plan Selection Period, and MassHealth is extremely strict about what we are allowed to say, even if we did know. Needless to say, this is very frustrating, and we are still pondering how to address this latest setback.

New Access Point Funding (NAP) Opportunity: After many more visits to Ware, we are very close to completing our NAP application. We will not have the whole application for tomorrow's meeting, but Frank and I will give an update on our final proposal, and will ask for your approval of our submitting the application next week. We will present the final application at the next Board meeting.

Telehealth: Next week, Michael Purdy and I are attending a two-day conference for community health centers on telehealth – what technology and legal issues are important, how to set it up, how to implement it into your practice, etc. The conference was developed by the New York Primary Care Association (the NY equivalent of the Mass League) and Finger Lakes CHC, which is a leader in using telehealth. The timing for this is perfect: 1) we have significant funds available from a HRSA grant that we received last year, so we can pay for the conference and the equipment, 2) MassHealth just announced that it will pay for telebehavioral health visits as if they were conducted in person, and 3) we need to address our providers' and our patients' access to psychiatry, and telepsychiatry is a growing and successful model of telehealth. We also just learned that HRSA will be distributing \$145,000 per health center this summer for behavioral health integration, so that we can use those funds to support our contracting with a psychiatrist to be on the other end of the line. I met with the CEO and COO of the Behavioral Health Network in March, and we discussed how to strengthen and expand our collaboration and that telepsychiatry could be a perfect part of that partnership. They were going off to their own telehealth conference, and we agree to meet in early May.

Dental Infrastructure: HRSA just released a grant opportunity for dental infrastructure improvements. Frank is pulling together a meeting to discuss possible proposals with dental leadership. The grant could be for \$300,000 for equipment and minor alterations and renovations. It had a fairly quick turnaround, so we will let you know next meeting whether we're applying and for what.

Goal 3: Improved Organizational Infrastructure

Financial Stability:

We continue to struggle with **providers and scheduling**, particularly in Worthington. Dr. Grimes will be leaving in two weeks, and we have developed a plan that may mean a day occasionally with no medical services on-site, but that does not require fully closing the site on a regular basis. This is because Dr. Coates has agreed that, until she leaves on sabbatical in August, she will increase her hours, and Dr. Chmura, who does not have a regular schedule or site, will also work more hours in Worthington. We interviewed an MD who is moving to Berkshire County from Maine, and she has expressed interest in the position, sending references. We are happy about this development, and will continue to pursue conversations with her. We also have an experienced nurse practitioner who is interested in joining the practice, at least for a few hours a week, so we may also hire her to create more capacity. Until either or both come on, however, we will have days with only one provider, and will continue to be shifting patients to our other sites as much as possible. When combined with a shortage in MAs, there is still a lot of concern by providers that they are being adequately supported. We do have a new nurse starting next week in Worthington, but we lost a nurse in Amherst, so our recruitment efforts continue.

I have been working on longer-term help for our financial challenges through increased conversations with our **Legislative delegation**. I presented at a briefing for legislators at the State House this month,

and was happy to run into State Representative Mindy Domb, who represents Amherst. She suggested that contact her about a possible earmark in the state budget for HCHC, so I presented her with our case for needing help with our MassHealth payback. I also spoke to State Senator Jo Comerford about this, and she said she would support us as well. I haven't heard anything back from Domb's office since I submitted my request, but I imagine we will see what the House includes in the budget that will be released very soon. Comerford and I also discussed her bill that would increase dental rates for CHCs, and I told her that in 2018, the proposed rate would have meant an additional \$115,000 in revenue for HCHC. She will let me know when the hearing on the bill is scheduled, and that she may ask me to testify. All of these things could help in the long run, but obviously we face significant challenges in the short run.

Other Reports

The Mass League has said that if you would like to choose a month for a training in preparation for the Operational Site Visit in November, they would be happy to come out. Also, I was asked to nominate myself for the position of Vice-Chair of the League's Governmental Affairs Committee by the outgoing chair, which I did, but I have recently learned that there is some hesitancy on the part of the new Chair in promoting my candidacy because of HCHC not being members of NACHC. We would like to join, but the membership fee is \$20,000, which is not even remotely affordable. I have reached out to NACHC, at the League's suggestion, to see if we can negotiate a more reasonable rate, but I can't see that they will come down enough to be manageable. I am looking into whether I can become an individual member, which could be more affordable. In any case, if I cannot assume the Vice Chair position (which has very few if any responsibilities), I will certainly understand why.

State and National Outlook:

- **Congressman Jim McGovern** (2nd District) visited the Musante Health Center on the morning of Wednesday, March 20th. It was very informal, and was an opportunity for John Follet and I to give him a tour and talk about HCHC, the JPMHC, and the federal priorities for all FQHCs. I then met with his staff in DC last week, and he continues to be a champion for our cause.
- I also met with **Congressman Richard Neal** (1st District) in the Capitol last week, and given his new role as Chair of the House Ways and Means Committee, it was exciting to hear him express strong support for the legislative priorities. The same support was expressed at the meeting with Senator Elizabeth Warren's health policy staffer that afternoon. The message to Congress included: continued funding for both discretionary appropriations and mandatory funding line items for FQHCs, with a real push to get five years of funding authorized, instead of the usual two years; support for workforce initiatives, including teaching health centers and loan repayment; and support for the 340B pharmacy program, Medicaid programs, and more. I will include the fact sheets to my email for your information.

Community Health Center Funding Appropriations



An Annual Investment in a Successful Model

Sustaining and Growing Health Centers to Meet Rising Demand

Federal grant funding for the Health Center program currently comes from two sources that combine to support the federal Section 330 grant that all health centers receive:

- **\$1.63 billion in annual discretionary appropriations** and
- \$4.0 billion in the Community Health Centers Fund (CHCF).

For decades, Congress has made an annual bipartisan investment that provides the foundation for the health center model of care. This investment is critical to the success of health centers as they meet growing demand and respond to changing health care needs of their communities. Further, a number of independent studies have shown that health centers consistently save money – resulting in fewer emergency room visits, fewer inpatient hospitalizations and readmissions, and reduced length of stays.

Specifically, health centers rely on Section 330 grant funding to:

- provide high-quality, cost-effective primary medical care, dental, behavioral health, pharmacy, and vision care for more than 28 million patients in rural and urban communities – 1.4 million of whom are experiencing homelessness and 23% of whom are uninsured;
- expand their facilities, open new sites, and broaden their services to meet unmet need in areas with limited access to care;
- invest in services that enable patients to receive care, including transportation, care coordination, and translation and interpretation services.
- respond to emerging health care needs, including providing care to some of the hardest to reach urban and rural populations across America impacted by the opioid epidemic. Specifically, in 2017 health centers provided 5.7 million visits for patients with substance use disorders, 65,000 of whom received Medication-Assisted Treatment (MAT).

How you can help: Provide predictable and stable discretionary Section 330 federal grant funding for Community Health Centers in the FY20 Labor, Health and Human Services, Education and Related Agencies Appropriations bill by:

1. Signing the **DeGette-Bilirakis** letter in the House and the **Wicker-Stabenow** letter in the Senate.
2. Requesting **level discretionary funding (\$1.63 billion)** in individual submission letters to Appropriators.

Community Health Center Fund Mandatory



Reauthorizing Investment in a Successful Model

Sustaining and Growing Health Centers to Meet Rising Demand

Federal grant funding for the Health Center program currently comes from two sources:

- \$1.63 billion in annual discretionary appropriations and
- **\$4.0 billion in the Community Health Centers Fund (CHCF) - which will expire on September 30, 2019 without Congressional action.**

Federal investments supporting the health center system of **care must be sustained in a long term and stable manner** to ensure health centers' ability to plan for the future, recruit staff, and expand services for patients, as well as to reduce the uncertainty caused by year-to-year renewals of this critical investment in access to care.

Health centers deliver an excellent return on this federal investment:

- They **reach individuals with the greatest difficulty accessing or affording health care services**, including those with chronic disease at risk for costly health complications, and guarantee them access to high quality care, improving health outcomes and narrowing health disparities.
- Health centers are efficient and **save the health care system \$24 billion every year**, reducing unnecessary inpatient hospitalizations and ER use.
- As local, non-profit businesses, health centers promote economic growth in distressed communities, generating \$54.6 billion in total economic activity each year and employing over 220,000 people across the country. **In fact, every \$1 in federal 330 investments generates \$5.73 in economic activity.**

How you can help: Cosponsor at least one piece of legislation to extend long term and stable funding for the Community Health Center Fund:

- **S. 106, Community Health Investment, Modernization, and Excellence (CHIME) Act (Blunt/Stabenow)** - provides 5 years of funding for the CHCF including ~4% annual growth (\$4.2B in FY20 through \$5.0B in FY24).
- **S. 192, Community and Public Health Programs Extension Act (Alexander/Murray)** - provides 5 years of level funding for the CHCF (\$4B/year FY20-24).
- **Community Health Center and Primary Care Workforce Expansion Act (Sanders, Clyburn)** - provides 5 years of funding for the CHCF including ~10% annual growth (\$5.6B in FY20 through \$8.2B in FY24).





Community Health Centers

2019 Federal Policy Issues in Brief

Health Centers are an American success story. They demonstrate that communities can improve health, reduce health disparities, generate taxpayer savings, and effectively address a multitude of costly and significant public health and social problems, including substance use disorder, mental illness, veterans access to care, natural disasters, and homelessness.

Over the last decade, **Congress has affirmed the crucial role that health centers play** in ensuring access to quality primary and preventive care for millions by investing in health centers. Today, that investment includes mandatory and discretionary federal grant funds, both of which need to be extended this year, alongside funding for critical workforce programs.

Additionally, health centers serve as a committed partner on the following issues:

Enhancing Care through the 340B Drug Pricing Program.

Health centers successfully utilize the 340B program, ensuring that patients can buy their medications at affordable prices; and that health centers can reinvest the savings into improved quality of care and expanded services for all patients.

***Health centers support** ensuring continued access to the 340B program to sustain their essential model of care.*

Protecting a Robust Medicaid Program.

Medicaid is a critical program for health centers and their patients:

- Half of all health center patients are covered by Medicaid
- Medicaid payments represent health centers' largest revenue source

***Health centers support** preserving a strong Medicaid program including the unique and cost effective FQHC PPS payment methodology.*

Taking Action to Prevent and Treat Substance Use Disorders.

As communities across America cope with a dramatic increase in substance use disorders, including opioid addiction, health centers are leaders in integrating medical, dental and behavioral health care, along with other services, to respond to the pressing need for enhanced care. ***Health centers support** targeted and sustainable investments and policy changes to continue to meet this challenge.*

Expanding Access through Telehealth.

Telehealth offers great benefits to patients and providers in both rural and urban areas alike, especially when workforce shortages and geography present barriers to accessing care. ***Health centers support** further utilization of telehealth services alongside sustainable reimbursement.*





Recruiting, Training, and Retaining the Best

Growing Today's Primary Care Workforce to Meet
Tomorrow's Health Care Needs

Community Health Centers depend upon a network of over 220,000 clinicians, providers, and staff to deliver on the promise of affordable and accessible health care. Better access to primary and preventive care is associated with improved outcomes and lower costs. Health centers must attract, train, and recruit an integrated, multidisciplinary workforce to provide high quality care.

Federal and state workforce programs enable health centers to overcome persistent national clinician shortages and other staffing challenges, particularly in rural and medically-underserved areas. **Funding for two of these programs, the National Health Service Corps (NHSC) and the Teaching Health Center Graduate Medical Education Program (THCGME), will expire on September 30, 2019, without Congressional action.**

- **The NHSC supports roughly 11,000 clinicians in urban, rural, and frontier communities. More than half of all NHSC placements are at health centers.** Thousands of additional applications to join the NHSC go unfunded each year. Increased funding would boost the number of approved applications, extending this opportunity to additional underserved communities
- **The THC model uniquely trains providers directly in underserved communities, improving their understanding of the issues facing health center patients and increasing the chances they will chose to practice in these communities after they finish their training.** In the 2017-2018 academic year, THCGME supported the training of 732 residents in 57 health centers in 24 states. Since it began in 2011, the program has supported the training of over 630 new primary care physicians and dentists who have graduated and entered the workforce.

How you can help: Cosponsor legislation to extend long term and stable funding for the National Health Service Corps and Teaching Health Centers Programs, including:

1. **S. 304, Training the Next Generation of Primary Doctors Act (Collins/Tester/Capito/Jones)** - includes 5 years of enhanced funding for THCGME and a pathway for increasing the number of residents trained.
2. **S. 106, Community Health Investment, Modernization, and Excellence (CHIME) Act (Blunt/Stabenow)** - includes 5 years of funding for the NHSC with ~4% annual growth (\$325m in FY20 - \$385m in FY24).
3. **S. 192, Community and Public Health Programs Extension Act (Alexander/Murray)** - includes 5 years of level funding for the NHSC(\$310m/year) and THCGME (\$126.5m/year)
4. **Community Health Center and Primary Care Workforce Expansion Act (Sanders, Clyburn)** - includes 5 years of funding for the NHSC with ~10% annual growth (\$850m in FY20 - \$1.24B in FY24).

Hilltown Community Health Centers, Inc.

Administration

SUBJECT: NAME OF POLICY – CREDIT AND COLLECTION POLICY

REGULATORY REFERENCE: MASSACHUSETTS EXECUTIVE OFFICE OF
HEALTH AND HUMAN SERVICES 101 CMR 613.00: M.G.L. c. 118E

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal document process to maintain accurate credit and collection procedures in accordance with State and Federal regulations and laws.

Original Draft: MARCH 2016

Reviewed /Revised: MARCH 2019

Approved by the Board of Directors, Date: March 7, 2019

Approved by:

Name: Eliza B Lake
Eliza B. Lake
Executive Director, HCHC
Date: 10/4/18

Name: John Follet
John Follet, MD
President, HCHC Board of Directors
Date: 10/4/18

Hilltown Community Health Centers, Inc.

Credit & Collection Policy March 7, 2019

Health Safety Net (HSN) 2018 Credit and Collection (C&C) Policy Cross Reference Index				
CONTACT INFORMATION				
Provider Name: HILLTOWN COMMUNITY HEALTH CENTER, INC.				
Contact Name: FRANK MERTES			Title: CHIEF FINANCIAL OFFICER	
Contact #: 413-238-4116			Contact Email: FMERTES@HCHCWEB.ORG	
CFO Name: FRANK MERTES			CFO Email: FMERTES@HCHCWEB.ORG	
The descriptions below are for convenience only -- please refer to the applicable provisions of 101 CMR 613.00 for the actual requirement.				
Part #	Exceptions	Reference	CC/FAP Page # (or N/A)	101 CMR 613.00 Credit & Collection Regulatory Requirements
1. General Filing Requirements - Section 613.08(1)(c)				
1-1		613.08(1)(c)	Page 2	Electronic Filing with Table of Contents
2. General Definitions of Emergency Care and Urgent Care - Section 613.02				
2-1	Hospitals Only	613.02	Page 2	Emergency Services definition to be used in determining Allowable Bad Debt under § 613.06
2-2		613.02	Page 2	Urgent Care Services definition to be used in determining Allowable Bad Debt under § 613.06
3. General Collection Policies & Procedures - Sections 613.08(1)(c)2 and 613.04(6)(c)3				
3-1		613.08(1)(c)2a	Page 2	Standard collection policies and procedures for patients
3-2		613.08(1)(c)2b	Page 3	Policies and procedures for collecting financial information from patients
3-3	Hospitals Only	613.08(1)(c)2c	N/A	Emergency Care classification; elective or scheduled services differentiated
3-4		613.08(1)(c)2d	Page 4	Policy for deposits and payment plans
3-5		613.08(1)(c)2e	Page 4	Copies of billing invoices and notification of assistance
3-6		613.08(1)(c)2f	Page 4	Description of any discount or charity program for the uninsured
3-7	Hospitals Only	613.08(1)(c)2g	N/A	Acute hospital's deductible payment option at each HLHC, satellite, and/or student health center (specified in Part 3-8)
3-8	Hospitals Only	613.04(6)(c)5a	N/A	Full or 20% deductible payment option for all partial HSN patients at HLHC, satellite, and/or student health center
3-9	CHCs Only	613.04(6)(c)5a	Page 5	Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients
3-10		613.08(1)(c)2h	Page 6	Direct Website(s) or URL(s) where the Provider's Credit and Collection Policy, Provider Affiliate List (if applicable), and other financial assistance policies are posted
3-11	Hospitals Only	613.08(1)(d)	N/A	Provider Affiliate List, effective the first day of the Acute Hospital's fiscal year beginning after December 31, 2016
4. Collection of Financial Information - Section 613.06(1)(a)				
4-1		613.06(1)(a)1	Page 6	Inpatient, Emergency, Outpatient, & CHC Services
4-2	Hospitals Only	613.06(1)(a)2a	N/A	Inpatient Verification
4-3		613.06(1)(a)2b	Page 6	Outpatient/CHC Verification
5. Deposits & Payment Plans - Section 613.08(1)(f)				
5-1		613.08(1)(g)1	Page 7	Deposits may not be required for Emergency Services or Low Income Patients
5-2		613.08(1)(g)2	Page 7	Deposits requests from Low Income Patients
5-3		613.08(1)(g)3	Page 7	Deposits requirement from Medical Hardship patient
5-4		613.08(1)(g)4	Page 7	Interest-free payment plans on balances less than, and greater than, \$1000
6. Populations Exempt From Collection Action - Section 613.08(3) and 613.05(2)				
6-1		613.08(3)(a)	Page 7	MassHealth and Emergency Aid to the Elderly, Disabled, and Children (EAEDC) enrollees
6-2		613.08(3)(b)	Page 7	Participants in the Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) income equal to or less than 300% FPL
6-3		613.08(3)(c)	Page 7	Low Income Patients, except Dental-Only Low Income Patients
6-4		613.08(3)(d)	Page 7	Low Income Patient with HSN Partial
6-5		613.08(3)(e)	Page 8	Low Income Patient consent on billing for non-Reimbursable Health Services
6-6		613.08(3)(e)1	Page 8	Low Income Patient consent exclusion for medical errors including Serious Reportable Events (SREs)
6-7		613.08(3)(e)2	Page 8	Low Income Patient consent exclusion for administrative or billing errors
6-8		613.08(3)(f)	Page 8	Low Income Patient consent for CommonHealth one-time deductible billing
6-9		613.08(3)(g)	Page 8	Medical Hardship patient & Emergency Bad Debt eligible for Medical Hardship
6-10		613.05(2)	Page 8	Provider fails to timely submit Medical Hardship application
7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt - Section 613.06(1)(2)(3) and (4)				
7-1		613.06(1)(a)3bi	Page 8	Initial Bill
7-2		613.06(1)(a)3bii	Page 8	Collection action subsequent to Initial Bill
7-3		613.06(1)(a)3biii	Page 8	Documentation of alternative collection action efforts
7-4		613.06(1)(a)3biv	Page 8	Final Notice by Certified Mail
7-5		613.06(1)(a)3bv	Page 9	Continuous collection action with no gap exceeding 120 days
7-6		613.06(1)(a)3d	Page 9	Collection action file
7-7	Hospitals Only	613.06(2)	N/A	Emergency Bad Debt claim and Eligibility Verification System (EVS) check
7-8	Hospitals Only	613.06(3)	N/A	HLHC Bad Debt claim and EVS check
7-9	CHCs only	613.06(4)	Page 9	CHC Bad Debt claim and EVS check
8. Available Third Party Resources - Section 613.03(1)(c)3				
8-1		613.03(1)(c)3	Page 9	Diligent efforts to identify and obtain payment from all liable parties
8-2		613.03(1)(c)3a	Page 9	Determining the existence of insurance including, when applicable, motor vehicle liability insurance
8-3		613.03(1)(c)3b	Page 9	Verification of patient's other health insurance coverage
8-4		613.03(1)(c)3c	Page 10	Submission of claims to all insurers
8-5		613.03(1)(c)3d	Page 10	Compliance with insurer's billing and authorization requirements
8-6		613.03(1)(c)3e	Page 10	Appeal of denied claim
8-7		613.03(1)(c)3f	Page 10	Return of HSN payments upon availability of third party resource
9. Serious Reportable Events - Section 613.03(1)(d)				
9-1		613.03(1)(d)1	Page 10	Billing & collection for services provided as a result of SRE
9-2		613.03(1)(d)2	Page 10	Billing & collection for services that cause or remedy SRE
9-3		613.03(1)(d)3	Page 10	Billing & collection by provider not associated with SRE for SRE-related services
9-4		613.03(1)(d)4	Page 10	Billing & collection for readmission or follow-up on SRE associated with provider
10. Provider Responsibilities - Section 613.08(1)(a)(b)(h)				
10-1		613.08(1)(a)	Page 10	Nondiscrimination
10-2		613.08(1)(b)	Page 10	Board approval for legal execution against patient home or motor vehicle
10-3		613.08(1)(h)	Page 11	Provider responsibility to advise patient on duties and responsibilities
11. Patient Rights and Responsibilities - Section 613.08(1)(2)				
11-1		613.08(2)(a)1	Page 11	Provider responsibility to advise patient on right to apply for MassHealth, Health Connector programs, HSN, Medical Hardship
11-2		613.08(1)(e)2a	Page 11	Provider responsibility to provide individual notice of Eligible Services and programs of public assistance during the Patient's initial registration with the Provider
11-3		613.08(1)(e)2c	Page 11	Provider responsibility to provide individual notice of Eligible Services and programs of public assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
11-4		613.08(2)(a)2	Page 11	Provider responsibility to advise patient of the right to a payment plan
11-5		613.08(2)(b)1	Page 11	Provider responsibility to advise patient on duty to provide all required documentation
11-6		613.08(2)(b)2	Page 11	Provider responsibility to advise patient on duty to inform of change in eligibility status & available Third Party Liability (TPL)
11-7		613.08(2)(b)3	Page 11	Provider responsibility to advise patient on duty to track patient deductible
11-8		613.08(2)(b)4	Page 11	Provider responsibility to advise patient on duty to inform HSN/MassHealth of any TPL claim/lawsuit
11-9		613.08(2)(b)4a	Page 12	Provider responsibility to advise patient on duty to file TPL claim on accident, injury or loss
11-10		613.08(2)(b)4bi	Page 12	Provider responsibility to advise patient on assigning right to recover HSN payments from TPL claim proceeds
11-11		613.08(2)(b)4bii	Page 12	Provider responsibility to advise patient on duty to provide TPL claim or proceeding information
11-12		613.08(2)(b)4biii	Page 12	Provider responsibility to advise patient on duty to notify HSN/MassHealth within ten days of filing TPL claim/lawsuit
11-13		613.08(2)(b)4biv	Page 12	Provider responsibility to advise patient on duty to repay HSN for Eligible Services from TPL proceeds
11-14		613.08(1)(e)1a	Page 12	Provider responsibility to provide individual notice of financial assistance during the Patient's initial registration with the Provider
11-15		613.08(1)(e)1c	Page 12	Provider responsibility to provide individual notice of financial assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
11-16		613.08(2)(c)	Page 12	Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds
12. Distribution of Financial Assistance Program Information - Section 613.08(1)(f)				
12-1		613.08(1)(f)1	Page 12	Location of the signs
12-2		613.08(1)(f)1	Page 12	Size of the signs
12-3		613.08(1)(f)1	Page 13	Multi-lingual signs when applicable
12-4		613.08(1)(f)1	Page 13	Wording in signs
12-5		613.08(1)(f)2	Page 13	Providers must make their Credit and Collection Policy and Provider Affiliate List (if applicable) available on the Provider's website
13. Sample Documents & Notices on Availability of Assistance - Section 613.08(1)(e)(f)				
13-1		613.08(1)(e)1b	Attachment 1	Sample of assistance notice on billing invoice
13-2		613.08(1)(e)2b	Attachment 2	Sample of Eligible Services and programs of assistance notice on billing invoice
13-3		613.08(1)(e)3	Attachment 3	Sample of assistance notice in collection actions (billing invoices)
13-4		613.08(1)(e)4	Attachment 4	Sample of payment plan notice to Low Income or Medical Hardship patients
13-5		613.08(1)(f)	Attachment 5	Sample of posted Signs

CREDIT & COLLECTION POLICY

1. General Filing Requirement 613.08(1) (c)

1.1 The Hilltown Community Health Center will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to this regulation that would require a change in the Credit & Collection Policy; when the health center changes its Credit & Collection Policy; or when requested by the HSN Office .

2. General Definitions 613.02

2.1 *Emergency Services – N/A*

2.2 The Urgent Care Services Definition used to determine allowable Bad Debt under 613.06 is: Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

3. General Collection Policies & Procedures 613.08(1)(c)2 and 613.04(6)(c)3

3.1 Standard Collection Policies and Procedures for patients 613.08(1)(c)2a

(a) The health center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form.

A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff ask returning patients, at the time of visit, whether there have been any changes in their income or insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

- (1) an initial bill is sent to the party responsible for the patient's financial obligations;
- (2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;
- (3) efforts to locate the patient or the correct address on mail returned as an incorrect

address are documented, and

(4) a final notice is sent by certified mail for balances over \$1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04 (6) (b) and deductibles in accordance with 101 CMR 613.04(6) (c), that they will be responsible for these co-payments.

(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of \$1 for antihyperglycemic, antihypertensive, and antihyperlipidemic generic prescription and \$3.65 for generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of \$250 per year.

(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net - Partial Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, the health center determines their deductible (40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL). If any member of the PBFG has an FPL below 150.1 % there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services, provided up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one Deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information from patients

613.08(1)(c)2b

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.

(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:

a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. *613.04(3)a*

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address. *613.04(3)b*

Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the Provider determines the individual is presumptively a Low Income Patient, The health center will submit claims for Reimbursable Health Services provided to individuals with time-limited presumptive Low Income Patient determinations for dates of service beginning on the date on which the Provider makes the presumptive determination and continuing until the earlier of: a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a complete Application, or b. The date of the determination notice described in 101 CMR 613.04(2)(a) related to the individual's Application. 613.04 (4)

3.3 *Emergency Care Classification - NA*

3.4 Policy for Deposits and Payment Plans 613.08(1)(c)2d

The health center's billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 101 CMR 613.08. Each payment plan must be authorized by the Billing Manager or the Chief Financial Officer.

3.5 Copies of Billing Invoices and Notices of Assistance 613.08(1)(c)2e

(a) **Billing Invoices:** The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call 413-238-5511. Financial assistance is available."

(b) **Notices:** The Health center provides all applicants with notices of the availability of financial assistance programs, including MassHealth, subsidized Health Connector Programs, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with individual notice of approval for Health Safety Net or denial of Health Safety Net once this has been determined. The following language is used on billing statements sent to low income patients: "If you are unable to pay this bill, please call 413-238-5511. Financial assistance is available." The Health center will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) **Signs:** The Health center posts signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and programs of public assistance and the offices of Health center Navigators at which to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will in English and any other language that is used by 10 or more of the residents in the service area.

3.6 Discount/Charity Programs for the Uninsured 613.08(1)(c)2f

The health center offers a Sliding Fee Discount Program (SFDP) to patients.. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients

Hilltown Community Health Centers, Inc.
Credit & Collection Policy March 7, 2019

with incomes between 100% and 200% of the FPIG. The Sliding Fee Discount Schedule applies to standard charges and to amounts left unpaid by insurances in compliance with the Federal Health and Resources and Services Administration (HRSA) PIN 2014-02.

Sliding Fee Discount Schedule

2019 FEDERAL INCOME POVERTY GUIDELINES					
	Coverable by Federal Grant Resources *				
		125%	150%	175%	200%
	100%	101-125%	126-150%	151-175%	176-200%
	Slide A	Slide B	Slide C	Slide D	E
SIZE OF FAMILY UNIT	Maximum Annual Income Level Sliding Fee Discount Program				
1	\$ 12,490	\$ 15,613	\$ 18,735	\$ 21,858	\$ 24,980
2	\$ 16,910	\$ 21,138	\$ 25,365	\$ 29,593	\$ 33,820
3	\$ 21,330	\$ 26,663	\$ 31,995	\$ 37,328	\$ 42,660
4	\$ 25,750	\$ 32,188	\$ 38,625	\$ 45,063	\$ 51,500
5	\$ 30,170	\$ 37,713	\$ 45,255	\$ 52,798	\$ 60,340
6	\$ 34,590	\$ 43,238	\$ 51,885	\$ 60,533	\$ 69,180
7	\$ 39,010	\$ 48,763	\$ 58,515	\$ 68,268	\$ 78,020
8	\$ 43,430	\$ 54,288	\$ 65,145	\$ 76,003	\$ 86,860
For each additional person , add	\$ 4,420	\$ 5,525	\$ 6,630	\$ 7,735	\$ 8,840
Discount Allowed	100%	80%	60%	40%	20%
Charge to Patient	0%	20%	40%	60%	80%

		Coverable by State Health			
		Full HSN	Partial HSN		
		up to 200%	up to 300%		
	SIZE OF FAMILY UNIT	Maximum Annual Income Level HSN			
	1	\$ 24,980	\$ 37,470		
	2	\$ 33,820	\$ 50,730		
	3	\$ 42,660	\$ 63,990		
	4	\$ 51,500	\$ 77,250		
	5	\$ 60,340	\$ 90,510		
	6	\$ 69,180	\$ 103,770		
	7	\$ 78,020	\$ 117,030		
	8	\$ 86,860	\$ 130,290		
	For each additional person , add	\$ 8,840	\$ 13,260		
Policy and Procedure:					
* "Sliding Fee Scale" (SFS) is used by the federal Section 330 program to allow for discounts to patients with					
** MA Health Safety Net Office (HSN) for discounts to eligible patients with incomes below or at 300% of the FPL. (per 114.6 CMR 13.04)					

3.7 *Hospital deductible payment option at HLHC – NA*

3.8 *Full or 20% Deductible Payment Option for all Partial HSN Payments at HLCH Satellite or Student Health Center – NA*

3.9 Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients 613.04(6)(c)5a

The health center charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.

3.10 Direct Website(s) (or URL(s)) where the provider's Credit & Collection Policy, Provider Affiliate List (if applicable) and other financial assistance Policies are posted.

Credit & Collection Policy <https://www.hchcweb.org/for-patients/established-patients/pay-your-bill/>

Insurance Affiliation List <https://www.hchcweb.org/for-patients/insurance-information/>

Sliding Fee Scale Policy <https://www.hchcweb.org/for-patients/insurance-information/>

3.11 Provider Affiliate List effective the first day of the acute hospital's fiscal year beginning after December 31, 2016 - NA

4. Collection of Financial Information 613.06(1)(a)

4.1 Inpatient, Emergency, Outpatient & CHC Services: 613.06(1)(a)1 The Health center makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.

4.2 Inpatient Verification - NA

4.3 Outpatient/CHC Financial Verification 613.06(1)(a)2b

The Health center makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

1. Verification of gross monthly-earned income is mandatory. When possible this is done through electronic data matching using the eligibility procedures and requirements under 130 CMR 502 or 516. If the information received is not compatible or is unavailable, the following are required:

- a. Two recent pay stubs;
- b. A signed statement from the employer; or
- c. The most recent U.S. tax return.

2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:

- a. A copy of a recent check or pay stub showing gross income from the source;
- b. A statement from the income source, where matching is not available;
- c. The most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. Deposits and Payment Plans 613.08(1)(f)

5.1 The health center does not require pre-treatment deposits from Low Income patients. 613.08(1)(g)1

5.2 Deposit Requests for Low Income Patients: The Health center does not require a deposit from individuals determined to be Low Income Patients 613.08(1)(g)2

5.3 Deposit Requirement for Medical Hardship Patients: The Health center does not require a deposit from patients eligible for Medical Hardship. 613.08(1)(g)3

5.4 Interest Free Payment Plans on Balances less than, and greater than, \$1000. A Patient with a balance of \$1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than \$25. A Patient with a balance of more than \$1,000, after initial deposit, must be offered at least a two-year, interest-free payment plan. . 613.08(1)(g)4

6. Populations Exempt from Collection Action 613.08(3)& 613.05(2)

6.1 MassHealth, Emergency Aid to the Elderly, Disabled, and Children EAEDC enrollees: The health center does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that the health center may bill patients for any required co-payments and deductibles. The Health center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Health center will cease its collection activities. 613.08(3)(a)

6.2 Participants in Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) under 300% FPL: are also exempt from Collection Action. The Health center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health center will cease all collection activities. 613.08(3)(b)

6.3 Low Income Patients except Dental-only Low Income Patients.
Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income equal or less than 150.1% of the FPL, are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. 613.08(3)(c)

6.4 Low Income Patients with HSN Partial
Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 200.1% and 300.1% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 13.04(6)(b) and (c). The Health center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. 613.08(3)(d)

6.5 Low Income Patient Consent to billing for non-reimbursable services: The Health center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed in writing to be responsible. 613.08(3)(e)

6.6 Low Income Patient Consent Exclusion for Medical Errors, including Serious Reportable Events (SRE)

The health center will not bill low income patients for claims related to medical errors occurring on the health center's premises. 613.08(3)(e)1

6.7 Low Income Patient Consent Exclusion for Administrative or Billing Errors The health center will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error. 613.08(3)(e)2

6.8 Low income Patient Consent for CommonHealth one-time deductible billing. At the request of the patient, the health center may bill a low-income patient in order to allow the patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009. 613.08(3)(f)

6.9 Medical Hardship Patient & Emergency Bad Debt Eligible for Medical Hardship: The Health center will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. 613.08(3)(g).

6.10 Provider Fails to Timely Submit Medical Hardship Application

The health center will not undertake a collection action against any individual who has qualified for Medical Hardship with respect to any bills that would have been eligible for HSN payment in the event that the health center has not submitted the patient's Medical Hardship documentation within 5 days. 613.05(2).

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt 613.06(1)(2)(3) and (4)

The Health center makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications. Any collection agency used by the health center is required to conform to the above policies.

The minimum requirements before writing off an account to the Health Safety Net include:

7.1 Initial Bill: The health center sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations. 613.06(1)(a)3bi

7.2 Collection action subsequent to Initial Bill: The health center will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification methods that constitute a genuine effort to contact the party responsible for the bill. 613.06(1)(a)3bii

7.3 Documentation of alternative collection action efforts: The health center will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable." 613.06(1)(a)3biii

7.4 Final Notice by Certified Mail: The health center will send a final notice by certified mail for balances over \$1,000 where notices have not been returned as "incorrect address" or "undeliverable" 613.06(1)(a)3biv

7.5 Continuous Collection Action with no gap exceeding 120 days: The health center will document that the required collection action has been undertaken on a regular basis and to the extent possible, does not allow a gap in this action greater than 120 days. If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office. *613.06(1)(a)3bv*

7.6 *Collection Action File* The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made. *613.06(1)(a)3d*

7.7 *Emergency Bad Debt Claim and EVS Check – NA*

7.8 *HLHC Bad Debt Claim and EVS Check – NA*

7.9 *CHC Bad Debt Claim and EVS Check.* The health center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. The health center will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The health center will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom the health center assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) The Health center provided Urgent Services as defined in 101 CMR 613.02 to the patient. The Health center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible provider determined that the patient required Urgent Services. The health center will submit a claim only for urgent care services provided during the visit.

(d) The Health center undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days. *613-06(4)*

8. Available Third Party Resources *613.03(1)(c)3*

8.1 Diligent efforts to identify & obtain payment from all liable parties: The health center will make diligent efforts to identify and obtain payment from all liable parties. *613.03(1)(c)3*

8.2 Determining the existence of insurance, including when applicable motor vehicle liability:

In the event that a patient seeks care for an injury, the health center will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. The health center will retain evidence of efforts to obtain third policy payer information. *613.03(1)(c)3a*

8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. The health center will verify, through EVS, or any other health

insurance resource available to the health center, on each date of service and at the time of billing. *613.03(1)(c)3b*

8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, the health center will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims. *613.03(1)(c)3c*

8.5 Compliance with insurer's billing and authorization requirements: The health center will comply with the insurer's billing and authorization requirements. *613.03(1)(c)3d*

8.6 Appeal of denied claim. The health center will appeal denied claims when the stated purpose of the denial does not appear to support the denial. *613.03(1)(c)3e*

8.7 Return of HSN payments upon availability of 3rd-party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the health center will promptly report the recovery to the HSN. *613.03(1)(c)3f*

9. Serious Reportable Events (SRE) *613.03(1)(d)*

9.1 Billing & collection for services provided as a result of SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control; and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c). *613.03(1)(d)1*

9.2 Billing & collection for services that cause or remedy SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to: a. The occurrence of the SRE;

b. The correction or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis. *613.03(1)(d)2*

9.3 Billing and collection by provider not associated with SRE for SRE-related services: The health center will submit claims for services it provides that result from an SRE that did not occur on its premises *613.03(1)(d)3*

9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by the health center is not billable if the services are associated with the SRE as described above. *613.03(1)(d)4*

10. Provider responsibilities *613.08(1)(a)(b) & (h)*

10.1 Non-discrimination: The health center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. *613.08(1)(a)*

10.2 Board Approval Before seeking legal execution against patient home or motor vehicle. Before seeking legal execution against a low-income patient's home or motor vehicle, the health center requires its Board of Directors to approve such action on an individual basis. *613.08(1)(b)*

10.3 Advise patient on TPL duties and responsibilities: The health center will advise patients of the responsibilities described in 101 CMR 613.08(2) at the time of application and at subsequent visits. *613.08(1)(h)*

11. Patient Rights and Responsibilities *613.08(1)(2)*

11.1 Provider Responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship: The health center informs all patients of their right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship. *613.08(2)(a)1*

11.2 Provider responsibility to provide individual notice of eligible services and programs of public assistance during the patient's initial registration with the provider. The health center informs all Low Income Patients and patients determined eligible for Medical Hardship of their right to a payment plan as described in 101 CMR 613.08(1)(f). *613.08(1)(e)2a [change*

11.3 Provider responsibility to provide individual notice of eligible services and programs of public assistance when a provider becomes aware of a change in the patient's eligibility for health insurance coverage: The health center provides patients with individual notices of eligible services and programs of public assistance when we become aware of a change in the patient's eligibility for health insurance coverage. *613.08(1)(e)2c*

11.4 Provider responsibility to advise patient of the right to a payment plan: The health center advises patients of their right to an payment plan. *613.08(2)(a)2*

11.5 Provider responsibility to advise patient on duty to provide all required documentation: The health center advises patients of their duty to provide all required documentation. *613.08(2)(b)1*

11.6 Provider responsibility to advise patient of duty to inform of change in eligibility status and available third party liability (TPL): The health center informs all patients that they have a responsibility to inform the health center and/or MassHealth when there has been a change in their MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), insurance coverage, insurance recoveries, and/or TPL status. *613.08(2)(b)2*

11.7 *Provider responsibility* to advise patient on duty to track patient deductible: At the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider. *613.08(2)(b)3*

11.8 Provider responsibility to inform the HSN Office or MassHealth of a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to inform the HSN Office or MassHealth of a TPL claim/lawsuit as well as to: *613.08(2)(b)4*

11.9 Provider responsibility to advise patient on duty to file TPL claims on accident, injury or loss: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to file TPL claims. *613.08(2)(b)4a.*

11.10 Provider responsibility to inform patient on Assigning the right to recover HSN payments from TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to assign the right to recover HSN payments from the TPL proceeds. *613.08(2)(b)4bi*

11.11 Provider responsibility to inform patient to provide TPL claim or legal proceedings information: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to provide TPL claims or legal proceedings information. *613.08(2)(b)4bii*

11.12 Provider responsibility advise patient to notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible to notify HSN/MassHealth of it within 10 days. *613.08(2)(b)4biii*

11.13 Provider responsibility to advise patient of duty to repay the HSN for applicable services from TPL Proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible for repaying the HSN for applicable services from TPL proceeds. *613.08(2)(b)4biv*

11.14 Provider responsibility to provide individual notice of financial assistance during the patient's initial registration with the provider: The health center provides individual notice of financial assistance during the patient's initial registration. *613.08(1)(e)1a*

11.15 Provider's responsibility to provide individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage: The health center provides individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage. *613.08(1)(e)1c*

11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that recovery from TPL payments is limited to the HSN expenditures for eligible services. *613.08(2)(c)*

12. Signs *613.08(1)(f)*

12.1 Location of the signs. The Health center has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs. *613.08(1)(f)1*

12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by patients visiting these areas. *613.08(1)(f)1*

12.3 Multi-lingual signs when applicable: All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English. 613.08(1)(f)1

12.4 Wording in Signs: The health center signs notify patients of the availability of financial assistance and of programs of financial assistance. 613.08(1)(f)1

12.5 Providers must make their Credit & Collection Policy and provider affiliate list, if applicable, available on the provider's website. 613.08(1)(f)2

<https://www.hchcweb.org/>

13. Sample Documents & Notices on Availability of Assistance 613.08(1)(e) & (f)

13.1 Sample of Assistance Notice on Billing Invoice Attached (*Attachment 1*)
613.08(1)(e)1b

13.2 Sample of Eligible Services and programs of assistance – notice on billing invoice.– Attached (*Attachment 2*) 613.08(1)(e)2b

13.3 Sample of Assistance notice in collection actions (billing invoices) – Attached (*Attachment 3*) 613.08 (1)(e)3

13.4 Sample of Payment plan notice to Low Income or Medical Hardship patients – Attached (*Attachment 4*) 613.08(1)(e)4

13.5 Sample of Posted Signs –attached (*Attachment 5*) 613.08(1)(f)

Hilltown Community Health Centers, Inc.
Credit & Collection Policy March 7, 2019

Attachment 1

PLEASE CALL:
JOHN BERGERON 413-667-2203
To see if you qualify for help with
your medical/dental bills.

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To see if you qualify for help with
your medical/dental bills.

PLEASE CALL:
JOHN BERGERON 413-667-2203
To see if you qualify for help with
your medical/dental bills.

Hilltown Community Health Centers, Inc.
Credit & Collection Policy March 7, 2019

STATEMENT

Attachment 2

This is a statement for professional services rendered by your physician. You may receive a separate bill from the hospital for its services.

PATIENT NAME		
[REDACTED]		
BILL DATE	ACCOUNT NO.	AMOUNT PAID
03/21/2016	[REDACTED]	

[REDACTED]

[REDACTED]

[REDACTED]

THIS IS A STATEMENT OF SERVICES RENDERED BY PHYSICIAN(S) WHO ARE MEMBERS OF:

Hilltown Community Health Ctrs Inc
58 Old North Road
Worthington, MA 010989753
413-238-5511

DATE OF SERVICE	DESCRIPTION OF SERVICE	AMOUNT
12/03/2015	Claim:162509, Provider: JONATHAN LIEBMAN, NP	
12/03/2015	99213 Office Visit, Est Pt., Level 3	172.00
03/21/2016	If you are unable to pay this bill please call 413-238-5511 financial assistance is available. Your Balance Due On These Services ...	20.00

DATE	PATIENT NAME	ACCOUNT NO.	PAY THIS AMOUNT
03/21/2016	[REDACTED]	[REDACTED]	20.00

MAKE CHECK
PAYABLE TO: Hilltown Community Health Centers Inc

IMPORTANT MESSAGE REGARDING YOUR ACCOUNT

[REDACTED]

Hilltown Community Health Centers, Inc.
Credit & Collection Policy March 7, 2019

Attachment 3



HILLTOWN COMMUNITY HEALTH CENTERS, INC.

58 Old North Road • Worthington, MA 01098
(413) 238-5511 Clinical Fax: (413) 923-9355

3/29/2016

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

Our billing department has made a number of attempts to bring your attention to this long overdue account.

The balance of 33.04 has now gone considerably beyond our normal credit limits and you have reached the final stage of our collection process.

Because we are a non-profit Community Health Center, delinquent accounts are especially burdensome for us, as we have no profits to help offset bad debt accounts. We have valued you as a patient in the past and we do not want to jeopardize your credit rating by turning you over to a collection agency. If there is anything we can do to assist you in the payment of this account, please contact our Patient Billing Department at 413-238-5511, option 6.

If for any reason, we do not hear from you within 15 days of the date on this letter, we will be forced to proceed with collection action. Please be aware that our policy is to refuse all non-emergency services to patients whose account status has reached this point, unless payments on this overdue amount are being made. If you do not make an effort to work out a payment settlement, we may also choose to terminate you as a patient.

Thank you,

Karen Rida
HCHC Billing

Worthington Health Center • 58 Old North Road • Worthington, MA 01098 • (413) 238-4100 • Fax (413) 923-9355
Huntington Health Center • 73 Russell Road • Huntington, MA 01050 • (413) 667-3009 • Fax (413) 923-9355
Hilltown Social Services • 9 Russell Road • Huntington, MA 01050 (413) 667-2203 • Fax (413) 667-2225
Gateway School-Based Health Center • 12 Littleville Road • Huntington, MA 01050 • (413) 667-0142 • Fax (413) 923-9355

"This institution is an equal opportunity provider."

Hilltown Community Health Centers, Inc.
Credit & Collection Policy March 7, 2019

Attachment 4



HILLTOWN COMMUNITY HEALTH CENTERS, INC.

58 Old North Road • Worthington, MA 01098
(413) 238-5511 Clinical Fax: (413) 923-9355

3/29/2016

[REDACTED]
[REDACTED]
[REDACTED]

Dear [REDACTED],

Your account has a balance of 33.04. Your payment is now overdue.

In order to avoid further collection action, we request that you pay your outstanding balance in full or that you work out a monthly payment plan that will enable you to pay your account in full within a reasonable amount of time.

If you believe a discrepancy exists in the amount owed, please contact the billing department at 413-238-5511, option 6.

Thank you,

Karen Rida
Billing Department

Worthington Health Center • 58 Old North Road • Worthington, MA 01098 • (413) 238-4100 • Fax (413) 923-9355
Huntington Health Center • 73 Russell Road • Huntington, MA 01050 • (413) 667-3009 • Fax (413) 923-9355
Hilltown Social Services • 9 Russell Road • Huntington, MA 01050 (413) 667-2203 • Fax (413) 667-2225
Gateway School-Based Health Center • 12 Littleville Road • Huntington, MA 01050 • (413) 667-0142 • Fax (413) 923-9355

"This institution is an equal opportunity provider."

Attachment 5

**ARE YOU
UNABLE TO PAY OUR BILL?**

**PLEASE CALL
413-238-5511**

**FINANCIAL ASSISTANCE
IS AVAILABLE**



Hilltown Community Health Centers, Inc.

Administration

SUBJECT: NAME OF POLICY – SLIDING FEE DISCOUNT PROGRAM (SFDP)

REGULATORY REFERENCE: HRSA/BPHC [Public Health Service Act 330(k)(3)(G) and Code of Federal Regulations – 42 CFR Part c.303(f)]

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) Board of Directors have adopted this policy to make available a sliding fee discount program to ensure that no patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin.

This policy includes a formal documented process designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical, optometry, behavioral health and dental services (Uninsured or Underinsured). The HCHC Navigators and the Billing Manager's role under this policy is to act as a patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives.

Discounts are offered based on family size and annual income which is documented through the completion of the "Sliding Fee Discount Application".

The Sliding Fee Discount Program will only be made available for medical, dental, optometry and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry and/or Dental hardware, such as dentures and eye glasses and not for those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services.

The Federal Poverty Guidelines, <http://aspe.hhs.gov/poverty>, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

Policy:

To make available discount services to those in need.

No patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin.

Questions regarding this policy or any related procedure should be directed to the Chief Financial Officer at 413-238-4116

Originally Drafted: JANUARY 2013

Reviewed or Revised: MARCH 2019

Approved by Board of Directors, Date: September 28, 2016

Approved by:

Name: Eliza B. Lake

Eliza B. Lake

Date: 3/7/2019

Executive Director, HCHC

Name: John Follet, MD

John Follet, MD

President, HCHC Board of Directors

Date: 3/7/2019

Procedure: The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** HCHC will notify patients of the Sliding Fee Discount Program by:
 - Notification of Sliding Fee Discount Program in the clinic waiting area.
 - Notification of the Sliding Fee Discount Program will be offered to each patient upon registration as a patient of HCHC.
 - Notification of financial assistance on each invoice and collection notice sent out by HCHC.
 - An explanation of our Sliding Fee Discount Program and our application form are available on HCHC's website.
2. **All patients** seeking healthcare services at HCHC are assured that they will be served regardless of ability to pay. **No one is refused service because of lack of financial means to pay.**
3. **Request for discount:** Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for medical, dental, optometry and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry or Dental hardware and not for those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. Information and forms can be obtained from the Front Desk, Billing Department and from Navigators.
4. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Finance Department / Billing Manager or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application with Navigators and /or the Billing Manager. Dignity will be respected and confidentiality maintained for all who seek and/or are provided charitable services.
5. **Alternative payment sources:** All alternative payment resources must be exhausted, including all third-party payment from insurance(s) and Federal and State programs, including Health Safety Net (HSN).
6. **Completion of Application:** The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Every effort will be made to collect the required family income information in conjunction with any Mass Health and/or HSN applications. By signing the application, persons authorize HCHC access in confirming income as disclosed on the application form. Providing false information may result in the Sliding Fee Discount Program discounts being revoked and the full balance of the

account(s) restored and payable under the HCHC Credit and Collection Policy.

7. **Eligibility:** Sliding Fee Discounts will be based on income and family size only. HCHC uses the Census Bureau definitions of each.
 - a. Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together and any person who is claimed as a dependent for Federal tax purposes; all such people (including related subfamily members) are considered as members of one family.
 - b. Income includes: earnings, unemployment compensation, workers' compensation, Social Security, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as SNAP benefits and housing subsidies) do not count as income.
 - c. Income verification: Applicants must provide one of the following: prior year W-2, prior year federal tax return (1040, etc.), two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business and prior year Federal Form 1040 Schedule C. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.
8. **Discounts:** Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee discount schedule will be applied to any standard charges or any remaining charges after any insurance payment. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest federal poverty guidelines (FPG), <http://aspe.hhs.gov/poverty>.
9. **Nominal Fee:** Patients receiving a full discount **will not** be assessed a nominal charge per visit.

10. **Waiving of Charges:** In certain situations, patients may not be able to pay the discount fee. Waiving of charges may only be used in special circumstances and must be approved by HCHC's CEO, CFO, or their designee. Any waiving of charges should be documented in the patient's file along with an explanation (e.g., ability to pay, good will, health promotion event).
11. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with HCHC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.
12. **Refusal to Pay:** If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, HCHC can implement procedures under the HCHC Credit and Collection Policy.
13. **Record keeping:** Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Billing Department Manager's Office.
14. **Policy and procedure review:** Annually, all aspects of the SFDP will be reviewed, including the nominal fee from the perspective of the patient to ensure it does not create a financial barrier to care. The SFDP will be reviewed by the CEO and/or CFO and presented to the Board of Directors for further review and approval. The review process will include a method to obtain feedback from patients. The Sliding Fee Scale will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future budget planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

15. **Referral contracts:** All HCHC referral contracts must include a clause detailing that HCHC patients receive services on a discounted fee equal to or better than the SFDS criteria of the Health Center Program. If the referral provider offers the services discounted on a SFDS with income at or below 250% FPG, as long as health center patients at or below 200% of the FPG receive a greater discount for these services than if the health center's SFDS were applied to the referral provider's fee schedule, and patients at or below 100% of the FPG receive no charge or only a nominal charge for the services, the referral arrangement is in compliance.

HILLTOWN COMMUNITY HEALTH CENTER SLIDING FEE SCHEDULE

2019 FEDERAL INCOME POVERTY GUIDELINES

	Coverable by Federal Grant Resources *				
		125%	150%	175%	200%
	100% Slide A	101-125% Slide B	126-150% Slide C	151-175% Slide D	176-200% E
SIZE OF FAMILY UNIT	Maximum Annual Income Level Sliding Fee Discount Program				
1	\$ 12,490	\$ 15,613	\$ 18,735	\$ 21,858	\$ 24,980
2	\$ 16,910	\$ 21,138	\$ 25,365	\$ 29,593	\$ 33,820
3	\$ 21,330	\$ 26,663	\$ 31,995	\$ 37,328	\$ 42,660
4	\$ 25,750	\$ 32,188	\$ 38,625	\$ 45,063	\$ 51,500
5	\$ 30,170	\$ 37,713	\$ 45,255	\$ 52,798	\$ 60,340
6	\$ 34,590	\$ 43,238	\$ 51,885	\$ 60,533	\$ 69,180
7	\$ 39,010	\$ 48,763	\$ 58,515	\$ 68,268	\$ 78,020
8	\$ 43,430	\$ 54,288	\$ 65,145	\$ 76,003	\$ 86,860
For each additional person , add	\$ 4,420	\$ 5,525	\$ 6,630	\$ 7,735	\$ 8,840
Discount Allowed	100%	80%	60%	40%	20%
Charge to Patient	0%	20%	40%	60%	80%

	Coverable by State Health	
	Full HSN	Partial HSN
	up to 200%	up to 300%
SIZE OF FAMILY UNIT	Maximum Annual Income Level HSN	
1	\$ 24,980	\$ 37,470
2	\$ 33,820	\$ 50,730
3	\$ 42,660	\$ 63,990
4	\$ 51,500	\$ 77,250
5	\$ 60,340	\$ 90,510
6	\$ 69,180	\$ 103,770
7	\$ 78,020	\$ 117,030
8	\$ 86,860	\$ 130,290
For each additional person , add	\$ 8,840	\$ 13,260

Policy and Procedure:

* "Sliding Fee Scale" (SFS) is used by the federal Section 330 program to allow for discounts to patients with

** MA Health Safety Net Office (HSN) for discounts to eligible patients with incomes below or at 300% of the FPL. (per 114.6 CMR 13.04)



Hilltown Community Health Centers, Inc.

Sliding Fee Discount Application

It is the policy of Hilltown Community Health Centers, Inc. (HCHC), to make available a sliding fee discount program to ensure that no patient will be denied health care services provided by HCHC due to an inability to pay or on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. Discounts are offered based on family size and annual income. Please complete the following information to determine if you or members of your family are eligible for a discount.

The Sliding Fee Discount Program will only be made available for medical, dental, optometry and behavioral health clinic visits. Sliding Fee Discounts are not available for Optometry and/or Dental hardware, such as dentures and eye glasses and not for those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

If you have questions or need assistance completing this form please contact an HCHC Navigators at 413-667-2203 or the Billing Manager at 413-238-4114.

HOUSEHOLD/FAMILY INFORMATION

Family is defined as: a group of two people or more (one of whom is the head of household) related by birth, marriage, or adoption and residing together and any person who is claimed as a dependent for Federal tax purposes; all such people (including related subfamily members) are considered as members of one family.

PATIENT NAME :	
RELATIONSHIP TO HEAD OF HOUSEHOLD:	
HOUSEHOLD MAILING ADDRESS:	
PHONE NUMBER:	

Defined Family Living at Household Address:

Name:	Date of Birth:	Relationship

Annual Household Income:

Income Source:	Self	Other Family Member(s)	Total
Gross Wages, salaries, tips, etc.			
Income from business and self-employment.			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income.			
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.			
Total			

NOTE: Please attach copies of all documents or self-declaration statements being used to verify income.

I certify that the family size and income information shown above is correct.

Name (Print):

Signature:

Date:

—

Official Use Only

Patient Name:
Approved Discount:
Approved By:
Date Approved:
List of Documents used to verify Income, please attach copy;

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

Date Requested: 03/05/2019 12:02 PM EST
Date of Last Report Refreshed: 03/05/2019 12:02 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Contact Information

Do you self-identify as an NMHC?: No

Title	Name	Phone	Fax	Email
UDS Contact	Frank Mertes	(413) 238 4116	(413) 238 5570	fmertes@HCHCweb.org
Project Director	Eliza Lake	(413) 238 4128	Not Available	elake@hchcweb.org
Clinical Director	Michael Purdy	(413) 667 3009 Ext. 270	(413) 238 5570	mpurdy@hchcweb.org
Chair Person	Not Available	Not Available	Not Available	Not Available
CEO	Not Available	Not Available	Not Available	Not Available

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
 Worthington, MA

Date Requested: 03/05/2019 12:02 PM EST
 Date of Last Report Refreshed: 03/05/2019 12:02 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Patients by ZIP Code

ZIP Codes

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01379		11		1	12
01376	1	3		6	10
01375	7	11	1	7	26
01373	3	4	3	4	14
01370	2	26	13	10	51
01360	2	1	3	1	7
01346	1	4		1	6
01341	2	10	4	5	21
01340	2	9	7	2	20
01339	3	17	11	3	34
01338	1	5	2	4	12
01330	7	49	11	29	96
01301	5	13	3	2	23
01270	6	20	15	30	71
01267	0	3	6	1	10
01256	3	10	10	10	33
01253	1	12	1	9	23
01247	1	39	12	8	60
01245	3	1	5	0	9

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01243	4	20	11	36	71
01238	0	5	1	4	10
01237	0	9	1	2	12
01235	25	84	49	103	261
01226	3	22	11	22	58
01225	3	10	1	4	18
01223	8	62	23	56	149
01220	5	32	9	12	58
01201	10	63	26	27	126
01151	0	6	1	1	8
01129	0	1	6	3	10
01119	1	1	2	4	8
01118	2	3	4	10	19
01109	4	7	3	9	23
01108	3	9	4	7	23
01107	2	6	0	1	9
01106	0	0	2	8	10
01105	0	1	2	3	6
01104	2	5	2	17	26
01098	42	171	142	302	657
01097	4	21	5	12	42
01096	17	82	42	89	230
01095	1	0	1	3	5
01090	0	2	1	1	4
01089	10	24	10	38	82
01088	1	6	0	2	9
01086	3	12	6	13	34
01085	70	337	108	352	867

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01084	4	17	13	25	59
01077	7	34	22	24	87
01075	5	8	2	9	24
01073	6	5	13	18	42
01071	28	87	32	179	326
01070	24	117	72	120	333
01069	0	1	0	3	4
01062	8	45	20	29	102
01061	0	3	1	4	8
01060	23	57	26	23	129
01057	1	3	1	1	6
01056	0	4	3	6	13
01054	0	7	2	1	10
01053	1	10	4	2	17
01050	83	327	159	608	1177
01040	8	25	4	14	51
01039	2	46	13	18	79
01038	1	6	3	1	11
01035	9	21	8	4	42
01034	11	39	9	28	87
01033	3	0	2	3	8
01032	9	18	7	33	67
01030	0	6	1	16	23
01029	4	23	12	11	50
01028	0	3	2	7	12
01027	17	85	31	48	181
01026	31	125	99	188	443
01022	0	0	1	3	4

ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
01020	3	13	12	13	41
01013	5	11	6	8	30
01012	24	55	39	74	192
01011	27	169	74	308	578
01008	20	87	55	196	358
01007	8	14	5	7	34
01002	84	44	26	31	185
01001	29	82	39	40	190
01367		1	3	1	5
01351	1	2	3		6
					0
01255	0	3	1	0	4
01240	1	5	0	2	8
01227	1	2	0	1	4
01202	0	2	1	1	4
01103	1	3	0	0	4
01101	1	2	0	1	4
01082	1	0	1	2	4
01072	4	3	1	3	11

Other ZIP Codes					
ZIP Code (a)	None/Uninsured (b)	Medicaid/Chip/OtherPub (c)	Medicare (d)	Private (e)	Total Patients (f)
Other ZIP Codes	18	50	31	42	141
Unknown Residence					0
Total (Zip Codes + Other Zip Codes)	783	2919	1439	3430	8571

Comments

Comments are disabled for this article. If you have any feedback, please contact the author or the site administrator.

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
 Worthington, MA

Date Requested: 03/05/2019 12:02 PM EST
 Date of Last Report Refreshed: 03/05/2019 12:02 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Table 3A - Patients By Age And By Sex Assigned At Birth

Universal

S.No	Age Groups	Male Patients (a)	Female Patients (b)
1.	Under Age 1	18	15
2.	Age 1	24	18
3.	Age 2	21	21
4.	Age 3	21	21
5.	Age 4	30	41
6.	Age 5	38	39
7.	Age 6	49	44
8.	Age 7	38	41
9.	Age 8	40	48
10.	Age 9	50	53
11.	Age 10	36	26
12.	Age 11	52	39
13.	Age 12	40	39
14.	Age 13	54	46
15.	Age 14	48	42
16.	Age 15	55	45
17.	Age 16	36	44
18.	Age 17	54	37
Subtotal Patients (Sum lines 1-18)		704	659
19.	Age 18	36	45
20.	Age 19	31	44

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Table 3B - Demographic Characteristics

Universal

S.No	Patients by Race	Hispanic/Latino (a)	Non-Hispanic/Latino (b)	Unreported/Refused to Report Ethnicity (c)	Total (d) (Sum Columns a+b+c)
1.	Asian	1	75		76
2a.	Native Hawaiian	1	6		7
2b.	Other Pacific Islander	0	1		1
2.	Total Native Hawaiian/Other Pacific Islander (Sum Lines 2a + 2b)	1	7		8
3.	Black/African American	8	78		86
4.	American Indian/Alaska Native	2	35		37
5.	White	179	5694		5873
6.	More than one race	0	1		1
7.	Unreported/Refused to report race	79	79	2332	2490
8.	Total Patients (Sum Lines 1 + 2 + 3 to 7)	270	5969	2332	8571

S.No	Patients by Linguistic Barriers to Care	Number (a)
12.	Patients Best Served in a Language Other Than English	218

S.No	Patients by Sexual Orientation	Number (a)
------	--------------------------------	---------------

S.No	Patients by Sexual Orientation	Number (a)
13.	Lesbian or Gay	66
14.	Straight (not lesbian or gay)	8115
15.	Bisexual	71
16.	Something else	
17.	Don't know	80
18.	Chose not to disclose	239
19.	Total Patients (Sum Lines 13 to 18)	8571

S.No	Patients by Gender Identity	Number (a)
20.	Male	3843
21.	Female	4680
22.	Transgender Male/ Female-to-Male	6
23.	Transgender Female/ Male-to-Female	2
24.	Other	0
25.	Chose not to disclose	40
26.	Total Patients (Sum Lines 20 to 25)	8571

Program Name: Health Center 330

Submission Status: Change Requested





UDS Report - 2018

Table 4 - Selected Patient Characteristics

Universal

Income As Percent Of Poverty Guideline

S.No	Characteristic	Number of Patients (a)
1.	100% and below	759
2.	101 - 150%	1266
3.	151 - 200%	1536
4.	Over 200%	2168
5.	Unknown	2842
6.	Total (Sum lines 1-5)	8571

S.No	Principal Third Party Medical Insurance	0-17 Years Old (a)	18 and Older (b)
7.	None/Uninsured	68	715
8a.	Medicaid (Title XIX)	675	2244
8b.	CHIP Medicaid		
8.	Total Medicaid (Sum lines 8a+8b)	 675	 2244
9a.	Dually eligible (Medicare and Medicaid)		189
9.	Medicare (Inclusive of dually eligible and other Title XVIII beneficiaries)		1439
10a.	Other Public Insurance (Non-CHIP) (specify)		
10b.	Other Public Insurance CHIP		
10.	Total Public Insurance (Sum lines 10a+10b)	 0	 0
11.	Private Insurance	620	2810
12.	Total (Sum lines 7+8+9+10+11)	1363	7208

Managed Care Utilization						
S.No	Managed Care Utilization	Medicaid (a)	Medicare (b)	Other Public Including Non-Medicaid CHIP (c)	Private (d)	Total (e)
13a.	Capitated Member Months					
13b.	Fee-for-service Member Months	11734			22758	34492
13c.	Total Member Months (Sum lines 13a+13b)	11734	0	0	22758	34492

S.No	Special Populations	Number of Patients (a)
16.	Total Agricultural Workers or Dependents (All health centers report this line)	
23.	Total Homeless (All health centers report this line)	
24.	Total School Based Health Center Patients (All health centers report this line)	669
25.	Total Veterans (All health centers report this line)	486
26.	Total Patients Served at a Health Center Located In or Immediately Accessible to a Public Housing Site (All health centers report this line)	

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

Date Requested: 03/05/2019 12:03 PM EST
Date of Last Report Refreshed: 03/05/2019 12:03 PM EST

Program Name: Health Center 330







Submission Status: Change Requested

UDS Report - 2018



Table 5 - Staffing And Utilization

Universal



Medical Care Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
1.	Family Physicians	2.83	4776	
2.	General Practitioners			
3.	Internists			
4.	Obstetrician/Gynecologists			
5.	Pediatricians	1	2295	
7.	Other Specialty Physicians			
8.	Total Physicians (Sum lines 1-7)	 3.83	 7071	
9a.	Nurse Practitioners	5.21	7715	
9b.	Physician Assistants	1	1931	
10.	Certified Nurse Midwives			
10a.	Total NP, PA, and CNMs (Sum lines 9a - 10)	 6.21	 9646	
11.	Nurses	8.36	920	
12.	Other Medical Personnel	13.22		
13.	Laboratory Personnel			
14.	X-Ray Personnel			
15.	Total Medical (Sum lines 8+10a through 14)	 31.62	 17637	5392

Dental Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
16.	Dentist	6.03	10737	
17.	Dental Hygienists	5.57	4763	
17a.	Dental Therapists			
18.	Other Dental Personnel	9.64		
19.	Total Dental Services (Sum lines 16-18)	 21.24	 15500	5014

Mental Health Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
20a.	Psychiatrists			
20a1.	Licensed Clinical Psychologists			
20a2.	Licensed Clinical Social Workers	5.09	4306	
20b.	Other Licensed Mental Health Providers			
20c.	Other Mental Health Staff			
20.	Total Mental Health (Sum lines 20a-20c)	 5.09	 4306	472



Substance Use Disorder Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
21.	Substance Use Disorder Services			

Other Professional Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22.	Other Professional Services Specify			



Vision Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
22a.	Ophthalmologists			
22b.	Optometrists	1.56	2381	
22c.	Other Vision Care Staff			
22d.	Total Vision Services (Sum lines 22a-22c)	 1.56	 2381	1485

Pharmacy Personnel

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
23.	Pharmacy Personnel			


Enabling Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
24.	Case Managers	6.49	2173	
25.	Patient/Community Education Specialists	1.98	1697	
26.	Outreach Workers			
27.	Transportation Staff			
27a.	Eligibility Assistance Workers	1.06		
27b.	Interpretation Staff			
27c.	Community Health Workers			
28.	Other Enabling Services Specify			
29.	Total Enabling Services (Sum lines 24-28)	 9.53	 3870	1054

Other Programs/Services

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
29a.	Other Programs/Services Specify:			
29b.	Quality Improvement Staff	1.91		

Administration And Facility

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
30a.	Management and Support Staff	4.45		
30b.	Fiscal and Billing Staff	6.96		
30c.	IT Staff	1		
31.	Facility Staff	0.81		
32.	Patient Support Staff	16.41		
33.	Total Facility and Non-Clinical Support Staff (Lines 30a - 32)	 29.63		

Grand Total

S.No	Personnel by Major Service Category	FTEs (a)	Clinic Visits (b)	Patients (c)
34.	Grand Total (Lines 15+19+20+21+22+22d+23+29+29a+29b+33)	100.58	43694	

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

Date Requested: 03/05/2019 12:03 PM EST

Date of Last Report Refreshed: 03/05/2019 12:03 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Table 5A - Tenure for Health Center Staff

Universal

S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)
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S.No	Health Center Staff	Full and Part Time Persons (a)	Full and Part Time Total Months (b)	Locum, On-Call, etc Persons (c)	Locum, On-Call, etc Total Months (d)
1.	Family Physicians	4	378		
2.	General Practitioners				
3.	Internists				
4.	Obstetrician/Gynecologists				
5.	Pediatricians	1	88		
7.	Other Specialty Physicians				
9a.	Nurse Practitioners	5	215		
9b.	Physician Assistants	1	12		
10.	Certified Nurse Midwives				
11.	Nurses	8	1043		
16.	Dentists	9	739		
17.	Dental Hygienists	9	1178		
17a.	Dental Therapists				
20a.	Psychiatrists				
20a1.	Licensed Clinical Psychologists				
20a2.	Licensed Clinical Social Workers	7	283		
20b.	Other Licensed Mental Health Providers				
22a.	Ophthalmologist				
22b.	Optometrist	2	117		
30a1.	Chief Executive Officer	1	75		
30a2.	Chief Medical Officer	1	52		
30a3.	Chief Financial Officer	1	37		
30a4.	Chief Information Officer				

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Table 6A - Selected Diagnoses And Services Rendered

Universal

Selected Infectious And Parasitic Diseases

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
1-2.	Symptomatic / Asymptomatic HIV	B20, B97.35, O98.7-, Z21	24	7
3.	Tuberculosis	A15- through A19-, O98.01	0	0
4.	Sexually transmitted infections	A50- through A64- (exclude A63.0)	24	19
4a.	Hepatitis B	B16.0-B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, O98.4-	6	5
4b.	Hepatitis C	B17.10, B17.11, B18.2, B19.20, B19.21	44	21

Selected Diseases Of The Respiratory System

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
5.	Asthma	J45-	869	512
6.	Chronic lower respiratory diseases	J40- through J44-, J47-	924	411

Selected Other Medical Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
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S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3-, N60-, N63-, R92-	138	101
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	34	26
9.	Diabetes mellitus	E08- through E13-, O24-(exclude O24.41-)	1517	518
10.	Heart disease (selected)	I01-, I02- (exclude I02.9), I20- through I25-, I27-, I28-, I30- through I52-	1022	472
11.	Hypertension	I10- through I16-	3369	1427
12.	Contact dermatitis and other eczema	L23- through L25-, L30- (exclude L30.1, L30.3, L30.4, L30.5), L58-	250	205
13.	Dehydration	E86-	10	9
14.	Exposure to heat or cold	T33-, T34-, T67-, T68-, T69-	5	1
14a.	Overweight and obesity	E66-, Z68- (exclude Z68.1, Z68.20 through Z68.24, Z68.51, Z68.52)	1068	744

Selected Childhood Conditions (Limited To Ages 0 Through 17)

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
15.	Otitis media and Eustachian tube disorders	H65- through H69-	83	62
16.	Selected perinatal medical conditions	A33-, P19-, P22-through P29- (exclude P29.3), P35- through P96- (exclude P54-, P91.6-, P92-, P96.81), R78.81, R78.89	9	5
17.	Lack of expected normal physiological development (such as delayed milestone; failure to gain weight; failure to thrive); nutritional deficiencies in children only. Does not include sexual or mental development.	E40- through E46-, E50- through E63-, P92-, R62- (exclude R62.7), R63.2, R63.3	29	21

Selected Mental Health And Substance Use Disorder Conditions

S.No	Diagnostic Category	Applicable ICD-10-CM Code	Number of Visits by Diagnosis Regardless of Primacy (a)	Number of Patients with Diagnosis (b)
18.	Alcohol related disorders	F10-, G62.1	367	142
19.	Other substance related disorders (excluding tobacco use disorders)	F11- through F19- (exclude F17-), G62.0, O99.32-	205	75
19a.	Tobacco use disorder	F17-, O99.33	627	344
20a.	Depression and other mood disorders	F30- through F39-	3423	748
20b.	Anxiety disorders including PTSD	F06.4, F40- through F42-, F43.0, F43.1-, F93.0	4336	982
20c.	Attention deficit and disruptive behavior disorders	F90- through F91-	496	125
20d.	Other mental disorders excluding drug or alcohol dependence	F01- through F09- (exclude F06.4), F20- through F29-, F43- through F48- (exclude F43.0-and F43.1-), F50- through F99- (exclude F55-, F84.2, F90-, F91-, F93.0, F98-), O99.34, R45.1, R45.2, 45.5, R45.6, R45.7, R45.81, R45.82, R48.0	1431	396

Selected Diagnostic Tests/Screening/Preventive Services

S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
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S.No	Service Category	Applicable ICD-10-CM Code or CPT-4/II Code	Number of Visits (a)	Number of Patients (b)
21.	HIV test	CPT-4: 86689, 86701 through 86703, 87389 through 87391, 87534 through 87539, 87806	0	0
21a.	Hepatitis B test	CPT-4: 86704 through 86707, 87340, 87341, 87350	0	0
21b.	Hepatitis C test	CPT-4: 86803, 86804, 87520 through 87522	0	0
22.	Mammogram	CPT-4: 77052, 77057, 77065, 77066, 77067 OR ICD-10: Z12.31	0	0
23.	Pap test	CPT-4: 88141 through 88153, 88155, 88164 through 88167, 88174, 88175 OR ICD-10: Z01.41-, Z01.42, Z12.4 (exclude Z01.411 and Z01.419)	140	137
24.	Selected immunizations: hepatitis A; haemophilus influenzae B (HiB); pneumococcal; diphtheria; tetanus; pertussis (DTaP) (DTP) (DT); mumps; measles; rubella (MMR); poliovirus; varicella; hepatitis B	CPT-4: 90632, 90633, 90634, 90636, 90643, 90644, 90645, 90646, 90647, 90648, 90669, 90670, 90696, 90697, 90698, 90700, 90701, 90702, 90703, 90704, 90705, 90706, 90707, 90708, 90710, 90712, 90713, 90714, 90715, 90716, 90718, 90720, 90721, 90723, 90730, 90731, 90732, 90740, 90743, 90744, 90745, 90746, 90747, 90748	560	500
24a.	Seasonal flu vaccine	CPT-4: 90630, 90653 through 90657, 90661, 90662, 90672, 90673, 90674, 90682, 90685 through 90688, 90749, 90756	1459	1451
25.	Contraceptive management	ICD-10: Z30-	315	213
26.	Health supervision of infant or child (ages 0 through 11)	CPT-4: 99381 through 99383, 99391 through 99393	354	268
26a.	Childhood lead test screening (9 to 72 months)	ICD-10: Z13.88 CPT-4: 83655	15	15
26b.	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	CPT-4: 99408, 99409 HCPCS: G0396, G0397, H0050	0	0
26c.	Smoke and tobacco use cessation counseling	CPT-4: 99406, 99407 OR HCPCS: S9075 OR CPT-II: 4000F, 4001F, 4004F	1	1
26d.	Comprehensive and intermediate eye exams	CPT-4: 92002, 92004, 92012, 92014	969	969

Selected Dental Services

S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
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S.No	Service Category	Applicable ADA Code	Number of Visits (a)	Number of Patients (b)
27.	Emergency Services	ADA: D9110	308	297
28.	Oral Exams	ADA: D0120, D0140, D0145, D0150, D0160, D0170, D0171, D0180	5715	3779
29.	Prophylaxis - adult or child	ADA: D1110, D1120	5926	3795
30.	Sealants	ADA: D1351	435	145
31.	Fluoride treatment - adult or child	ADA: D1206, D1208 CPT-4:99188	1410	987
32.	Restorative services	ADA: D21xx through D29xx	4668	3268
33.	Oral surgery (extractions and other surgical procedures)	ADA:D7xxx	837	558
34.	Rehabilitative services (Endo, Perio, Prostho, Ortho)	ADA: D3xxx, D4xxx, D5xxx, D6xxx, D8xxx	278	93

Sources of Codes:

ICD-10-CM (2018). National Center for Health Statistics (NCHS).

CPT (2018). American Medical Association (AMA).

Code on Dental Procedures and Nomenclature CDT Code (2018) - Dental Procedure Codes. American Dental Association (ADA).

Note: "X" in a code denotes any number including the absence of a number in that place. "-" (Dashes) in a code indicate that additional characters are required.

ICD-10-CM codes all have at least four digits. These codes are not intended to reflect if a code is billable or not. Instead they are used to point out that other codes in the series are to be considered.

BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

Program Name: Health Center 330

Submission Status: Change Requested

Date Requested: 03/05/2019 12:04 PM EST
Date of Last Report Refreshed: 03/05/2019 12:04 PM EST

UDS Report - 2018

Table 6B - Quality Of Care Measures

Universal

[X]: Prenatal Care Provided by Referral Only (Check if Yes)

Section A - Age Categories For Prenatal Care Patients:

Demographic Characteristics Of Prenatal Care Patients

S.No	Age	Number of Patients (a)
1.	Less than 15 years	0
2.	Ages 15-19	1
3.	Ages 20-24	2
4.	Ages 25-44	13
5.	Ages 45 and over	0
6.	Total Patients (Sum lines 1-5)	16

Section B - Early Entry Into Prenatal Care

S.No	Early Entry into Prenatal Care	Women Having First Visit with Health Center (a)	Women Having First Visit with Another Provider (b)
7.	First Trimester	16	0
8.	Second Trimester	0	0
9.	Third Trimester	0	0

Section C - Childhood Immunization Status

S.No	Childhood Immunization Status	Total Patients with 2nd Birthday (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Immunized (c)
10.	MEASURE: Percentage of children 2 years of age who received age appropriate vaccines by their 2nd birthday	18	18	8

Section D - Cervical Cancer Screening

S.No	Cervical Cancer Screening	Total Female Patients Aged 23 through 64 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Tested (c)
11.	MEASURE: Percentage of women 23-64 years of age who were screened for cervical cancer	1710	1710	632

Section E - Weight Assessment And Counseling For Nutrition And Physical Activity Of Children And Adolescents

S.No	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Total Patients Aged 3 through 17 (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Counseling and BMI Documented (c)
12.	MEASURE: Percentage of patients 3-17 years of age with a BMI percentile and counseling on nutrition and physical activity documented	535	535	120

Section F - Preventive Care And Screening: Body Mass Index (BMI) Screening And Follow-Up Plan

S.No	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with BMI Charted and Follow-Up Plan Documented as Appropriate (c)
13.	MEASURE: Percentage of patients 18 years of age and older with (1) BMI documented and (2) follow-up plan documented if BMI is outside normal parameters	4375	4375	1704

Section G - Preventive Care And Screening: Tobacco Use: Screening And Cessation Intervention

S.No	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Total Patients Aged 18 and Older (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Assessed for Tobacco Use and Provided Intervention if a Tobacco User (c)
14a.	MEASURE: Percentage of patients aged 18 years of age and older who (1) were screened for tobacco use one or more times within 24 months, and (2) if identified to be a tobacco user received cessation counseling intervention	3857	3857	1714

Section H - Use Of Appropriate Medications For Asthma

S.No	Use of Appropriate Medications for Asthma	Total Patients Aged 5 through 64 with Persistent Asthma (a)	Number Charts Sampled or EHR Total (b)	Number of Patients with Acceptable Plan (c)
16.	MEASURE: Percentage of patients 5 through 64 years of age identified as having persistent asthma and were appropriately ordered medication	137	137	123

Section I - Coronary Artery Disease (CAD): Lipid Therapy

S.No	Coronary Artery Disease (CAD): Lipid Therapy	Total Patients Aged 18 and Older with CAD Diagnosis (a)	Number Charts Sampled or EHR Total (b)	Number of Patients Prescribed a Lipid Lowering Therapy (c)
17.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy	100	100	94

Section J - Ischemic Vascular Disease (IVD): Use Of Aspirin Or Another Antiplatelet

S.No	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antiplatelet	Total Patients Aged 18 and Older with IVD Diagnosis or AMI, CABG, or PCI Procedure (a)	Charts Sampled or EHR Total (b)	Number of Patients with Documentation of Aspirin or Other Antiplatelet Therapy (c)
18.	MEASURE: Percentage of patients 18 years of age and older with a diagnosis of IVD or AMI, CABG, or PCI procedure with aspirin or another antiplatelet	229	229	206

Section K - Colorectal Cancer Screening

S.No	Colorectal Cancer Screening	Total Patients Aged 50 through 75 (a)	Charts Sampled or EHR Total (b)	Number of Patients with Appropriate Screening for Colorectal Cancer (c)
19.	MEASURE: Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer	2202	2202	1314

Section L - HIV Linkage To Care

S.No	HIV Linkage to Care	Total Patients First Diagnosed with HIV (a)	Charts Sampled or EHR Total (b)	Number of Patients Seen Within 90 Days of First Diagnosis of HIV (c)
20.	MEASURE: Percentage of patients whose first ever HIV diagnosis was made by health center staff between October 1, of the prior year and September 30, of the measurement year and who were seen for follow-up treatment within 90 days of that first-ever diagnosis	0	0	0

Section M - Preventive Care And Screening: Screening For Depression And Follow-Up Plan

S.No	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Total Patients Aged 12 and Older (a)	Charts Sampled or EHR Total (b)	Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate (c)
21.	MEASURE: Percentage of patients 12 years of age and older who were (1) screened for depression with a standardized tool and, if screening was positive,(2) had a follow-up plan documented	3558	3558	1299

Section N - Dental Sealants For Children Between 6-9 Years

S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
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S.No	Dental Sealants for Children between 6-9 Years	Total Patients Aged 6 through 9 at Moderate to High Risk for Caries (a)	Charts Sampled or EHR Total (b)	Number of Patients with Sealants to First Molars (c)
22.	MEASURE: Percentage of children 6 through 9 years of age at moderate to high risk of caries who received a sealant on a first permanent molar	54	54	32

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Table 7 - Health Outcomes and Disparities

Deliveries and Birth Weight

S.No	Prenatal Services	Patients (a)
0	HIV-Positive Pregnant Women	0
2	Deliveries Performed by Health Center's Providers	0

Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
1a.	Asian	0	0	0	0
1b1.	Native Hawaiian	0	0	0	0
1b2.	Other Pacific Islander	0	0	0	0
1c.	Black/African American	0	0	0	0
1d.	American Indian/Alaska Native	0	0	0	0
1e.	White	0	0	0	0
1f.	More Than One Race	0	0	0	0
1g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Hispanic/Latino		0	0	0	0

Non-Hispanic/Latino

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
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S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
2a.	Asian	0	0	0	0
2b1.	Native Hawaiian	0	0	0	0
2b2.	Other Pacific Islander	0	0	0	0
2c.	Black/African American	0	0	0	0
2d.	American Indian/Alaska Native	0	0	0	0
2e.	White	15	0	1	5
2f.	More Than One Race	0	0	0	0
2g.	Unreported/Refused to Report Race	0	0	0	0
Subtotal Non-Hispanic/Latino		15	0	1	5




Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Prenatal Care Patients Who Delivered During the Year (1a)	Live Births: < 1500 grams (1b)	Live Births: 1500 - 2499 grams (1c)	Live Births: > = 2500 grams (1d)
h.	Unreported/Refused to Report Race and Ethnicity	0	0	0	0
i.	Total	15	0	1	5




Controlling High Blood Pressure

Hispanic/Latino




S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
------	--------------------	---	--	---

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
1a.	Asian	0	0	0
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	2	2	1
1d.	American Indian/Alaska Native	0	0	0
1e.	White	15	15	13
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	9	9	7
Subtotal Hispanic/Latino		 26	 26	 21

Non-Hispanic/Latino




S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
2a.	Asian	7	7	7
2b1.	Native Hawaiian	2	2	1
2b2.	Other Pacific Islander	0	0	0
2c.	Black/African American	13	13	8
2d.	American Indian/Alaska Native	4	4	4
2e.	White	1207	1207	881
2f.	More Than One Race	0	0	0
2g.	Unreported/Refused to Report Race	8	8	6
Subtotal Non-Hispanic/Latino		 1241	 1241	 907

Unreported/Refused to Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 85 Years of Age with Hypertension (2a)	Charts Sampled or EHR Total (2b)	Patients with Hypertension Controlled (2c)
h.	Unreported/Refused to Report Race and Ethnicity	34	34	23
i.	Total	 1301	 1301	 951




Diabetes: Hemoglobin A1c Poor Control

Hispanic/Latino




S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
1a.	Asian	1	1	0
1b1.	Native Hawaiian	0	0	0
1b2.	Other Pacific Islander	0	0	0
1c.	Black/African American	3	3	1
1d.	American Indian/Alaska Native	0	0	0
1e.	White	7	7	2
1f.	More Than One Race	0	0	0
1g.	Unreported/Refused to Report Race	6	6	3
Subtotal Hispanic/Latino		 17	 17	 6

Non-Hispanic/Latino

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
------	--------------------	--	----------------------------------	---

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
2a.	Asian	7	7	3
2b1.	Native Hawaiian	1	1	0
2b2.	Other Pacific Islander	0	0	0
2c.	Black/African American	8	8	4
2d.	American Indian/Alaska Native	4	4	1
2e.	White	411	411	115
2f.	More Than One Race	0	0	0
2g.	Unreported/Refused to Report Race	7	7	0
Subtotal Non-Hispanic/Latino		 438	 438	 123

Unreported/Refused To Report Race And Ethnicity

S.No	Race and Ethnicity	Total Patients 18 through 75 Years of Age with Diabetes (3a)	Charts Sampled or EHR Total (3b)	Patients with HbA1c >9% or No Test During Year (3f)
h.	Unreported/Refused to Report Race and Ethnicity	9	9	3
i.	Total	 464	 464	 132

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Date of Last Report Refreshed: 03/05/2019 12:04 PM EST

Program Name: Health Center 330

Submission Status: Change Requested







UDS Report - 2018

Table 8A - Financial Costs

Universal











* Column c is equal to the sum of column a and column b.

Financial Costs For Medical Care

S.No	Cost Center	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$
1.	Medical Staff	2460530	619786	 3080316
2.	Lab and X-ray			 0
3.	Medical/Other Direct	294534	366336	 660870
4.	Total Medical Care Services (Sum lines 1-3)	 2755064	 986122	 3741186

Financial Costs For Other Clinical Services

S.No	Services	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$
------	----------	---------------------------	---	---

S.No	Services	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$
5.	Dental	1957089	721952	 2679041
6.	Mental Health	319760	159503	 479263
7.	Substance Use Disorder			 0
8a.	Pharmacy not including pharmaceuticals	3675	926	 4601
8b.	Pharmaceuticals	27313		 27313
9.	Other Professional Specify:			 0
9a.	Vision	295078	113807	 408885
10.	Total Other Clinical Services (Sum lines 5-9a)	 2602915	 996188	 3599103

Financial Costs Of Enabling And Other Services

S.No	Services	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$

S.No	Services	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$
11a.	Case Management	389488		389488
11b.	Transportation	248		248
11c.	Outreach			0
11d.	Patient and Community Education	106921		106921
11e.	Eligibility Assistance	58808		58808
11f.	Interpretation Services			0
11g.	Other Enabling Services Specify:			0
11h.	Community Health Workers			0
11.	Total Enabling Services Cost (Sum lines 11a-11h)	555465	147812	703277
12.	Other Related Services Specify:			0
12a.	Quality Improvement	143640	36182	179822
13.	Total Enabling and Other Services (Sum Lines 11, 12, and 12a)	699105	183994	883099

Facility And Non-Clinical Support Services And Totals

S.No	Services	Accrued Cost (a) \$	Allocation Of Facility and Non-Clinical Support Services (b) \$	Total Cost After Allocation of Facility and Non-Clinical Support Services (c) \$
14.	Facility	630712		
15.	Non-Clinical Support Services	1535592		
16.	Total Facility And Non-Clinical Support Services (Sum Lines 14 And 15)	2166304		
17.	Total Accrued Costs (Sum lines 4+10+13+16)	8223388		8223388
18.	Value of Donated Facilities, Services and Supplies Specify: Space donated by Gateway School for school-based services			30000
19.	Total with Donations (Sum lines 17 and 18)			8253388

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Table 9D - Patient Related Revenue (Scope of Project Only)

[illegible]

S.No	Payer Category	Full Charges This Period (a) \$	Amount Collected This Period (b) \$	Collection of Reconciliati / Wrap Around Current Year (c1) \$	Collection of Reconciliati / Wrap Around Previous Year (c2) \$	Collection of Other Payments: P4P, Risk Pools, etc. (c3) \$	Penalty / Payback (c4) \$	Allowances (d) \$	Sliding Fee Discounts (e) \$	Bad Debt Write Off (f) \$
8b.	Other Public including Non-Medicaid CHIP (Managed Care fee-for- service)									
9.	Total Other Public (Sum lines 7+8a+8b)	0	0	0	0	0	0	0		
10.	Private Non-Managed Care	1536276	898846					556746		
11a.	Private Managed Care (capitated)									
11b.	Private Managed Care (fee-for-service)	1033105	657692			37698		399101		
12.	Total Private (Sum lines 10+11a+11b)	2569381	1556538			37698	0	955847		
13.	Self-pay	1175913	687128						445195	58489
14.	Total (Sum lines 3+6+9+12+13)	7410799	4965602			37698		2031213	445195	58489

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Program Name: Health Center 330



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
Table 9E - Other Revenues

Universal


BPHC Grants (Enter Amount Drawn Down - Consistent With PMS-272)

S.No	Source	Amount (a) \$
1a.	Migrant Health Center	
1b.	Community Health Center	1719762
1c.	Health Care for the Homeless	
1e.	Public Housing Primary Care	
1g.	Total Health Center (Sum lines 1a through 1e)	 1719762
1j.	Capital Improvement Program Grants	367080
1k.	Capital Development Grants, including School Based Health Center Capital Grants	
1.	Total BPHC Grants (Sum lines 1g+1j+1k)	 2086842

Other Federal Grants

S.No	Source	Amount (a) \$
2.	Ryan White Part C HIV Early Intervention	
3.	Other Federal Grants Specify:	
3a.	Medicare and Medicaid EHR Incentive Payments for Eligible Providers	8500
5.	Total Other Federal Grants (Sum lines 2-3a)	 8500

Non-Federal Grants Or Contracts

S.No	Source	Amount (a) \$
6.	State Government Grants and Contracts Specify: DPH1422, Dept of Early Ed & Care, DSRIP, DPH School Based, Mass Office of Victim Assistance, State Navigator	474006
6a.	State/Local Indigent Care Programs Specify: State Free Care	397855
7.	Local Government Grants and Contracts Specify: Northern Hilltown Council on Aging, Pioneer Valley Planning Commission, Hilltown Community Dev. Corp, Friends of Hilltown Safety at Home, Safe Passage, Highland Valley Elder Services	187973
8.	Foundation/Private Grants and Contracts Specify: Mass Development, BCBS, Cooley Dickinson Hospital, Holyoke YMCA, City of Northampton, Mass League of Comm Hlth Ctrs, Scholastic, UMass, United Way	224393
9.	Total Non-Federal Grants and Contracts (Sum lines 6+6a+7+8)	 1284227
10.	Other Revenue (non-patient related revenue not reported elsewhere) Specify: Dividend Income, Unrealized gain/loss on investments, Mavis Rolland Fund donation, Donations, Pledges, Rental income, Interest income, medical report income	84929
11.	Total Revenue (Sum lines 1+5+9+10)	3464498

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UDS Report - 2018

Health Center Health Information Technology (HIT) Capabilities

HIT

1. Does your center currently have an Electronic Health Record (EHR) system installed and in use?:

☒ Yes, installed at all sites and used by all providers

☐ Yes, but only installed at some sites or used by some providers

☐ No

1a. Is your system certified by the Office of the National Coordinator for Health IT (ONC) Health IT Certification Program?:

☒ Yes

☐ No

Vendor: eClinicalWorks, LLC

Other (Please specify):

Product Name: eClinicalWorks version

Version Number: 10

ONC-certified Health IT Product List Number: 07312014-3002-1

Vendor:

Other (Please specify):

Product Name:

Version Number:

1b. Did you switch to your current EHR from a previous system this year?:

☐ Yes

☒ No

1c. How many sites have the EHR system in use?:

1d. How many providers use the EHR system?:

1e. When do you plan to install the EHR system?:

☐ a. 3 months

☐ b. 6 months

☐ c. 1 Year or more

☐ d. Not planned

2. Does your center send prescriptions to the pharmacy electronically? (Do not include faxing):

☒ Yes

☐ No

☐ Not Sure

3. Does your center use computerized, clinical decision support, such as alerts for drug allergies, checks for drug-drug interactions, reminders for preventive screening tests, or other similar functions?:

☒ Yes

☐: No

☐: Not Sure

4. Does your center exchange clinical information electronically with other key providers/health care settings, such as hospitals, emergency rooms, or subspecialty clinicians?:

☒: Yes

☐: No

☐: Not Sure

5. Does your center engage patients through health IT, such as patient portals, kiosks, or secure messaging (i.e., secure email) either through the EHR or through other technologies?:

☒: Yes

☐: No

☐: Not Sure

6. Does your center use the EHR or other health IT system to provide patients with electronic summaries of office visits or other clinical information when requested?:

☒: Yes

☐: No

☐: Not Sure

7. How do you collect data for UDS clinical reporting (Tables 6B and 7)?:

☐: We use the EHR to extract automated reports

☐: We use the EHR but only to access individual patient charts

☒: We use the EHR in combination with another data analytic system

☐: We do not use the EHR

8. Are your eligible providers participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program commonly known as Meaningful Use?:

☐: Yes, all eligible providers at all sites are participating

☐: Yes, some eligible providers at some sites are participating

☐: No, our eligible providers are not yet participating

☒: No, because our providers are not eligible

☐: Not Sure

8a. If yes (a or b), at what stage of Meaningful Use (MU) are the majority (more than half) of your participating providers attested (i.e., what is the stage for which they most recently received incentive payments)?:

☐: Received MU for Modified Stage 2

☐: Received MU for Stage 3

☐: Not Sure

8b. If no (c only), are your eligible providers planning to participate?:

☐: Yes, over the next 3 months

☐: Yes, over the next 6 months

☐: Yes, over the next 12 months or longer

☐: No, they are not planning to participate

9. Does your center use health IT to coordinate or to provide enabling services, such as outreach, language translation, transportation, case management, or other similar services?:

☒: Yes

☐: No

If yes, specify the type(s) of service: Outreach, case management, language translation requirements

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UDS Report - 2018

Other Data Elements

Other Data Elements

1. Medication-Assisted Treatment (MAT) for Opioid Use Disorder

1a. How many physicians, certified nurse practitioners and physician assistants, on-site or with whom the health center has contracts, have obtained a Drug Addiction Treatment Act of 2000 (DATA) waiver to treat opioid use disorder with medications specifically approved by the U.S. Food and Drug Administration (FDA) for that indication?: 0

1b. How many patients received medication-assisted treatment for opioid use disorder from a physician, certified nurse practitioner, or physician assistant, with a DATA waiver working on behalf of the health center?: 0

2. Did your organization use telehealth in order to provide remote clinical care services? (The term 'telehealth' includes 'telemedicine' services, but encompasses a broader scope of remote healthcare services. Telemedicine is specific to remote clinical services whereas telehealth may include remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.):

☐: Yes

☒: No

2a1. Who did you use telehealth to communicate with? (Select all that apply):

☐: Patients at remote locations from your organization (e.g., home telehealth, satellite locations)

☐: Specialists outside your organization (e.g., specialists at referral centers)

2a2. What telehealth technologies did you use? (Select all that apply):

☐: Real-time telehealth (e.g., video conference)

☐: Store-and-forward telehealth (e.g., secure email with photos or videos of patient examinations)

☐: Remote patient monitoring

☐: Mobile Health (mHealth)

2a3. What primary telehealth services were used at your organization? (Select all that apply):

☐: Primary care

☐: Oral health

☐: Behavioral health: Mental health

☐: Behavioral health: Substance use disorder

☐: Dermatology

☐: Chronic conditions

☐: Disaster management

☐: Consumer and professional health education

☐: Other (Please specify)

Other (Please specify):

2b. If you did not have telehealth services, please comment why (Select all that apply):

☐: Have not considered/unfamiliar with telehealth service options

☐: Lack of reimbursement for telehealth services

☐: Inadequate broadband/telecommunication service (Select all that apply)

☐: Lack of funding for telehealth equipment

☐: Lack of training for telehealth services

☐: Not needed

☒: Other (Please specify)

Other (Please specify): We have received funding to implement telehealth and will do so in 2019.

Inadequate broadband/telecommunication service (Select all that apply):

☐: Cost of service

☐: Lack of infrastructure

☐: Other (Please specify)

Other (Please specify):

3. Provide the number of all assists provided during the past year by all trained assisters (e.g., certified application counselor or equivalent) working on behalf of the health center (employees, contractors, or volunteers), regardless of the funding source that is supporting the assisters' activities. Outreach and enrollment assists are defined as customizable education sessions about affordable health insurance coverage options (one-on-one or small group) and any other assistance provided by a health center assister to facilitate enrollment.

Enter number of assists: 7848

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Date Requested: 03/05/2019 12:06 PM EST

Date of Last Report Refreshed: 03/05/2019 12:06 PM EST

Program Name: Health Center 330

Submission Status: Change Requested

UDS Report - 2018

Data Audit Report

Table 3A-Patients by Age and by Sex Assigned at Birth

Edit 03951: Numbers Questioned For Patients Aged 65+ - Patients aged 65 and older is outside the typical range when compared to total patients. Please correct or explain. Persons aged 65 and older: (1727); Total Patients(8571); Ratio of Persons aged 65+ to Total Patients(0.20)

Related Tables: Table 3A(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:22 AM EST: Number of patients aged 65 and older is correct.

Table 3B-Demographic Characteristics

Edit 05142: Unreported Race/Ethnicity in Question - A large proportion of patients (27.21)% are reported as having no race or ethnicity on Line 7 Col c: Unreported/Refused to report race. Please correct or explain.

Related Tables: Table 3B(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:23 AM EST: Confirmed that this data was unreported.

Table 4-Selected Patient Characteristics

Edit 03860: Income as Percent of Poverty Level in Question. - Number of patients reported with income over 200% FPL Line 4 Column (a) (2168) is greater than 25% of the total patients reported (8571). Income must be verified. If income is not verified, please report patients under unknown income. Please correct or explain.

Related Tables: Table 4(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:25 AM EST: Income was verified and the number of patients is accurate.

Table 5-Staffing and Utilization

Edit 00158: PA Productivity Questioned - A significant change in Productivity (visits/FTE) of PAs on Line 9b (1931) is reported from the prior year (950). Please check to see that the FTE and visit numbers are entered correctly.

Related Tables: Table 5(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:30 AM EST: Confirmed that FTE and visit numbers are accurate.

Edit 04135: Substantial Inter-year variance in Providers - The number of Mid-Level FTEs reported on Line 10a Column a differs from the prior year. Current Year - (6.21). Prior Year - (4.95). Confirm that this is consistent with staffing changes and that the FTE is calculated based on paid hours.

Related Tables: Table 5(UR)

Patricia Kirouac (Health Center) on 02/15/2019 7:35 AM EST: Confirmed that the numbers reported are accurate.

Edit 06349: Mental Health Visit per Patient in Question - On Universal - Mental Health visits per mental health patient varies substantially from national average.CY (9.12); PY National Average (4.82). Please correct and explain.

Related Tables: Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 12:21 PM EST: Reviewed and we believe this is correct, we have integrated BH into our practice.

Table 6A-Selected Diagnoses and Services Rendered

Edit 02170: Pap Test Patients Questioned - The number of patients who had a pap test reported Line 23 Column (b) (137) on Table 6A, is unreasonably low based on the number of women aged 21-64 reported on Table 3A (2984). Check to be sure that you are using the CPT Code or the ICD Code, not both.

Related Tables: Table 6A(UR), Table 3A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:14 AM EST: We have verified that this number is correct. The explanation is twofold - we serve an older population that clinically only needs a pap test done every five years, which brings down the number completed, and we have had turnover in our providers, which has affected our consistency with completing the test.

Edit 06350: Dental Sealant Visits in Question - You are reporting (3) dental sealant visits per dental patient. This is high compared to the national average. Only count dental sealants on this line if they occurred at a dental visit by a dental provider (dentist or hygienist) in a clinic setting (do not count sealants that were done by a non-dental provider, or as part of a mass screening (for example- health fair). Please correct or explain.

Related Tables: Table 6A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:10 AM EST: We have verified that this number is correct. A large number of patients, some of whose parents had previously refused sealants, had three or four molars treated at once, which increased the number of visits per patient.

Table 6B-Quality of Care Indicators

Edit 05772: Line 10 Universe in Question - You are reporting (68.12)% of total possible medical patients in the universe for the Childhood Immunization measure (line 10 Column A). This appears low compared to estimated medical patients in the age group being measured. Please review and correct or explain.

Related Tables: Table 6B, Table 3A(UR), Table 4(UR), Table 5(UR)

Eliza Lake (Health Center) on 02/15/2019 9:28 AM EST: We have verified that this number is correct. We live in a community where many parents choose to only vaccinate their children with some available vaccines, or none at all.

Edit 05894: Missing Clinical Measure - You report no patients newly diagnosed with HIV. Please confirm that this is the case. If not, please complete Line 20.

Related Tables: Table 6B, Table 3A(UR)

Eliza Lake (Health Center) on 02/15/2019 9:25 AM EST: We have verified that this number is correct. There were no newly diagnosed patients with HIV in 2018.

Table 7-Health Outcomes and Disparities

Edit 05088: Deliveries in question - A large difference between deliveries and births is reported. Please correct or explain. Deliveries (15); Births (6).

Related Tables: Table 7

Eliza Lake (Health Center) on 02/15/2019 9:30 AM EST: We have verified that this number is correct, based on the data available. HCHC does not provide prenatal obstetrical care, and refers out all pregnant patients. While every effort is made to receive delivery data for patients, we do not always receive it, particularly if the child is not then enrolled as a patient at HCHC.

Edit 06316: Hypertension Patients by Race or Ethnicity in Question - The total number of Asian patients with hypertension reported on Table 7 (7) is low compared to total Asian patients reported on Table 3B (76). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06324: Hypertension Patients by Race or Ethnicity in Question - The total number of Hispanic/Latino patients with hypertension reported on Table 7 (26) is low compared to total Hispanic/Latino patients reported on Table 3B (270). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06326: Hypertension Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with hypertension reported on Table 7 (34) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (2332). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:38 AM EST: We have verified that this data is correct.

Edit 06332: Diabetes Patients by Race or Ethnicity in Question - The total number of White patients with Diabetes reported on Table 7 (418) is low compared to total White patients reported on Table 3B (5873). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06334: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to report race patients with diabetes reported on Table 7 (13) is low compared to total Unreported/Refused to report race patients reported on Table 3B (158). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:36 AM EST: We have verified that this data is correct.

Edit 06335: Diabetes Patients by Race or Ethnicity in Question - The total number of Hispanic/Latino patients with diabetes reported on Table 7 (17) is low compared to total Hispanic/Latino patients reported on Table 3B (270). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06336: Diabetes Patients by Race or Ethnicity in Question - The total number of Non-Hispanic/Latino patients with diabetes reported on Table 7 (438) is

low compared to total Non-Hispanic/Latino patients reported on Table 3B (5969). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:37 AM EST: We have verified that this data is correct.

Edit 06337: Diabetes Patients by Race or Ethnicity in Question - The total number of Unreported/Refused to Report Race and Ethnicity patients with diabetes reported on Table 7 (9) is low compared to total Unreported/Refused to Report Race and Ethnicity patients reported on Table 3B (2332). Please correct or explain.

Related Tables: Table 7, Table 3B(UR)

Eliza Lake (Health Center) on 02/15/2019 9:38 AM EST: We have verified that this data is correct.

Table 8A-Financial Costs

Edit 04117: Cost Per Visit Questioned - Total Medical Care Cost Per Visit is substantially different than the prior year. Current Year (223.80); Prior Year (195.44).

Related Tables: Table 8A, Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 10:54 AM EST: Yes costs are up.

Edit 06306: Costs and FTE Questioned - Quality Improvement is reported on Table 8A, Line 12a (143640) and Table 5, Line 29b (1.91). Review and confirm that FTEs relate to costs or correct.

Related Tables: Table 8A, Table 5(UR)

Frank Mertes (Health Center) on 02/15/2019 10:59 AM EST: Confirmed that FTE is correctly related to quality costs

Edit 03727: Inter-Year Variance Questioned - Current Year Facility costs vary substantially from last years cost for Line 14 Column a on Table 8A. (Current Year: (630712); Prior Year: (443297)). Please correct or explain.

Related Tables: Table 8A

Frank Mertes (Health Center) on 02/15/2019 10:43 AM EST: Amount correct we added a new site in FY 2018

Edit 03945: Inter-Year variance questioned - Current Year Non-Clinical Support costs, Line 15 Column (a) (1535592) varies substantially from cost on the same line last year (1793296). Please correct or explain.

Related Tables: Table 8A

Frank Mertes (Health Center) on 02/15/2019 10:53 AM EST: Amount correct in PY we had significant fundraising costs and related staff. We also had a 50K charge for the membership in the ACO in the PY. We were also short staffed in the billing department for FY 2018.

Table 9D-Patient Related Revenue (Scope of Project Only)

Edit 03989: Self-pay numbers questioned - more collections and write-offs than charges - More collections and write-offs are reported than charges for self-pay, Line 13. Please review that proper re-allocations of all deductibles and co-payments to the self-pay category is being done. Please correct or explain. Current Year Accounts Receivable (-14899); Prior Year Accounts Receivable (54384);

Related Tables: Table 9D

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BHCMIS ID: 010330 - HILLTOWN COMMUNITY HEALTH CENTER, INC.,
Worthington, MA

Date Requested: 03/05/2019 12:06 PM EST

Program Name: Health Center 330
Submission Status: Change Requested

Date of Last Report Refreshed: 03/05/2019 12:06 PM EST

UDS Report - 2018

Comments

Report Comments

HCHC added a new site that provides both medical and dental services. This site opened on June 11, 2018.

Table 7 Comments

HCHC does not provide obstetrical services, but refers all patients out to other providers. The data here is for those patients for whom the data was received back after delivery.

Hilltown CHC
UDS Summary

No. of Patients

	\---FY 2018---/		\---FY 2017---/		\---FY 2016---/		\---FY 2015---/	
HSN/Uninsured	783	9%	651	8%	665	8%	851	10%
Medicaid	2,919	34%	2,777	34%	2,707	34%	2,928	35%
Medicare	1,439	17%	1,248	15%	1,058	13%	1,274	15%
Private	3,430	40%	3,408	42%	3,589	45%	3,233	39%
Total	8,571	100%	8,084	100%	8,019	100%	8,286	100%

FTE's & Visits

	\---FY 2018---/		\---FY 2017---/		\---FY 2016---/		\---FY 2015---/	
	Visits	FTE's	Visits	FTE's	Visits	FTE's	Visits	FTE's
Medical Visits	17,637	31.62	18,716	27.62	18,122	27.00	18,497	28.10
Dental Visits	15,500	21.24	14,882	19.07	14,398	18.25	14,653	17.33
Mental Health Visits	4,306	5.09	3,809	4.65	2,928	3.71	3,806	4.33
Vision Visits	2,381	1.56	2,329	1.91	2,282	1.76	2,078	2.00
Enabling Visits	3,870	9.53	3,898	11.27	2,947	13.16	4,666	9.00
	43,694	69.04	43,634	64.52	40,677	63.88	43,700	60.76
All Other Support Staff		31.54		32.44		29.40		28.67
Total Staff		100.58		96.96		93.28		89.43

Selected Quality of Care Measurements

	\---FY 2018---/		\---FY 2017---/		\---FY 2016---/		\---FY 2015---/	
<i>Cervical Cancer Screening</i>								
Total Female Patients Aged 23 through 64		1,710		1,678		1,588		1,691
Number of Patients Tested		632		763		788		578
Percent		37%		45%		50%		34%
<i>Colorectal Cancer Screening</i>								
Total Patients Aged 50 through 75		2,202		2,172		2,056		2,312
Number of Patients with Appropriate Screening for Colorectal Cancer		1,314		1,324		1,211		1,337
Percent		60%		61%		59%		58%
<i>Preventive Care and Screening: Screening for Depression and Follow-Up Plan</i>								
Total Patients Aged 12 and Older		3,558		3,380		3,253		3,297
Number of Patients Screened for Depression and Follow-Up Plan Documented as Appropriate		1,299		994		940		846
Percent		37%		29%		29%		26%

Hilltown CHC
UDS Summary

Cost per Patient

	\\--FY 2018---/	\\--FY 2017---/	\\--FY 2016---/	\\--FY 2015---/	2017 MA Avgerage	2017 Natioanl Avg. (Our size)
Medical Cost	\$ 3,741,186	\$ 3,412,270	\$ 3,170,979	\$ 3,331,559		
Patients	5,392	5,200	5,174	4,952		
Cost per visit	\$ 693.84	\$ 656.21	\$ 612.87	\$ 672.77	\$ 752.82	\$ 601.51
Dental Cost	\$ 2,679,041	\$ 2,492,536	\$ 2,285,298	\$ 2,319,546		
Patients	5,014	4,610	4,527	4,646		
Cost per visit	\$ 534.31	\$ 540.68	\$ 504.82	\$ 499.26	\$ 555.45	\$ 513.03
Mental Health Cost	\$ 479,263	\$ 448,285	\$ 401,004	\$ 423,015		
Patients	472	465	341	345		
Cost per visit	\$ 1,015.39	\$ 964.05	\$ 1,175.96	\$ 1,226.13	\$ 1,147.11	\$ 823.66
Vision Health Cost	\$ 408,885	\$ 371,338	\$ 320,741	\$ 344,062		
Patients	1,485	1,808	1,219	1,009		
Cost per visit	\$ 275.34	\$ 205.39	\$ 263.12	\$ 340.99	\$ 205.93	\$ 223.07

Cost per Visit

	\\--FY 2018---/	\\--FY 2017---/	\\--FY 2016---/	\\--FY 2015---/	2017 MA Avgerage	2017 Natioanl Avg. (Our size)
Medical Cost	\$ 3,741,186	\$ 3,412,270	\$ 3,170,979	\$ 3,331,559		
Visits *	16,717	17,459	17,128	17,109		
Cost per visit	\$ 223.80	\$ 195.44	\$ 185.13	\$ 194.73	\$ 222.17	\$ 192.34
Dental Cost	\$ 2,679,041	\$ 2,492,536	\$ 2,285,298	\$ 2,319,546		
Visits	15,500	14,882	14,398	14,653		
Cost per visit	\$ 172.84	\$ 167.49	\$ 158.72	\$ 158.30	\$ 177.54	\$ 200.31
Mental Health Cost	\$ 479,263	\$ 448,285	\$ 401,004	\$ 423,015		
Visits	4,306	3,809	2,928	3,806		
Cost per visit	\$ 111.30	\$ 117.69	\$ 136.95	\$ 111.14	\$ 173.73	\$ 170.89
Vision Health Cost	\$ 408,885	\$ 371,338	\$ 320,741	\$ 344,062		
Visits	2,381	2,329	2,282	2,078		
Cost per visit	\$ 171.73	\$ 159.44	\$ 140.55	\$ 165.57	\$ 139.06	\$ 168.43

* Does not iclude RN visits in calcaultion



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: HIPAA PRIVACY MANAGEMENT POLICY

REGULATORY REFERENCE: Title 45 CFR 164.500 – 534(e)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring the confidentiality and privacy of its patients and to establish procedures to prevent, detect, contain, and correct violations.

Policy:

1. HCHC's patient privacy process must include policies and procedures for the following:
 - a. Assignment of Security Responsibilities
 - b. Disclosure of PHI with and without patient consent
 - c. HIPAA Documentation requirements
 - d. HIPAA privacy safeguards
 - e. HIPAA training requirements
 - f. A patient's right to access and copy
 - g. Handling requests for confidential communication and access restrictions
 - h. Handling requests for amendments to records
 - i. Safeguarding deceased patient information
 - j. Use of Business Associate Agreements
 - k. Procedures for reporting violations
2. This policy will serve as the overarching HIPAA Privacy Policy. Its approval by the Board of Directors signifies subsequent approval of all underlying policies as identified in the above listing.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018

Approved by Board of Directors, Date: _____

Approved by:

Eliza B. Lake
Chief Executive Officer, HCHC

Date: _____

John Follet, MD
Chair, HCHC Board of Directors



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: ASSIGNED HIPAA PRIVACY OFFICER

REGULATORY REFERENCE: Title 45 CFR 164.500 – 534(e)

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that patient privacy is protected.

Policy:

1. HCHC's Chief Executive Officer is designated as the HIPAA Privacy Officer and is responsible for the development and implementation of all policies and procedures necessary to appropriately protect the confidentiality of HCHC patients.
2. The Privacy Officer's duties and responsibilities include but are not limited to
 - a. Maintain current knowledge of applicable federal and state privacy laws.
 - b. Maintain all business associate agreements and respond appropriately if problems arise.
 - c. Oversee all policies and procedures for addressing patient requests for confidential communications, restrictions to access, requests to obtain or amend patient records, or obtain accountings of disclosures.
 - d. Oversee grievance and appeal processes for denials or requests related to patient access or amendments.
 - e. Oversee the privacy training for the organization.
 - f. Participate in disciplinary actions where appropriate, related to the failure of the practice's workforce to comply with the practice's privacy policies and procedures and the Privacy Rule.
 - g. Cooperate with the Office of Civil Rights in any compliance review or investigation.
 - h. Perform periodic review and assessment of ongoing compliance.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy All Clinical Departments

SUBJECT: CLINICAL RECORD DOCUMENTATION, STORAGE AND ARCHIVING
REGULATORY REFERENCE: 42 CFR 51c.303(c)(1)-(2)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the documentation, storage and destruction of clinical records, both hard-copy and electronic.

Policy:

1. All clinical charts for active patients will be completed using the electronic medical record (EMR) or Electronic Dental Record (EDR).
2. New patients will have their paper charts abstracted in accordance with the abstraction protocol. Once abstracted, clinical charts will be put in secure storage in the Worthington record storage facility.
3. In cases where film dental X-rays are necessary, dental charts will be kept secured in the dental reception area.
4. Hard copy charts will be kept for a minimum of 20 years following the last annotation after which time they will be destroyed.

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

Originally Drafted: APR 2014

Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: DISCLOSURE OF BEHAVIORAL HEALTH PHI REQUIRING PATIENT CONSENT

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for disclosing patient behavioral health information that requires patient authorization.

Policy:

1. All psychotherapy notes require patient authorization for disclosure except for the following:
 - a. Use by the originator of the psychotherapy notes for treatment.
 - b. Use or disclosure by the covered entity in training programs where students, trainees or practitioners learn under supervision to practice or improve their skills.
 - c. Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual.
2. An authorization to release patient health information will be scanned into the patient's chart and filed in patient documents.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: DISCLOSURE OF PHI REQUIRING PATIENT CONSENT

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for disclosing patient information that requires patient authorization

Policy:

1. All psychotherapy notes require patient authorization for disclosure except for the following:
 - a. Use by the originator of the psychotherapy notes for treatment.
 - b. Use or disclosure by the covered entity in training programs where students, trainees or practitioners learn under supervision to practice or improve their skills.
 - c. Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual.
2. An authorization to release patient health information will be scanned into the patient's chart and filed in patient documents.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: HIPAA DOCUMENTATION REQUIREMENTS

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process storing and destroying HIPAA related documentation.

Policy:

1. All documentation related to HIPAA privacy implementation must be maintained for six (6) years.
2. Documentation includes but is not limited to
 - a. Notice of Privacy Practices (Privacy Notice) and any subsequent revisions.
 - b. Written acknowledgement by patient of receipt of the Privacy Notice or the reason documented for not being able to obtain patient acknowledgment.
 - c. Copies of any patient requests made for confidential communications, restrictions to uses and disclosures and any related agreements or denials to the requests.
 - d. Copies of any requests for inspection or copying of medical records made by patients and any subsequent denials.
 - e. Copies of any requests made to have the practice amend the record and any subsequent denials.
 - f. Accounting of disclosures as required by the privacy rule.
 - g. Copies of all signed authorizations.
 - h. Copies of all complaints received and any disposition.
 - i. Documentation of workforce privacy policy and procedure training.
 - j. Any employee sanctions that are applied as a result of non-compliance.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: HIPAA TRAINING REQUIREMENT

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that all employees receive required HIPAA training.

Policy:

1. New employees will receive training on the HIPAA privacy rule within ten (10) working days of their start date.
2. All employees will receive annual HIPAA training conducted through the use of HCHC's online training system through HealthStream, at an In-service session, or through some other means provided by the organization. The In-service attendance roster will serve as verification of that training.
3. The Human Resources Coordinator will include proof of annual training in every staff members' personnel file.
4. The Human Resources Coordinator will work with Supervisors and Managers to ensure that all staff complete their training as required by this policy and regulation.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: PATIENT'S RIGHT TO ACCESS, INSPECT AND/OR COPY

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for complying with a patient's right to access and inspect or copy their clinical records.

Policy:

1. Requests to access, inspect or copy clinical charts must be made in writing.
2. The Practice Manager or delegated representative will conduct the initial review of requests.
3. If access is denied, the denial must be made in writing and must include the basis for denial, instructions of filing an appeal or a complaint to the Privacy Officer and the contact information of the Privacy Officer.
4. A patient may request a denial be reviewed by a licensed health care provider provided the denial was based on reviewable grounds.
5. Copying of patient charts will be in accordance with the HCHC Clinical Records Request Policy.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018

Procedure:

A patient may request a denial be reviewed by a licensed health care provider provided the denial was based on reviewable grounds.

1. Requests to review records may be denied by the practice.
2. Denials are deemed to be unreviewable if they are based on any of the following:
 - a. The records contain psychotherapy notes
 - b. The records are part of information compiled in reasonable anticipation of or for use in a civil, criminal or administrative action or proceeding
 - c. The records contain information obtained from someone else other than a health care provider under a promise of confidentiality and access would likely reveal the source of the information.
3. In the event of an unreviewable denial, the patient may not be granted a review of the denial but does have the right to file a complaint with the Privacy Officer or with the Office of Civil Rights.
4. Denials are deemed to be reviewable if they are based on any of the following:
 - a. Licensed health care professional, using professional judgment, determines access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
 - b. The information makes reference to another person (other than a health care provider) and the licensed health care professional, using professional judgment, determines access is reasonably likely to cause substantial harm to the other person.
 - c. The request for access is made by the individual's personal representative and a licensed health care professional, using professional judgment, determines provision of access to the personal representative is reasonably likely to cause substantial harm to the individual or another person.
5. In the event of a reviewable denial, the review will be conducted by a licensed health care provider, designated by HCHC, who did not participate in the original decision to deny access.
6. The review will be conducted within two weeks of notification of denial.
7. The reviewer will communicate their decision to the HCHC Privacy Officer within five (5) days of conducting the review.
8. The privacy officer will make written notification to the patient within 48 business hours.



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: PHYSICAL SAFEGUARDS FOR PATIENT PRIVACY

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that physical safeguards are in place to protect patient privacy.

Policy:

1. Written patient information will be kept confidential in public places.
2. Hallway phones are not to be used for calls which will include protected health information.
3. Computers screens will be placed in such a way that patient information is not visible by patients, or screen protectors must be used.
4. Every effort will be made to keep conversations with patients, whether by phone or in person, confidential.
5. All visitors to the agency must register and sign in at the Front Desk. Visitors will be given a badge upon registering and will return the badge upon leaving. Visitors are not allowed in any confidential areas, including but not limited to provider and nurse's offices and front desk areas.
6. Any printed PHI will be placed in the locked shredder bin(s) for destruction.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: REPORTING OF ALLEGED VIOLATIONS

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for reporting alleged violations and mitigating potential harm from those violations.

Policy:

1. Patients and employees may both file complaints of alleged violations of the Privacy Act.
2. Complaints will be forwarded to the Privacy Officer for investigation.
3. The Privacy Officer will report the violation and investigation to the Office of Civil Rights (OCR) as required by statute.
4. The Privacy Officer will make mitigation and sanction recommendations to the appropriate department director based on the severity of the violation.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: REQUESTS FOR CONFIDENTIAL COMMUNICATION OR RESTRICTED ACCESS TO ELECTRONIC CHART

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for handling a patient's request for confidential communication or to have access to their chart restricted.

Policy:

1. Patients have a right to request reasonable confidential communication from HCHC.
2. Request(s) for confidential communication must be made in writing.
3. Patients may request, in writing, to have access to their electronic clinical record restricted to specific individuals.

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

Originally Drafted: APR 2003

Reviewed or Revised: FEB 2018

Procedure:**Patients have a right to request reasonable confidential communication from HCHC.**

1. Patients will fill out a request for confidential communication contained in the standard registration packet.
2. Patients may change their authorization at any time provided it is done in writing
3. Once completed, the registration packet will be scanned into the patient documents section of the electronic record.

Patients may request, in writing, to have access to their electronic clinical record restricted to specific individuals

1. Patients requesting restricted access to their electronic record must do so in writing.
2. This request will be reviewed by the provider prior to restricting access.
 - a. A provider is not required to agree to a restriction.
 - b. An agreed upon restriction must be documented.
 - c. The following will be used to evaluate the request:
 - 1) Would we be able to provide or continue treatment if we honor the request?
 - 2) Would we be able to submit a valid claim if we were to honor the request?
 - 3) How would our agreement impact operations – can we operationally implement request?
 - 4) Would we be able to enforce the restriction internally now and in the future?
3. Once approved, the EHR Specialist will restrict access to the patient's chart in accordance with the patient's documented request.
4. Charts with restricted access will be reviewed on an annual basis for necessity.
5. Patients must be informed that such restriction could result in delays in receiving treatment



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: SAFEGUARDING PATIENT INFORMATION OF DECEASED PATIENTS
REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to safeguard the protected health information (PHI) of deceased patients

Policy:

1. PHI of deceased patients shall be afforded the same protection as active patients.
2. PHI may be disclosed to coroners and medical examiners for identification purposes of to determine the cause of death.
3. PHI may be disclosed to funeral directors as necessary to carry out their duties with respect to the decedent. Such disclosure may be made prior to but in anticipation of the patient's death.
4. PHI may be released to an executor, administrator or other person having authority to act on behalf of the deceased patient or the patient's estate provided such access is under law.

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: USES AND DISCLOSURES OF PHI WITHOUT PATIENT CONSENT

REGULATORY REFERENCE: 45 CFR 164.504

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to regulate the disclosure and use of protected health information (PHI).

Policy:

1. PHI may be disclosed without patient consent provided it is used for Treatment, Payment or ongoing operations.
2. PHI may be disclosed to another covered entity without patient consent provided it is used for treatment, payment or ongoing operations AND the covered entity has a current relationship with the patient.
3. PHI disclosed must always follow the “Minimum Necessary” guidelines.
4. PHI may be disclosed without consent as required by law, including law enforcement officials and court orders or subpoenas.
5. PHI may be disclosed without consent to a public health agency that is permitted by law to access PHI to control disease, injury or disability. These agencies include but are not limited to MA DPH and the U.S. FDA

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

Originally Drafted: APR 2003

Last Reviewed or Revised: FEB 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: SECURITY MANAGEMENT PROCESS POLICY

REGULATORY REFERENCE: 45 CFR 164.308(a)(1)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring the confidentiality, integrity, and availability of its information systems containing EPHI (Electronic Protected Health Information) by implementing policies and procedures to prevent, detect, contain, and correct security violations.

Policy:

1. HCHC's security management process must include policies and procedures for the following:
 - a. Assignment of Security Responsibilities
 - b. Defining the appropriate access, control and supervision of workforce members
 - c. Contingency planning, data backup planning and media controls
 - d. Facility and Information Access Controls
 - e. Risk Analysis & Management
 - f. Policy violation sanction
 - g. Security Awareness Training
 - h. Security Incident Reporting
 - i. Workforce Clearance and Security
 - j. Acceptable Use of company-owned workstations
2. This policy will serve as the overarching Information Security Policy. Its approval by the Board of Directors signifies subsequent approval of all underlying policies as identified in the above listing.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018

Approved by Board of Directors, Date: _____

Approved by:

Eliza B. Lake
Chief Executive Officer, HCHC

Date: _____

John Follet, MD
Chair, HCHC Board of Directors



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: ACCESS AUTHORIZATION

REGULATORY REFERENCE: 45 CFR 164.308(a)(4)(ii)(A)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for authorizing appropriate access to HCHC information systems containing EPHI (Electronic Protected Health Information).

Policy:

1. HCHC must have a formal documented process for granting access to HCHC information systems that contain EPHI. At a minimum, the process must include:
 - Procedure for granting different levels of access to HCHC information systems containing EPHI.
 - Procedure for tracking and logging authorization of access to HCHC information systems containing EPHI.
 - Procedure for regularly reviewing and revising, as necessary, authorization of access to HCHC information systems containing EPHI.
2. HCHC workforce members must not be allowed access to information systems containing EPHI until properly authorized.
3. The type and extent of access authorized to HCHC information systems containing EPHI must be based on risk analysis. At a minimum, the risk analysis must consider the following factors:
 - The importance of the applications running on the information system
 - The value or sensitivity of the EPHI on the information system
 - The extent to which the information system is connected to other information systems
4. Access to HCHC information systems containing EPHI must be authorized only for HCHC workforce members having a need for specific information in order to accomplish a legitimate task. All such access must be defined and documented. Such access must also be regularly reviewed and revised as necessary.
5. HCHC workforce members must not attempt to gain access to HCHC information systems containing EPHI for which they have not been given proper authorization.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018

Procedure:

1. Supervisors will fill out IT request form for all new hires and forward to Operations/IT. The level of access to EPHI is determined by role. These are preconfigured in the clinical system.
2. IT will maintain the form on file. Operations will maintain a spreadsheet reflecting access levels and review annually.



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: ACCESS CONTROL

REGULATORY REFERENCE: 45 CFR 164.312(a)(1)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to purchase and implement information systems that comply with HCHC's information access management policies.

Policy:

1. HCHC must purchase and implement information systems that comply with HCHC's information access management policy.
2. As appropriate, HCHC information systems must support one or more of the following types of access control to protect the confidentiality, integrity and availability of EPHI (Electronic Protected Health Information) contained on HCHC information systems:
 - User based
 - Role based
3. As appropriate, security controls or methods that allow access to HCHC information systems containing EPHI must include, at a minimum:
 - Unique user identifiers (user IDs) that enable persons and identities to be uniquely identified. User IDs must not give any indication of the user's privilege level.
 - A secret identifier (password).
 - The prompt removal or disabling of access methods for persons and entities that no longer need access to HCHC EPHI.
 - Verification that redundant user identifiers are not issued.
4. Access to HCHC information systems containing EPHI must be limited to workforce members and software programs that have a need to access specific information in order to accomplish a legitimate task.
5. HCHC workforce members must not provide access to HCHC's information systems containing EPHI to unauthorized persons.
6. All revisions to HCHC workforce member and software program access rights must be tracked and logged. This information must be securely maintained. and, at a minimum, must provide the following information:

- Data and time of revision
 - Identification of workforce member or software program whose access is being revised
 - Brief description of revised access right(s)
 - Reason for revision
7. HCHC workforce members must end electronic sessions between information systems that contain or can access EPHI when such sessions are finished, unless they can be secured by an appropriate locking method.
 8. Software accessing EPHI must be equipped with a feature allowing the system to automatically log the user off after a specified period of time.
 9. Emailing of EPHI is prohibited unless through a secure email system (encrypted through Office365).
 10. Encryption and decryption of stored EPHI is handled by Cooley-Dickinson as we are hosted on their servers.
 11. In the event of an emergency, patient care will be documented using manual means and scanned into the EMR once normal operations have resumed.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: ASSIGNED SECURITY POLICY

REGULATORY REFERENCE: 45 CFR 164.308(a)(2)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to assign a single employee overall final responsibility for the confidentiality, integrity, and availability of its EPHI (Electronic Protected Health Information).

Policy:

1. HCHC's CEO is designated as the Information Security Officer and is responsible for the oversight of the development and implementation of all policies and procedures necessary to appropriately protect the confidentiality, integrity, and availability of HCHC information systems and EPHI.
2. The HCHC Information Security Officer's responsibilities include, but are not limited to:
 - Ensure that no HCHC information system compromises the confidentiality, integrity, or availability of any other HCHC information system.
 - Develop, document, and ensure dissemination of appropriate security policies, procedures, and standards for the users and administrators of HCHC information systems and the data contained within them.
 - Ensure that newly acquired HCHC information systems have features that support required and/or addressable security Implementation Specifications.
 - Ensure HCHC workforce members receive regular security awareness and training.
 - Conduct periodic risk analysis of HCHC information systems and security processes.
 - Develop and implement an effective risk management program.
 - Maintain an inventory of all HCHC information systems that contain EPHI.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: AUDIT CONTROLS

REGULATORY REFERENCE: 45 CFR 164.312(b)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for using appropriate audit controls on its information systems that contain or use EPHI (Electronic Protected Health Information).

Policy:

1. Appropriate hardware, software, or procedural auditing mechanisms must be implemented on HCHC information systems that contain or use EPHI.
2. Logs created by audit mechanisms implemented on HCHC information systems must be reviewed regularly.
3. HCHC's electronic medical record system records:
 - Date and time of significant activity
 - Origin of significant activity
 - Identification of user performing significant activity
 - Description of attempted or completed significant activity
4. Information systems containing EPHI must employ technology to safeguard the integrity of EPHI. This is guaranteed by locking all progress notes in order to bill. Any additional information must be added as an addendum.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: AUTHORIZATION AND/OR SUPERVISION

REGULATORY REFERENCE: 45 CFR 164.308(a)(3)(ii)(A)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to ensure that all workforce members who can access HCHC information systems containing EPHI (Electronic Protected Health Information) are appropriately authorized or supervised.

Policy:

1. HCHC must ensure that the confidentiality, integrity, and availability of EPHI on HCHC information systems is maintained when its information systems are accessed by third parties.
2. Access by third party persons to HCHC information systems containing EPHI or HCHC locations where EPHI can be accessed must be allowed only after appropriate security controls have been implemented and an agreement has been signed defining the terms for access. The agreement must define the following:
 - The security processes and controls necessary to ensure compliance with HCHC's security policies.
 - Restrictions regarding the use and disclosure of HCHC data.
 - HCHC's right to monitor and revoke third party persons' access and activity.
3. Where appropriate, third party persons will be supervised by an appropriate HCHC employee when they are accessing HCHC information systems containing EPHI or in a HCHC location where EPHI might be accessed.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: BUSINESS ASSOCIATES CONTRACTS

REGULATORY REFERENCE:

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to only permit a business associate to create, receive, maintain, or transmit EPHI (Electronic Protected Health Information) on its behalf if there is a written agreement between the two parties which provides assurances that the business associate will appropriately safeguard the information.

Policy:

1. HCHC will permit a business associate to create, receive, maintain, or transmit EPHI on its behalf only if there is a written agreement between the two parties which ensures that the business associate will appropriately and reasonably safeguard the information.
2. Failure on the part of the business associate to adequately safeguard EPHI will result in immediate termination of any business agreements and the launching of an appropriate investigation.
3. The transmission of EPHI by HCHC to a health care provider concerning the treatment of an individual does not require a business associate agreement.
4. All business associate agreements must be documented and will follow the standard business associate agreement language of HCHC.
5. New contracts with existing business associates do not have to be obtained specifically for this purpose, if existing written contracts adequately address the applicable requirements or can be amended to do so.
6. All business agreements must contain specific security-related language governing the protection of any EPHI to which the business associate has access.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: CONTINGENCY PLAN

REGULATORY REFERENCE: 45 CFR 164.308(a)(7)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to effectively prepare for and respond to emergencies or disasters in order to protect the confidentiality, integrity and availability of its information systems.

Policy:

1. HCHC must have a formal process for both preparing for and effectively responding to emergencies and disasters that damage the confidentiality, integrity or availability of its information systems.
2. At a minimum, the process must include:
 - Regular analysis of the criticality of HCHC information systems.
 - Development and documentation of a disaster and emergency recovery strategy consistent with HCHC's business objectives and priorities.
 - Development and documentation of a disaster recovery plan that is in accordance with the above strategy.
 - Development and documentation of an emergency mode operations plan that is in accordance with the above strategy.
 - Regular testing and updating of the disaster recovery and emergency mode operations plans.
3. All EPHI (Electronic Protected Health Information) on HCHC information systems and electronic media must be regularly backed up and securely stored. All medical EPHI is backed up by Cooley-Dickinson and stored according to their plan. Dental EPHI is backed up nightly, both on site and in the cloud.
4. HCHC must have a formal, documented emergency mode operations plan to enable the continuance of crucial business processes that protect the security of its information systems containing EPHI during and immediately after a crisis situation.
5. HCHC must conduct regular testing of its disaster recovery plan to ensure that it is up to date and effective.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: DATA BACKUP PLAN

REGULATORY REFERENCE: 45 CFR 164.308(a)(7)(ii)(A)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to backup and securely store all EPHI (Electronic Protected Health Information) on its information systems and electronic media.

Policy:

1. Backup copies of all EPHI on HCHC electronic media and information systems must be made regularly. This includes both EPHI received by HCHC and created within HCHC.
2. All medical & Behavioral Health EPHI will be backed up in accordance with Cooley-Dickinson's data backup schedule.
3. All Dental EPHI will be backed up and stored on a remote server at the Worthington Health Center.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: DEVICE AND MEDIA CONTROLS

REGULATORY REFERENCE: 45 CFR 164.310(d)(1)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to appropriately control information systems and electronic media containing EPHI (Electronic Protected Health Information) moving into, out of and within its facilities.

Policy:

1. EPHI located on HCHC information systems or electronic media must be protected against damage, theft, and unauthorized access. This includes both EPHI received by HCHC and created within HCHC.
2. Information systems and electronic media for which this policy applies include, but are not limited to, computers (both desktop and laptop), tablets, CD-ROMs, zip drives, portable hard drives and smart phones.
3. All information systems and electronic media containing EPHI must be disposed of securely and safely when no longer required.
4. All EPHI on HCHC information systems and electronic media must be carefully removed before the media or information systems are made available for re-use.
5. All information systems and electronic media containing EPHI that are received or removed from HCHC or move within its facilities must be appropriately tracked and logged.
6. Backup copies of all EPHI located on HCHC information systems or electronic media must be regularly made and stored securely.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: EVALUATION POLICY

REGULATORY REFERENCE: 45 CFR 164.308(a)(8)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to regularly conduct a technical and non-technical evaluation of its security controls and processes.

Policy:

1. HCHC must regularly conduct a technical and non-technical evaluation of its security controls and processes to document its compliance with its security policies and the HIPAA Security Rule.
2. The evaluation may be carried out by an appropriate HCHC business unit such as the information security officer, internal audit department, or a third-party organization that has appropriate skills and experience.
3. HCHC will conduct an annual review of policies and procedures related to security of EPHI (Electronic Protected Health Information).

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: FACILITY ACCESS CONTROLS

REGULATORY REFERENCE: 45 CFR 164.310(a)(1)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to prevent unauthorized physical access to its facilities while ensuring that properly authorized access is allowed.

Policy:

1. HCHC must appropriately limit physical access to the information systems contained within its facilities while ensuring that properly authorized workforce members can physically access such systems.
2. HCHC information systems containing EPHI (Electronic Protected Health Information) must be physically located in such a manner as to minimize the risk that unauthorized persons can gain access to them.
3. All visitors must show proper identification and sign in prior to gaining physical access to HCHC areas where information systems containing EPHI are located.
4. HCHC must have formal, documented procedures for allowing authorized workforce members to enter its facilities to take necessary actions as defined in its disaster recovery and emergency mode operations plans.
5. All repairs / modifications to facility alarm systems are logged by the alarm company.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018

Procedure:

1. **HCHC must appropriately limit physical access to the information systems contained within its facilities while ensuring that properly authorized workforce members can physically access such systems.**
 - a. Access doors will be equipped with electronic proximity locks as budget permits. Installation priority should be based on job requirements, frequency of access and proximity to PHI.
 - b. Employee entry doors will remain secured with electronic HID proximity sensors
 - c. Access will be programmed into the ID badge proximity card.
 - d. Access will be determined by position requirements.
 - e. Server room doors will remain locked and should be equipped with proximity locks as budget permits
2. **All visitors must show proper identification and sign in prior to gaining physical access to HCHC areas where information systems containing EPHI are located.**
 - a. Receptionists will perform a count of visitor badges at the beginning of shift. Missing badges will be reported to Human Resources.
 - b. Reception will ensure that all visitors to the health center are signed in at the front desk.
 - c. Each visitor will be issued a numbered visitor's badge and instructed to have the badge visible while on HCHC property.
 - d. Visitors will sign out and return the visitor's badge prior to leaving the building.
3. **Employees will wear visible ID badges**
 - a. Employees must wear their ID badge while on company property
 - b. The badge must be visible to observers. In other words, it should be displayed on outer garments when inside the building.
 - c. The badge may be affixed using a lanyard, clip or retracting clip. If a lanyard is used, it must be a break-away lanyard.
 - d. Loss of an employee badge must be reported to Human Resources as soon as it is noticed. A new badge will be issued at a cost of \$10.00 to the employee.
 - e. Badges will not be shared by employees
 - f. Failure to report a lost badge will result in disciplinary action.



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: HIPAA SECURITY AWARENESS AND TRAINING

REGULATORY REFERENCE: 45 CFR 164.308(a)(5)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to provide regular HIPAA security awareness and training to its staff.

Policy:

1. HCHC develops, implements, and regularly reviews a formal, documented program for regularly providing appropriate security training and awareness to staff.
2. All HCHC staff are provided with sufficient regular training and supporting reference materials to enable them to appropriately protect HCHC information systems. Initial training must be provided prior to granting access to systems containing PHI (Protected Health Information) and annually for the duration of employment.
3. After training has been conducted, each staff member must verify that he or she has received the training, understood the material presented, and agrees to comply with it.
4. Business associates must be informed of HCHC security policies and procedures on a regular basis. Such awareness can occur through contract language or other means.
5. All HCHC information security policies and procedures must be readily available for reference and review by appropriate employees, business associates, and third-party workers.
6. HCHC must regularly train and remind its staff about its process for guarding against, detecting, and reporting malicious software that poses a risk to its information systems and data.
7. HCHC must regularly train and remind its staff about its process for monitoring log-in attempts and reporting discrepancies.
8. HCHC must regularly train and remind its staff about its process for creating, changing and safeguarding passwords.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: INFORMATION ACCESS MANAGEMENT

REGULATORY REFERENCE: 45 CFR 164.308(a)(4)(i)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for authorizing appropriate access to HCHC information systems containing EPHI (Electronic Protected Health Information).

Policy:

1. Access to HCHC information systems containing EPHI must be managed in order to protect the confidentiality, integrity and availability of EPHI.
2. HCHC must have a formal documented process for granting access to HCHC information systems containing EPHI. At a minimum, the process must include:
 - Procedure for granting different levels of access to HCHC information systems containing EPHI.
 - Procedure for tracking and logging authorization of access to HCHC information systems containing EPHI.
3. HCHC workforce members must not be allowed access to information systems containing EPHI until properly authorized.
4. Appropriate HCHC information system owners or their chosen delegates must define and authorize all access to HCHC information systems containing EPHI.
5. Access to HCHC information systems containing EPHI must be authorized only for HCHC workforce members having a need for specific information in order to accomplish a legitimate task. All such access must be defined and documented. Such access must also be regularly reviewed and revised as necessary.
6. HCHC workforce members must not attempt to gain access to HCHC information systems containing EPHI for which they have not been given proper authorization.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: RISK ANALYSIS

REGULATORY REFERENCE: 45 CFR 164.308(a)(1)(ii)(A)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for conducting accurate and thorough analysis of the potential risks to the confidentiality, integrity, and availability of its information systems containing EPHI (Electronic Protected Health Information).

Policy:

1. The identification, definition and prioritization of risks to HCHC information systems containing EPHI must be based on a formal, documented risk analysis process.
2. HCHC must conduct risk analysis on an annual basis.
3. 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.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: SANCTION POLICY

REGULATORY REFERENCE: 45 CFR 164.308(a)(1)(ii)(C)

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process for applying appropriate sanctions against workforce members who fail to comply with its security policies and procedures.

Policy:

1. HCHC workforce members must understand and comply with all applicable HCHC security policies and procedures. HCHC must provide regular training and awareness for workforce members on HCHC security policies and procedures.
2. HCHC must have a formal, documented process for applying appropriate sanctions against workforce members who do not comply with its security policies and procedures. At a minimum, the process must include:
 - Procedures for detecting and reporting workforce members' non-compliance with HCHC security policies and procedures.
 - Identification and definition of levels of sanctions, including their relative severity.
 - Identification of cause and rationale for issuing of sanction.
 - A defined, formal method for evaluating the severity of non-compliance with HCHC security policies and procedures.
3. Sanctions must be commensurate with the severity of the non-compliance with HCHC security policies and procedures and must occur with appropriate involvement of HCHC's human resources department.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: SECURITY INCIDENT RESPONSE AND REPORTING

REGULATORY REFERENCE: 45 CFR 164.308(a)(6)(i), 45 CFR 164.308(a)(6)(ii)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for detecting and responding to security incidents.

Policy:

1. HCHC must have a formal, documented process for quickly and effectively detecting and responding to security incidents that may impact the confidentiality, integrity, or availability of HCHC information systems.
2. HCHC workforce members must report any observed or suspected security incidents as quickly as possible via HCHC's security incident reporting procedure.
3. A workforce member must not prevent another member from reporting a security incident.
4. HCHC's Information Security Officer, in cooperation with the appropriate department manager, is authorized to investigate any and all alleged violations of HCHC security policies, and to take appropriate action to mitigate the infraction and apply sanctions as warranted.
5. For purposes of analysis and possible prosecution, HCHC must collect appropriate evidence regarding security incidents.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: WORKFORCE CLEARANCE AND SECURITY

REGULATORY REFERENCE: 45 CFR 164.308(a)(3)(ii)(B)

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to allow access to information systems containing EPHI (Electronic Protected Health Information) only to workforce members who have been appropriately authorized.

Policy:

1. HCHC must ensure that all workforce members who have the ability to access HCHC information systems containing EPHI are appropriately authorized or supervised.
2. The background of all HCHC workforce members must be adequately reviewed during the hiring process.
3. When defining a position, the HCHC human resources department and the hiring manager must identify the security responsibilities and supervision required for the position.
4. All HCHC workforce members who access HCHC information systems containing EPHI must sign a confidentiality agreement in which they agree not to provide EPHI or to discuss confidential information to which they have access to unauthorized persons.
5. HCHC must create and implement a formal, documented process for terminating access to EPHI when the employment of a workforce member ends.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018

Procedure:

The background of all HCHC workforce members must be adequately reviewed during the hiring process.

1. Verification checks must be made, as appropriate. Verification checks include, but are not limited to:
 - a. Character references
 - b. Confirmation of claimed academic and professional qualifications, when applicable
 - c. Professional license validation, when applicable
 - d. Criminal background check
 - e. Office of the Inspector General (OIG) database check
2. The type and number of verification checks conducted must be based on the employee's probable access to HCHC information systems containing EPHI and their expected ability to modify or change such EPHI.
3. The extent and type of screening must be based on HCHC's risk analysis process.

When defining a position, the HCHC human resources department and the hiring manager must identify the security responsibilities and supervision required for the position.

1. Security responsibilities include general responsibilities for implementing or maintaining security, as well as any specific responsibilities for the protection of the confidentiality, integrity, or availability of HCHC information systems or processes.

All HCHC workforce members who access HCHC information systems containing EPHI must sign a confidentiality agreement in which they agree not to provide EPHI or to discuss confidential information to which they have access to unauthorized persons.

1. Employees will sign the confidentiality statement at their on-boarding session.
2. The statement will be kept in their personnel file
3. Subsequent statements will not be used but all employees will complete annual HIPAA Privacy & Security training. The proof of annual training will serve as acknowledgement of a confidentiality agreement.



Hilltown Community Health Centers, Inc.

Administrative Policy

All Departments

SUBJECT: WORKSTATION ACCEPTABLE USE

REGULATORY REFERENCE: 45 CFR 164.310(b)

Purpose:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to appropriately use and protect its workstations.

Policy:

1. HCHC workstations must be used only for authorized purposes: to support the research, education, clinical, administrative, and other functions of HCHC.
2. All workforce members who use HCHC workstations must take all reasonable precautions to protect the confidentiality, integrity, and availability of EPHI (Electronic Protected Health Information) contained on the workstations.
3. Workforce members must not use HCHC workstations to engage in any activity that is either illegal under local, state, federal, or international law or is in violation of HCHC policy.
4. Access to all HCHC workstations containing EPHI must be controlled with a username and password.
5. HCHC workstations containing EPHI must be physically located in such a manner as to minimize the risk that unauthorized individuals can gain access to them.
6. HCHC workforce members must activate their workstation locking software whenever they leave their workstation unattended for 20 minutes or more. HCHC workforce members must log off from or lock their workstation(s) when their shifts are complete.
7. Workstations removed from HCHC premises must be protected with security controls equivalent to those for on-site workstations.

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

Originally Drafted: SEP 2012

Reviewed or Revised: MAR 2018

Procedure:

Workforce members must not use HCHC workstations to engage in any activity that is either illegal under local, state, federal, or international law or is in violation of HCHC policy.

Activities that workforce members must not perform while using HCHC workstations include, but are not limited to:

1. Violations of the rights to privacy of protected healthcare information of HCHC's patients.
2. Violations of the rights of any person or company protected by copyright, trade secret, patent, or other intellectual property or similar laws or regulations. This includes, but is not limited to, the installation or distribution of "pirated" or other inappropriately licensed software products.
3. Purposeful introduction of malicious software onto a workstation or network (e.g., viruses, worms, Trojan horses).
4. Purposefully causing security breaches. Security breaches include, but are not limited to, accessing electronic data that the workforce member is not authorized to access or logging into an account that he or she is not authorized to access. HCHC employees that perform this activity as part of their defined job are exempt from this prohibition.
5. Performing any form of network monitoring that will intercept electronic data not intended for the workforce member. HCHC employees that perform this activity as part of their defined job are exempt from this prohibition.
6. Circumvent or attempt to avoid the user authentication or security of any HCHC workstation or account. Employees that perform this activity as part of their defined job are exempt from this prohibition.

Access to all HCHC workstations must be controlled with a username and password.

1. HCHC workforce members must not share passwords with others. If a HCHC workforce member believes that someone else is inappropriately using a user-ID or password, they must immediately notify their manager.
2. Where possible, the initial password(s) issued to a new HCHC workforce member must be valid only for the new user's first logon to a workstation. At initial logon, the user must be required to choose another password.
3. Where possible, this same process must be used when a workforce member's workstation password is reset.

HCHC workstations containing EPHI must be physically located in such a manner as to minimize the risk that unauthorized individuals can gain access to them.

1. The display screens of all HCHC workstations containing EPHI must be positioned such that information cannot be readily viewed through a window, by persons walking in a hallway, or by persons waiting in reception, public, or other related areas.

Workstations removed from HCHC premises must be protected with security controls equivalent to those for on-site workstations.

1. EPHI must not be stored on a portable workstation unless such information is appropriately protected. HCHC security office approved encryption should be used.
2. Locking software for unattended laptops must activate after 20 minutes.
3. HCHC portable workstations must be carried as carry-on (hand) baggage when workforce members use public transport. They must be concealed and/or locked when in private transport (e.g., locked in the trunk of an automobile).
4. Personal laptops will not be permitted access to the HCHC network and are not to be used to access EPHI.

Hilltown Community Health Centers, Inc. Emergency Management Plan



**Hilltown Community
Health Center**

April 2019

Table of Contents

Authorization.....	4
Interim Plan Revisions	5
Record of Distribution.....	7
Section 1 - Program Administration	8
1.1 Executive Summary.....	8
1.2 Purpose	8
1.3 Scope	8
1.4 Emergency Management Committee	9
Section 2 - Situation and Assumptions	9
2.1 Hazard Vulnerability Analysis.....	9
2.2 Key Plan Assumptions	9
Section 3 - Command and Control.....	11
3.1 Incident Command System.....	11
3.2 Notification of Incident and Authority to Activate	12
3.3 Activation	12
3.4 Deactivation	12
3.5 Information Collection, Documentation, Analysis, and Dissemination.....	12
3.6 Roles and Responsibilities	13
Section 4 - Continuity of Operations.....	15
Section 5 - Communications.....	16
5.1 Risk Communications.....	16
5.2 Staff and Patient Notifications	16
5.3 Emergency Mental Health.....	16
5.4 Communications with Partners	17
Section 6 - Buildings, Utilities, Safety and Security	18
6.1 Facilities Management	18
6.2 Evacuation Planning.....	18
6.3 Utility Mapping.....	18
6.4 Safety and Security	18
Section 7 – Finance, Logistics, and Staff Care.....	19
7.1 EOC Set-up	19

7.2	Emergency Supplies and Equipment.....	19
7.3	Staff Scheduling and Care.....	19
7.4	Timekeeping, Payroll, and Human Resource Considerations.....	20
Section 8 - Community Integration.....		21
8.1	Identification of Planning and Response Partners	21
8.2	Coalitions.....	21
8.3	Agreements	21
Section 9 - Plan Development and Maintenance		22
9.1	Plan Development, Review, and Storage	22
9.2	Training, Exercises, and Evaluation.....	22
Section 10 - Standards, Regulations, and Guidelines		24
Plan Appendices, Attachments, and Annexes		25
Appendix A – Hazard Vulnerability Analysis		26
Appendix B - Memoranda of Understanding [in process]		33
Attachment A – ICS Assignment List and Activation Instructions		34
Attachment B - Job Action Sheets		35
Attachment C – Incident Action Plan Quick Start and Activity Log		45
Attachment D - Staff Contact List		53
Attachment E – Partner Contact List.....		55
Attachment F – Draft Emergency Notifications and Activation Messaging		58
Attachment G– Instructions for Responding to Utility Disruptions and Utility Maps.....		61
Attachment H – Vendor Contact List		66
Attachment I - Multi-year Training and Exercise Plan		69
Attachment J – Employee Assistnace Program Resources.....		71
Annex A –Continuity of Operations Plan (COOP)		74
Annex B – Evacuation Plans		76
Annex C – Fire Safety Plan.....		87
Annex D—Hazard-Specific Plans.....		92

Authorization

The Board of Directors has approved this plan, and agree to support and uphold the Emergency Management Plan of Hilltown Community Health Centers, Inc.

John Follet, MD
Chair, Board of Directors

Eliza B. Lake
CEO

Interim Plan Revisions

The following are plan updates based on incidents, exercises, and/or policy changes that have been approved by the Emergency Management Committee and the Board of Directors at Hilltown Community Health Centers, Inc. These edits will be formally incorporated into the document as part of its regular review, which occurs every 12 months.

DATE	PLAN SECTION	REVISION	MADE BY
4/4/2019	Appendix A	Added Hazard Vulnerability Analysis for HHC, WHC, and JPMHC	TG
4/4/2019	Appendix B	Added HPHPC Memoranda	TG
4/4/2019	Attachment B	Added "Weather Job Action Sheet"	TG
4/4/2019	Attachment D	Amended Attach D to include Emergency Management Contacts instead of Instructions for Using Comm. System	TG, EL, DF
4/4/2019	Attachment E	Narrowed down list of relevant partners and inserted in table	TG, EL
4/4/2019	Attachment F	Added extension numbers to access PA system for each site	TG, DW
4/4/2019	Attachment G	Added JPMHC to site list. Drafted shut off instructions for each site.	TG, RJ
4/4/2019	Attachment H	Updated Vendor Contact List and inserted in table	TG
4/4/2019	Attachment I	Updated Training Plan for 2019	EL, TG, DF
4/4/2019	Attachment J	Added Attachment J and UNUM Brochure for Employee Assistance Program	TG
4/4/2019	Annex A	Updated Continuity of Operations Plan	EL
4/4/2019	Annex D	Added "Armed Intruder" to plans	TG

Record of Distribution

NAME	TITLE	ORGANIZATION	# OF COPIES (E)LECTRONIC OR (P)RINT	DATE

Section 1 - Plan Administration

1.1 Executive Summary

This Emergency Management Plan has been developed by Hilltown Community Health Centers, Inc. (HCHC) and is hereby approved for implementation and intended to supersede all previous versions. This Emergency Management Plan was established to promote a system to: save lives; protect the health and ensure the safety of HCHC staff, patients, and facilities; alleviate damage and hardship; and reduce future vulnerability to hazards that may disrupt normal health center operations. Furthermore, this document confirms HCHC's commitment to ongoing planning, training, and exercise activities that promote preparedness and build capabilities to respond to internal or external emergencies and disasters.

1.2 Purpose

The purpose of HCHC's Emergency Management Plan is to improve the capacity to plan for, respond to, recover from, and mitigate the adverse outcomes of emergencies and disasters. The plan establishes an all-hazard approach to coordinate timely and integrated actions in response to a wide range of incidents or events that may disrupt normal health center operations.

This Emergency Management Plan outlines actions to support the following objectives:

- Provide a safe environment and protection from injury for patients, visitors, and staff;
- Ensure all individuals requiring medical attention in an emergency situation are attended to promptly and efficiently;
- Outline a logical and flexible chain of command that supports the effective use of resources;
- Restore essential services as quickly as possible following an incident;
- Safeguard facilities, property, and equipment;
- Meet all applicable emergency management related regulatory and accreditation requirements;
- Inform stakeholders of any emergency that directly impacts the organization.

1.3 Scope

Within the context of this plan, an emergency is any event that overwhelms or threatens to disrupt health center operations. This all-hazards plan covers response actions that will take place in the event of natural disasters as well as technological, hazardous material, and terrorist events.

This plan also describes the policies and procedures HCHC will follow to mitigate, prepare for, respond to, and recover from the effects of emergencies.

1.4 Emergency Management Committee

The role of the HCHC Emergency Management Committee (EMC) is to coordinate the development and maintenance of the Emergency Management Plan, ensure the emergency preparedness program meets relevant standards and requirements, and provide and/or coordinate program activities, including training and exercises.

The committee is multidisciplinary and includes representation from various departments. The committee is chaired by the CEO or designee.

The Emergency Management Committee meets on a quarterly basis and is composed of the following staff members:

NAME	Eliza B. Lake
TITLE	CEO
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NAME	Cynthia Magrath
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NAME	Russ Jordan
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NAME	Dawn Flatt
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Section 2 - Situation and Assumptions

2.1 Hazard Vulnerability Analysis

A Hazard Vulnerability Analysis (HVA) is used to evaluate hazards, their risk of actual occurrence, and the impact on life, property, and business should the hazard occur. The HVA identifies top risks in order to prioritize mitigation and planning efforts.

An HVA is conducted on an annual basis, after an emergency event, and as deemed necessary by the Emergency Management Committee (EM Committee). The EM Manager is responsible for ensuring that the HVA is conducted, forwarding to the necessary committees, and carrying out any corrective measures identified through the HVA. To complete the HVA, the Emergency Management Committee uses the *Hazard and Vulnerability Assessment Tool* developed by Kaiser Permanente.

The current HVA was last completed on January 24, 2019. The top 5 hazards identified are as follows for each sites:

Worthington	Huntington	Amherst
1. Fire(<i>tied with Inclement Weather</i>)	1. Fire (<i>tied with Inclement Weather</i>)	1. Fire (<i>tied with Inclement Weather</i>)
2. Internal Fire	2. Internal Fire	2. Internal Fire
3. Infectious Disease Outbreak	3. Infectious Disease Outbreak	3. Infectious Disease Outbreak
4. Trauma	4. Trauma	4. Trauma
5. Community/Telephone Failure	5. Communication/Telphony Failure	5. Communication/Telphony Failure

The current HVA for HCHC, as well as regional community-based HVAs, may be found in [Appendix A](#). The completed HVA along with an analysis and recommendations for changes is submitted to the EMC for review and approval on an annual basis. Based on the HVA results, hazard-specific plans to address the top five risks are included in [Annex D](#)).

2.2 Key Plan Assumptions

The following assumptions are reflected in this plan:

- The health center will conduct emergency preparedness activities, including those described in this plan, in accordance with state and federal regulations.
- The Health Center will continue to be exposed and subject to hazards and incidents described in the HVA, as well as lesser hazards and others that may develop in the future.

- A major disaster could occur at any time, and at any place. In many cases, dissemination of warning to the public and implementation of increased readiness measures may be possible; however, some emergency situations occur with little or no warning.
- A single site incident (e.g., fire, gas main breakage) could occur at any time without warning and the employees affected cannot, and should not, wait for direction from local response agencies. Action is required immediately to save lives and protect property.
- There may be a number of injuries of varying degrees of seriousness to staff and/or patients; rapid and appropriate response will reduce the number and severity of injuries.
- Outside assistance from local fire, law enforcement, and emergency managers will be available in most serious incidents. Because it takes time to request and dispatch external assistance, it is essential to be prepared to carry out the initial incident response at the health center until responders arrive at the incident scene.
- Proper prevention, protection, and mitigation actions, such as maintaining the environment of care and conducting fire inspections, will prevent or reduce incident-related losses.
- Maintaining this plan and providing frequent opportunities for stakeholders (staff, patients, first responders, and healthcare system partners, etc.) to exercise the plan can improve readiness to respond to incidents.

Section 3 - Command and Control

3.1 Incident Command System

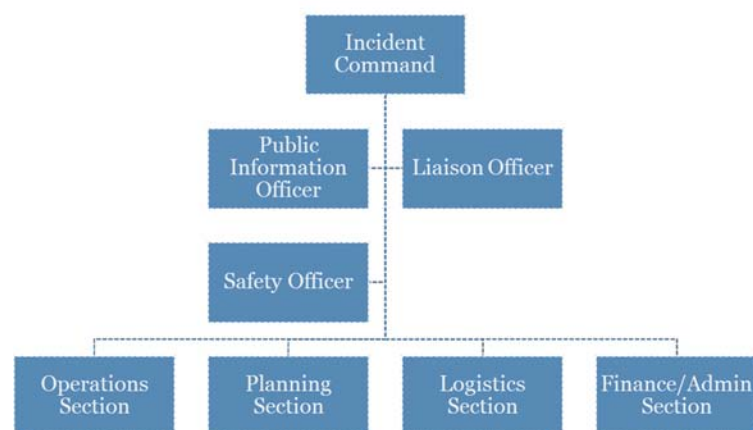
HCHC uses the Incident Command System (ICS) to manage emergencies that impact normal operations. ICS is a management structure with defined responsibilities, clear reporting channels, and standardized terms. The designated **Incident Commander (IC)** has overall authority and responsibility for conducting and managing incident operations. The Command Staff reports to the IC and consists of the following positions:

- **Public Information Officer** - responsible for interfacing with the public and media or with other agencies with incident-related information requirements.
- **Liaison Officer** - responsible for coordinating with representatives from cooperating and assisting agencies/organizations.
- **Safety Officer** - responsible for monitoring and assessing safety hazards or unsafe situations, and for developing measures for ensuring personnel safety.

The General Staff consists of four Section Chiefs, appointed by the IC. Each Section Chief may designate additional personnel to specialized roles. The four sections include:

- **Logistics** - responsible for providing facilities, services, and materials for the incident.
- **Planning** - responsible for the collection, evaluation, and dissemination of information related to the incident, and for the preparation and documentation of Incident Action Plans.
- **Finance/Administration** - responsible for all incident costs and financial considerations.
- **Operations** - responsible for all tactical operations at the incident.

This structure is illustrated in the ICS Organizational Chart shown below.



ICS positions are temporary assignments. Only necessary positions will be filled upon activation, and a single staff person may hold more than one position. It is the responsibility of the IC to determine which positions are required and to whom they are to be assigned. The IC will use an *ICS Assignment List and Activation Instructions* ([Attachment A](#)).

Each ICS position has a prioritized job description, or Job Action Sheet (JAS), which describes the duties of the person assigned to the role. Following a Job Action Sheet will allow an employee to carry out responsibilities that may not be part of his/her normal duties. The JAS will also define that person's reporting responsibilities. *Job Action Sheets* for each of the positions are included in [Attachment B](#). Copies are available in the Emergency Operations Center, or EOC.

3.2 Notification of Incident and Authority to Activate

When an employee becomes aware of an incident that needs a response, the employee is required to inform their direct supervisor. If the direct supervisor is not immediately responsible then the next highest authority is to be reached. Employees will use Attachment D, Management Emergency Contacts, for contact information. The highest superior reached will contact the CEO or other Senior Management member. The CEO or designee have the authority to activate ICS and will serve as the Incident Commander until relieved, or ICS deactivation.

3.3 Activation

Upon notification of an incident, the CEO or designee conducts a rapid assessment of the situation, considering the following decision factors for ICS activation:

- The impact of the incident on operations, patients, staff, and resources.
- The anticipated duration of the incident.

When the ICS is activated, a formal announcement is made, at a minimum, via email. Those assigned to an ICS role are to report to the Command Center, or EOC, located at a location that is included in the announcement.

3.4 Deactivation

Prior to deactivation, the IC will make an assessment of the situation, considering the ongoing impact on operations. Based on the factors considered and ability to return to normal operations, the IC will determine when to formally deactivate ICS. When the decision has been made to deactivate ICS, a formal announcement will be made via email, at a minimum, to all involved parties, which could include staff, patients, community partners, or the public at large.

3.5 Information Collection, Documentation, Analysis, and Dissemination

A record of actions taken to manage an incident from initial notification or detection of the incident, staff notification, implementation of ICS and of the incident-specific protocols that may have been activated, is critical for performance improvement, regulatory scrutiny, and possible

insurance reimbursement for damages and expenses.

When an incident extends beyond one operational period (generally 12 hours), an Incident Action Plan (IAP) containing general objectives reflecting the overall strategy for managing an incident is developed by the IC and/or the Planning Section Chief. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident. See [Attachment C](#) for *Incident Action Plan Quick Start and Activity Log*.

3.6 Roles and Responsibilities

There are four phases of emergency management, as defined below:

- **Mitigation:** Actions taken to lessen the severity and impact a potential disaster or emergency might have on a health center's operation.
- **Preparedness:** Preparedness activities are undertaken to build capacity and identify resources that may be used should a disaster or emergency occur.
- **Response:** Refers to the actual emergency and controls the negative effects of emergency situations.
- **Recovery:** Comprises those actions that are directed at restoring essential services and resuming normal operations. Recovery planning should occur almost concurrently with response activities.

HCHC's understanding of organizational roles and responsibilities in support of this plan under each phase of emergency management are listed below. The partners noted are not signatories to this facility-specific plan, and their actual roles and responsibilities may change under the law, or at their own discretion (as applicable).

- **Mitigation:** HCHC will mitigate the severity and impact of an emergency through an annual Hazards Vulnerability Analysis process; a regular assessment of the environmental safety of each HCHC site; and a review of all insurance policies on an annual basis to ensure suitability and sufficiency.
- **Preparedness:** HCHC will
 - establish and maintain an Incident Command System that is proportional to the size of the incident in accordance with national standards;
 - meet all state and federal regulatory requirements for emergency planning, training, and exercising;
 - test communication protocols and equipment for staff, patients, and partners; and
 - participate in local/regional/state coalitions, including the HMCC, to build partnerships for preparedness and response.
- **Response:** HCHC will
 - follow its policies and procedures to respond to any incident in a way that minimizes harm to individuals and facilities;

- report any incidents to state and federal regulatory bodies within specified timeframes; and
 - maintain situational awareness through communication and collaboration with partners, including the Mass League of Community Health Centers, the HMCC, the Mass Department of Public Health, etc.
- **Recovery:** HCHC will:
- document all expenses for potential reimbursement;
 - notify patients and staff of resumption of normal operations and hours; and
 - ensure that any information collected outside of the electronic medical records system during a disaster or emergency is incorporated into the system.

HCHC will work with its local, state, and federal partners in any response. Its understanding is that these partners will have the following roles in any incident.

- Mass League of Community Health Centers (State Primary Care Association)
 - **Mitigation** - share resource information and help identify potential collaborations to support or enhance mitigation efforts; represent health centers on state and national committees and working groups
 - **Preparedness** - provide tools and templates to assist in health center planning, training, exercising, and community integration; develop training and education opportunities related to emergency preparedness and management, assuring content is appropriate for health centers
 - **Response** - maintain situational awareness among health centers through notifications and information sharing, and communicate resource needs to local, state and federal partners; liaise with response partners; maintain 24/7 on-call system
 - **Recovery** - provide support with resource requests, and collect information to assess financial and operational impacts on health centers
- Western Mass Health and Medical Coordinating Coalition
 - **Mitigation** - Coordinate regional hazard vulnerability and risk analysis; support identification of partnerships for resource-sharing and development of pre-event agreements
 - **Preparedness** - Facilitate participation in local, regional, and statewide trainings and exercises; facilitate sharing of subject matter expertise and best practices among members; support development of preparedness plans.
 - **Response** - Facilitate sharing of subject matter expertise and best practices; facilitate communication and information sharing among members to support situational awareness; maintain 24/7 on-call system
 - **Recovery** – Coordinate situational awareness of ongoing recovery efforts amongst stakeholders; coordinate collection of post-event lessons learned and translation into best practices for future planning and response efforts, etc.
- Health Resources Services Administration
 - **Mitigation** – Assist health centers with ensuring coverage annually under the Federal Tort Claims Act (FTCA)
 - **Response** – Provide guidance on, and ensure facilitation of modifications to federal scope of project, as needed.

Section 4 - Continuity of Operations

HCHC will maintain operations to the extent possible and appropriate during any emergency. The prioritization of services, and the efforts to minimize the impact on staff and patients is outlined in the HCHC *Continuity of Operations Plan*, which may be found in [Annex A](#). Insurance information is found on file in the HCHC Finance Department.

Section 5 - Communications

5.1 Risk Communications

Information shared during an emergency must be timely, accurate, comprehensive, authoritative and relevant. Upon notification of an event that will impact the Health Center operations, the assigned Public Information Officer (PIO) is the conduit of information for internal and external stakeholders, including patients, staff, and partner organizations, as approved by the Incident Commander.

The PIO leverages available sources of information such as federal, State, and local agencies, coalitions/associations, and verified news reports to gather vital information and ensure accuracy. The PIO and/or designee(s) uses the information gathered to develop messaging to communicate with patients, staff, regulatory agencies, and partners in the local community via various appropriate channels of communication including email, phone, texting, radio, social media, newspapers, etc. The PIO also considers the language and literacy level of the intended audience for messaging.

All external inquiries are referred to the PIO. Staff are instructed to respond to such inquiries with the following statement: "HCHC policy is to refer all external inquiries to our Public Information Officer or Spokesperson. You can reach them at 413-238-5511 or info@hchcweb.org." Staff is instructed to contact the PIO whenever they have been approached by the media.

5.2 Staff and Patient Notifications

In the event of an emergency, HCHC notifies staff via email, phone, and/or other means. Patients are notified via phone calls, messages through the patient portal, television, social media, the HCHC Snow Line, or any other appropriate means. The Public Information Officer or designee develops the message to be relayed to staff and patients. *Draft Emergency Notification and Activation Messages* may be found in [Attachment F](#).

A *Staff Contact List* is available and contains current primary and secondary mobile telephone numbers and, if available, personal email addresses. All staff have designated preferred mode of contact as well. This contact list is utilized to inform, update and/or recall staff as needed in the event of an emergency. HCHC keeps this contact list readily available (hard copy and electronically) at all times. Hard copies are kept in the Human Resources Office, and can be accessed by members of the IC Team. Electronic copies are kept on the EP Folder on the Admin Drive. The Staff Contact List will be updated by the HR Coordinator on an annual basis or whenever informed of a change by a staff member, and will be reflected in an update of the master list. In addition, all managers will be given a copy of the list for their direct reports at least annually.

A staff communication drill is conducted at least annually by the EM Manager.

5.3 Emergency Mental Health

HCHC recognizes that psychological reactions to disasters are common, and while most people

do not require long-term mental health treatment following a disaster, crisis intervention to alleviate acute psychological stress may be necessary. HCHC addresses the mental health needs of staff and patients related to emergency response and/or post-disaster situations. The Behavioral Health Director and HR Coordinator is responsible for ensuring the availability of timely and appropriate screening and treatment for emergency mental health services. This includes informing all staff about the Employee Assistance Plan and its resources.

See [Attachment J](#) for information on HCHC's EAP Program.

5.4 Communications with Partners

HCHC's Incident Commander will communicate with the Duty Officer of the HMCC upon the activation of the response, and will describe the situation, HCHC's response, and any resources or support required. The HMCC serves as the coordinator of regional response, and therefore will relay any necessary information to other partners in the area. HCHC's IC will also communicate with the Mass League, either directly or in response to an incident survey. If necessary, HCHC's IC will also inform the Hampshire Public Health Preparedness Coalition, local hospitals, and other community partners/vendors as necessary and appropriate.

HCHC will share patient information during disasters as necessary to provide treatment, or to identify, locate and notify family members, guardians, or anyone else responsible for the individual's care of the individual's location, general condition, or death, in accordance with the September 2005 *Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations* issued by the U.S. Department of Health and Human Services (DHHS).

An external *Partner Contact List* may be found in [Attachment E](#). HCHC's communications plan complies with all federal, state, and local laws.

Section 6 - Buildings, Utilities, Safety and Security

6.1 Facilities Management

HCHC maintains all facilities owned and/or occupied by the health center in accordance with activities that mitigate hazards and facilitate emergency response. As part of normal operations, HCHC maintains a safe environment of care for its staff, patients, and visitors. In doing so, HCHC conducts quarterly inspections at each health center location to monitor compliance with all mitigation efforts. The School-Based Health Center site(s) will coordinate and participate in all emergency management activities of its host school(s). The John P. Musante Health Center will coordinate and participate in all emergency management activities of the Bangs Center, as directed by the Town of Amherst.

6.2 Evacuation Planning

All HCHC locations have posted evacuation plans indicating evacuation routes, and the location of emergency exits and emergency equipment. Health center staff are required to participate in evacuation drills on a regular basis. Each health center location maintains a Fire Plan in accordance with local ordinances including emergency procedures and contact information. The *Evacuation Plans* may be found in [Annex B](#). The *Fire Safety Plan* may be found in [Annex C](#).

6.3 Utility Mapping

On-site personnel have access to utility maps which specify the locations and instructions for accessing/shutting down building systems including alarms, electrical, gas, water, and HVAC. *Emergency Shut Off Sheets* may be found in [Attachment G](#).

6.4 Safety and Security

HCHC's current general safety and security protocols for staff and patients are described in the Employee Handbook, which is located in the Human Resources folder on the All Staff drive. All Managers and the Human Resources Coordinator are responsible for implementing the protocols. Hazard-specific plans are available on the EMP folder on the All Staff Drive, and as [Annex D](#).

Section 7 – Finance, Logistics, and Staff Care

7.1 EOC Set-up

HCHC's Command Center or EOC will be established in a safe location at an HCHC site, as appropriate and feasible. If possible, the EOC should be in the site at which the incident is occurring, but if this is not possible for safety/logistical reasons, it can be at any other site, or a community location that is appropriate. Suggested locations are:

- Huntington Health Center: second-floor conference room
- Worthington Health Center: lunch room
- Hilltown Community Center: Director's office

For those sites that are governed by its host organization's EMP, staff will cooperate with efforts to establish an EOC.

The EOC is the location where situational assessments are conducted and decisions are made; it also serves as the hub for internal and external communications. The EOC will be set up by IC or designee.

7.2 Emergency Supplies and Equipment

HCHC engages in planning efforts to effectively manage resources available for emergency response and recovery. This includes engaging partners and vendors, and proactively monitoring logistics and resources to ensure critical supply and equipment inventories are documented and current. Emergency supplies and equipment are located in the basement of the Worthington and Huntington Health Center. These supplies are in addition to the inventory of supplies that are maintained within each department for normal operations.

HCHC may receive aid through non-governmental organizations or governmental channels and has implemented processes to ensure resources associated with response/recovery are documented and tracked. As part of the ongoing planning process, HCHC has identified potential logistical partners and critical suppliers in an effort to promote cooperation and expedite response for the allocation of supplies, and/or delivery of services during an emergency situation.

Emergency supplies and equipment are tracked and paid for according to HCHC's finance policies.

A Vendor Contact List may be found in [Attachment H](#).

7.3 Staff Scheduling and Care

During an emergency, HCHC's hours of operation may need to be reduced or extended based on the status of the facility or needs of the community. Staff schedules may also be subject to change. Scheduling will be conducted by Practice Manager according to the Continuation of Operations Plan (see [Annex A](#)), in consultation with Department Heads.

7.4 Timekeeping, Payroll, and Human Resource Considerations

Human Resource management is a critical component of emergency management planning. Similar to equipment and supplies, HCHC has implemented processes to ensure staff time and effort associated with response/recovery is documented and tracked. HCHC will reference the *Federal Tort Claims Act (FTCA) Health Center Policy Manual* dated 7/21/2014 to ensure compliance with the FTCA, as necessary.

Section 8 - Community Integration

8.1 Identification of Planning and Response Partners

HCHC has identified and engaged key planning partners including the Region One (Western Mass) Health and Medical Coordinating Coalition, local hospitals, boards of health, health departments, school districts, local law enforcement and emergency response systems, and others that may assist the health center during an emergency. In order to effectively plan for and respond to a disaster, the health center has established protocols to integrate the health center's plan with the plans of its partner organizations/agencies via regular meetings/calls and/or joint exercises. HCHC communicates information regarding its emergency management responses to members of the community via online postings, media messages, and/or recorded messages on its snow line.

8.2 Coalitions

To support community integration, HCHC participates in the Region One (Western Mass) Health and Medical Coordinating Coalition and the Hampshire Public Health Preparedness Coalition. The EM Manager and other appropriate staff participate in meetings, trainings, regional planning, and other activities organized by these groups, in order to improve EM coordination and collaboration. Prior to participation in a coalition or community-wide activity, HCHC decides what information will be shared with its partners and what information is proprietary.

8.3 Agreements

To establish a formal partnership, HCHC utilizes a standard agreement, such as a Memorandum of Understanding (MOU), to outline the responsibilities of the parties involved. These include mutual aid agreements that describe the partners' willingness to cooperate and collaborate in the event of an emergency.

See [Appendix B](#) for copies of MOUs with community partners.

Section 9 - Plan Development and Maintenance

9.1 Plan Development, Review, and Storage

The EM Manager is responsible for developing, maintaining, and distributing this plan. The plan will be reviewed annually, and as required to incorporate lessons learned from events, exercises, or trainings; new state, federal, and regional guidelines or directives; and/or to address significant operational gaps. Changes may include additions of new or supplementary material and/or deletions of outdated information. No proposed change should contradict or override authorities or other plans contained in statute or regulation. All changes will be approved by the EM Committee prior to incorporation and distribution. The final plan is submitted to the Health Center's Board of Directors for annual approval. The master copy of this plan is stored electronically on the EMP folder on the All Staff drive, and a hard copy is available at the front desk of each site.

9.2 Training, Exercises, and Evaluation

HCHC has established an employee training and exercise program based on the health center's Emergency Management Plan, and in accordance with the 2016 CMS EP Rule. The Health Center's EM Committee reviews the number of trainings, exercises conducted and results of training/exercise activity on an annual basis to ensure the frequency and content is adequate for maintaining preparedness among health center staff.

HCHC provides staff training on emergency preparedness as part of the employee orientation and annual training programs. At a minimum, topics will include:

- Overview of the Health Center's Emergency Management Plan, and all related policies and procedures, as well as how to access it;
- Fire response and evacuation plans; and
- Infectious disease preparedness and Personal Protective Equipment (PPE).

Staff assigned to ICS positions are provided with training on their specific roles. Trainings are planned by EM Manager and members of the EM Committee. Participation in trainings is documented. The Command and General ICS staff must complete FEMA Independent Study courses IS-100.HCb, and IS-700. These courses may be found online at (<http://www.training.fema.gov/EMICourses/>). Upon successful completion of these courses, staff will submit certificates to the HR Coordinator and the EM Manager

HCHC conducts exercises to assess emergency management protocols and identify gaps in the emergency management plans and trainings. Observations of staff response during scheduled events is used to identify strengths, challenges, and potential improvements. The scenarios for the exercises is based on the top risks identified by the HVA. In accordance with the *2016 CMS EP Rule*, two exercises will be conducted at each health center location annually, at minimum. Facilities are required to participate in a full-scale exercise that is community-based, or an individual facility-based exercise (i.e., functional exercise) when a community-based exercise is not accessible. They must also conduct an additional exercise that, at minimum, is a tabletop exercise. The exercise components of the program are based on the *Homeland Security Exercise*

*and Evaluation Program (HSEEP)*¹. Exercises will be planned by EM Manager and members of the EM Committee and participation in exercises will be documented. Following each exercise, the EM Committee will conduct a “hotwash” to discuss player experiences, and strengths and weaknesses of the exercise. This information will be compiled in an After Action Report (AAR) and Improvement Plan (IP) in accordance with HSEEP templates. Findings and recommendations will be reported to the EM Committee and senior leadership.

See [Attachment I](#) for the *Multi-year Training and Exercise Plan*.

Section 10 - Standards, Regulations, and Guidelines

- Health Resources & Services Administration (HRSA) Policy Information Notice 2007-15- Health Center Emergency Management Program Expectations.
<http://bphc.hrsa.gov/about/pdf/pin200715.pdf>
- Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers (2016)
<https://www.federalregister.gov/documents/2016/09/16/2016-21404/medicare-and-medicaid-programs-emergency-preparedness-requirements-for-medicare-and-medicaid>
- Health Resources & Services Administration (HRSA) Program Assistance Letter- Updated Process for Requesting a Change in Scope to Add Temporary Sites in Response to Emergency Events. <http://bphc.hrsa.gov/programrequirements/pdf/pal201405.pdf>
- HRSA Federal Tort Claims Act Health Center Policy Manual (See Section I.F)
<http://bphc.hrsa.gov/policiesregulations/policies/ftcahcpolicymanualpdf.pdf>
- Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations (September 2005).
<https://www.hhs.gov/sites/default/files/katrinanhipaa.pdf>
- NFPA 1600 Standard on Disaster/Emergency Management and Business Continuity Programs. <http://www.nfpa.org/codes-and-standards/document-information- pages?mode=code&code=1600>

List of Plan Appendices, Attachments, and Annexes

Appendices

[Appendix A](#) - Hazard Vulnerability Analysis (HVA)

[Appendix B](#) - Memoranda of Understanding

Attachments

[Attachment A](#) - ICS Assignment List and Instructions for ICS Activation

[Attachment B](#) - Job Action Sheets

[Attachment C](#) - Incident Action Plan Quick Start and Activity Log

[Attachment D](#) - Management Emergency Contacts

[Attachment E](#) - Partner Contact List

[Attachment F](#) - Draft Emergency Notification and Activation Messages

[Attachment G](#) - Emergency Shut-Off Sheets

[Attachment H](#) - Vendor Contact List

[Attachment I](#) - Multi-Year Training and Exercise Plan

Annexes

[Annex A](#) – Continuity of Operations Plan (COOP)

[Annex B](#) - Evacuation Plans

[Annex C](#) - Fire Safety Plan

[Annex D](#) - Additional Annexes - Hazard-Specific Plans

Appendix A – Hazard Vulnerability Analysis

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Emergency Management

Hazards - Enter name of hospital
Hazard and Vulnerability Assessment Tool
Naturally Occurring Events- Huntington

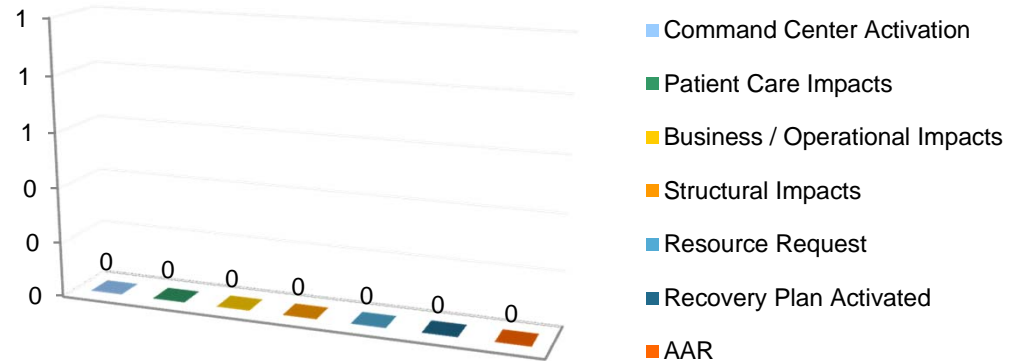
Event	PROBABILITY	ALERTS	ACTIVATIONS	SEVERITY = (MAGNITUDE - MITIGATION)						RISK
				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
SCORE	0 = N/A 1 = Low 2 = Moderate	Number of Alerts	Number of Activations	0 = N/A 1 = Low 2 = Moderate	0 = N/A 1 = Low 2 = Moderate	0 = N/A 1 = Low 2 = Moderate	0 = N/A 1 = High 2 = Moderate	0 = N/A 1 = High 2 = Moderate	0 = N/A 1 =High 2 = Moderate	0 - 100%
	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
Fire	3	0	0	2	3	3	1	1	1	37%
Internal Fire	3	0	0	2	3	3	1	1	1	37%
Infectious Disease Outbreak	3	0	0	3	1	1	2	2	1	33%
Trauma	3	0	0	3	1	3	1	1	1	33%
Communication / TelephonyFailure	3	0	0	1	1	2	1	1	3	30%
Epidemic	2	0	0	3	1	3	2	2	1	27%
Inclement Weather	3	0	0	1	1	3	1	1	1	27%
Pandemic	2	0	0	3	1	3	2	2	1	27%
Power Outage	3	0	0	1	1	3	1	1	1	27%
Suicide	2	0	0	3	1	2	2	2	2	27%
Suspicious Package / Substance	2	0	0	2	1	2	3	3	1	27%
Tornado	2	0	0	2	2	2	2	2	1	24%
Evacuation	3	0	0	1	1	2	1	1	1	23%
Flood	3	0	0	1	1	2	1	1	1	23%
Seasonal Influenza	3	0	0	1	1	1	1	1	1	20%
Workplace Violence / Threat	2	0	0	3	1	2	1	1	1	20%
Hurricane	2	0	0	1	2	2	1	1	1	18%
Temperature Extremes	2	0	0	2	1	2	1	1	1	18%
Active Shooter	1	0	0	3	2	3	2	2	3	17%
Shelter in Place	1	0	0	3	2	3	2	2	3	17%
Earthquake	1	0	0	2	2	2	3	3	2	16%
Generator Failure	2	0	0	1	1	2	1	1	1	16%
Hazmat Incident	2	0	0	1	1	2	1	1	1	16%
Internal Flood	2	0	0	1	2	1	1	1	1	16%
IT System Outage	2	0	0	1	1	2	1	1	1	16%
Water Disruption	2	0	0	1	1	2	1	1	1	16%
Weapon	2	0	0	2	1	1	1	1	1	16%
Bomb Threat	1	0	0	1	1	3	2	3	3	14%
Picketing	1	0	0	1	1	2	3	3	3	14%
Dam Failure	1	0	0	3	3	3	1	1	1	13%
Explosion	1	0	0	3	3	3	1	1	1	13%
Hazmat Incident with Mass Casualties	1	0	0	3	2	2	2	2	1	13%
HVAC Failure	2	0	0	1	1	1	1	1	1	13%
Mass Casualty Incident	1	0	0	3	2	2	2	2	1	13%
Suspicious Odor	2	0	0	1	1	1	1	1	1	13%
VIP Situation	2	0	0	1	1	1	1	1	1	13%
Chemical Exposure, External	1	0	0	2	1	1	3	3	1	12%
Civil Unrest	1	0	0	1	1	2	3	3	1	12%
Hostage Situation	1	0	0	2	1	2	2	2	2	12%
Strikes / Labor Action / Work Stoppage	1	0	0	1	1	2	3	3	0	11%
Patient Surge	1	0	0	1	1	2	2	2	1	10%
Natural Gas Disruption	1	0	0	1	1	3	1	1	1	9%
Natural Gas Failure	1	0	0	1	1	3	1	1	1	9%
Sewer Failure	1	0	0	1	1	3	1	1	1	9%
Water Contamination	1	0	0	2	1	2	1	1	1	9%
Supply Chain Shortage / Failure	1	0	0	1	1	2	1	1	1	8%
Large Internal Spill	1	0	0	1	1	1	1	1	1	7%
Planned Power Outages	1	0	0	1	1	1	1	1	1	7%
Radiation Exposure	1	0	0	1	1	1	1	1	1	7%
Acts of Intent	2	0	0	3	2	2	2	2	3	2%
Building Move	0	0	0	0	0	0	0	0	0	0%
Drought	0	0	0	0	0	0	0	0	0	0%
External Flood	0	0	0	0	0	0	0	0	0	0%
Forensic Admission	0	0	0	0	0	0	0	0	0	0%
Gas / Emmissions Leak	0	0	0	0	0	0	0	0	0	0%
Landslide	0	0	0	0	0	0	0	0	0	0%
Other	0	0	0	0	0	0	0	0	0	0%
Other Utility Failure	0	0	0	0	0	0	0	0	0	0%
Transportation Failure	0	0	0	0	0	0	0	0	0	0%
Tsunami	0	0	0	0	0	0	0	0	0	0%

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Emergency Management

Summary For - Enter name of hospital

ALERT TYPE	OCCURRENCE
Command Center Activation	0
Patient Care Impacts	0
Business / Operational Impacts	0
Structural Impacts	0
Resource Request	0
Recovery Plan Activated	0
AAR	0
Total Alert	0



0

TOP 10 HVA	RANK	OCCURRENCE
Fire	1	0
Internal Fire	2	0
Infectious Disease Outbreak	3	0
Trauma	4	0
Communication / Telephony Failure	5	0
Epidemic	6	0
Inclement Weather	7	0
Pandemic	8	0
Power Outage	9	0
Suicide	10	0

0

TOP 10 ACTUAL ALERTS	OCCURRENCE	HVA RANK
	0	

Kaiser Permanente

Emergency Management

Hazards - Enter name of hospital
Hazard and Vulnerability Assessment Tool
Naturally Occurring Events- WORTHINGTON

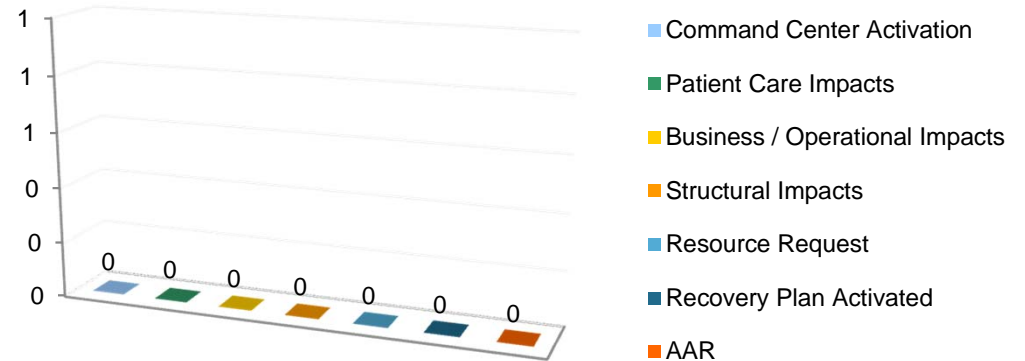
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				HUMAN IMPACT	PROPERTY IMPACT	BUSINESS IMPACT	PREPARED-NESS	INTERNAL RESPONSE	EXTERNAL RESPONSE	
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	Likelihood this will occur			Possibility of death or injury	Physical losses and damages	Interruption of services	Preplanning	Time, effectiveness, resources	Community/Mutual Aid staff and supplies	* Relative threat
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Internal Fire	3	0	0	2	3	3	1	1	1	37%
Infectious Disease Outbreak	3	0	0	3	1	1	2	2	1	33%
Trauma	3	0	0	3	1	3	1	1	1	33%
Communication / Telephony/Failure	3	0	0	1	1	2	1	1	3	30%
Epidemic	2	0	0	3	1	3	2	2	1	27%
Inclement Weather	3	0	0	1	1	3	1	1	1	27%
Pandemic	2	0	0	3	1	3	2	2	1	27%
Suicide	2	0	0	3	1	2	2	2	2	27%
Suspicious Package / Substance	2	0	0	2	1	2	3	3	1	27%
Tornado	2	0	0	2	2	2	2	2	1	24%
Evacuation	3	0	0	1	1	2	1	1	1	23%
Flood	3	0	0	1	1	2	1	1	1	23%
Power Outage	3	0	0	1	1	1	1	1	1	20%
Seasonal Influenza	3	0	0	1	1	1	1	1	1	20%
Workplace Violence / Threat	2	0	0	3	1	2	1	1	1	20%
Generator Failure	2	0	0	2	1	2	1	1	1	18%
Hurricane	2	0	0	1	2	2	1	1	1	18%
Temperature Extremes	2	0	0	2	1	2	1	1	1	18%
Active Shooter	1	0	0	3	2	3	2	2	3	17%
Shelter in Place	1	0	0	3	2	3	2	2	3	17%
Earthquake	1	0	0	2	2	2	3	3	2	16%
Hazmat Incident	2	0	0	1	1	2	1	1	1	16%
Internal Flood	2	0	0	1	2	1	1	1	1	16%
IT System Outage	2	0	0	1	1	2	1	1	1	16%
Water Disruption	2	0	0	1	1	2	1	1	1	16%
Weapon	2	0	0	2	1	1	1	1	1	16%
Bomb Threat	1	0	0	1	1	3	2	3	3	14%
Picketing	1	0	0	1	1	2	3	3	3	14%
Explosion	1	0	0	3	3	3	1	1	1	13%
Hazmat Incident with Mass Casualties	1	0	0	3	2	2	2	2	1	13%
HVAC Failure	2	0	0	1	1	1	1	1	1	13%
Mass Casualty Incident	1	0	0	3	2	2	2	2	1	13%
Suspicious Odor	2	0	0	1	1	1	1	1	1	13%
VIP Situation	2	0	0	1	1	1	1	1	1	13%
Chemical Exposure, External	1	0	0	2	1	1	3	3	1	12%
Civil Unrest	1	0	0	1	1	2	3	3	1	12%
Hostage Situation	1	0	0	2	1	2	2	2	2	12%
Strikes / Labor Action / Work Stoppage	1	0	0	1	1	2	3	3	0	11%
Patient Surge	1	0	0	1	1	2	2	2	1	10%
Sewer Failure	1	0	0	1	1	3	1	1	1	9%
Water Contamination	1	0	0	2	1	2	1	1	1	9%
Supply Chain Shortage / Failure	1	0	0	1	1	2	1	1	1	8%
Large Internal Spill	1	0	0	1	1	1	1	1	1	7%
Planned Power Outages	1	0	0	1	1	1	1	1	1	7%
Radiation Exposure	1	0	0	1	1	1	1	1	1	7%
Acts of Intent	2	0	0	3	2	2	2	2	3	2%
Building Move	0	0	0	0	0	0	0	0	0	0%
Dam Failure	0	0	0	0	0	0	0	0	0	0%
Drought	0	0	0	0	0	0	0	0	0	0%
External Flood	0	0	0	0	0	0	0	0	0	0%
Forensic Admission	0	0	0	0	0	0	0	0	0	0%
Gas / Emissions Leak	0	0	0	0	0	0	0	0	0	0%
Landslide	0	0	0	0	0	0	0	0	0	0%
Natural Gas Disruption	0	0	0	0	0	0	0	0	0	0%
Natural Gas Failure	0	0	0	0	0	0	0	0	0	0%
Other	0	0	0	0	0	0	0	0	0	0%
Other Utility Failure	0	0	0	0	0	0	0	0	0	0%
Transportation Failure	0	0	0	0	0	0	0	0	0	0%
Tsunami	0	0	0	0	0	0	0	0	0	0%

Kaiser Permanente

Emergency Management

Summary For - Enter name of hospital

ALERT TYPE	OCCURRENCE
Command Center Activation	0
Patient Care Impacts	0
Business / Operational Impacts	0
Structural Impacts	0
Resource Request	0
Recovery Plan Activated	0
AAR	0
Total Alert	0



0

TOP 10 HVA	RANK	OCCURRENCE
Fire	1	0
Internal Fire	2	0
Infectious Disease Outbreak	3	0
Trauma	4	0
Communication / Telephony Failure	5	0
Epidemic	6	0
Inclement Weather	7	0
Pandemic	8	0
Suicide	9	0
Suspicious Package / Substance	10	0

0

TOP 10 ACTUAL ALERTS	OCCURRENCE	HVA RANK
	0	

Kaiser Permanente

Emergency Management

Hazards - Enter name of hospital
Hazard and Vulnerability Assessment Tool
Naturally Occurring Events- JPMHC

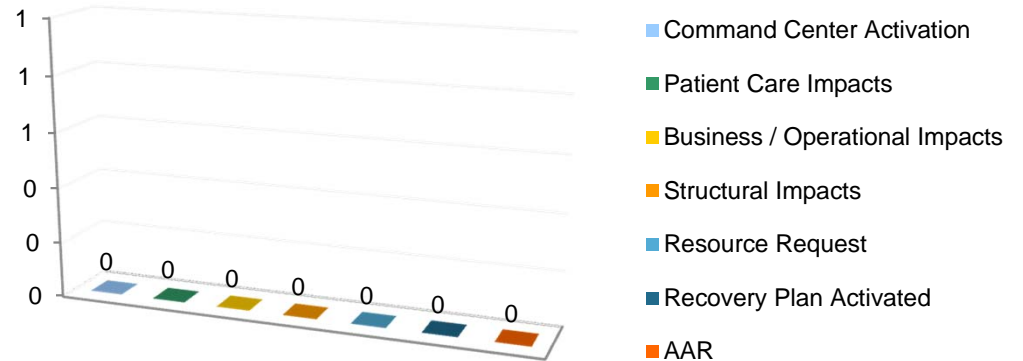
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Internal Fire	3	0	0	2	3	3	1	1	1	37%
#NAME?	3	0	0	3	1	1	2	2	1	33%
Trauma	3	0	0	3	1	3	1	1	1	33%
Communication / TelephonyFailure	3	0	0	1	1	2	1	1	3	30%
Epidemic	2	0	0	3	1	3	2	2	1	27%
Inclement Weather	3	0	0	1	1	3	1	1	1	27%
Pandemic	2	0	0	3	1	3	2	2	1	27%
Power Outage	3	0	0	1	1	3	1	1	1	27%
Suicide	2	0	0	3	1	2	2	2	2	27%
Suspicious Package / Substance	2	0	0	2	1	2	3	3	1	27%
Tornado	2	0	0	2	2	2	2	2	1	24%
Evacuation	3	0	0	1	1	2	1	1	1	23%
Flood	3	0	0	1	1	2	1	1	1	23%
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Hurricane	2	0	0	1	2	2	1	1	1	18%
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Active Shooter	1	0	0	3	2	3	2	2	3	17%
Shelter in Place	1	0	0	3	2	3	2	2	3	17%
Earthquake	1	0	0	2	2	2	3	3	2	16%
Hazmat Incident	2	0	0	1	1	2	1	1	1	16%
Internal Flood	2	0	0	1	2	1	1	1	1	16%
IT System Outage	2	0	0	1	1	2	1	1	1	16%
Water Disruption	2	0	0	1	1	2	1	1	1	16%
Weapon	2	0	0	2	1	1	1	1	1	16%
Bomb Threat	1	0	0	1	1	3	2	3	3	14%
Picketing	1	0	0	1	1	2	3	3	3	14%
Explosion	1	0	0	3	3	3	1	1	1	13%
Hazmat Incident with Mass Casualties	1	0	0	3	2	2	2	2	1	13%
HVAC Failure	2	0	0	1	1	1	1	1	1	13%
Mass Casualty Incident	1	0	0	3	2	2	2	2	1	13%
Suspicious Odor	2	0	0	1	1	1	1	1	1	13%
VIP Situation	2	0	0	1	1	1	1	1	1	13%
Chemical Exposure, External	1	0	0	2	1	1	3	3	1	12%
Civil Unrest	1	0	0	1	1	2	3	3	1	12%
Hostage Situation	1	0	0	2	1	2	2	2	2	12%
Strikes / Labor Action / Work Stoppage	1	0	0	1	1	2	3	3	0	11%
Patient Surge	1	0	0	1	1	2	2	2	1	10%
Transportation Failure	1	0	0	1	1	2	2	2	1	10%
Natural Gas Disruption	1	0	0	1	1	3	1	1	1	9%
Natural Gas Failure	1	0	0	1	1	3	1	1	1	9%
Sewer Failure	1	0	0	1	1	3	1	1	1	9%
Water Contamination	1	0	0	2	1	2	1	1	1	9%
Supply Chain Shortage / Failure	1	0	0	1	1	2	1	1	1	8%
Large Internal Spill	1	0	0	1	1	1	1	1	1	7%
Planned Power Outages	1	0	0	1	1	1	1	1	1	7%
Radiation Exposure	1	0	0	1	1	1	1	1	1	7%
Acts of Intent	2	0	0	3	2	2	2	2	3	2%
Building Move	0	0	0	0	0	0	0	0	0	0%
Dam Failure	0	0	0	0	0	0	0	0	0	0%
Drought	0	0	0	0	0	0	0	0	0	0%
External Flood	0	0	0	0	0	0	0	0	0	0%
Forensic Admission	0	0	0	0	0	0	0	0	0	0%
Gas / Emmissions Leak	0	0	0	0	0	0	0	0	0	0%
Generator Failure	0	0	0	0	0	0	0	0	0	0%
Landslide	0	0	0	0	0	0	0	0	0	0%
Other	0	0	0	0	0	0	0	0	0	0%
Other Utility Failure	0	0	0	0	0	0	0	0	0	0%
Tsunami	0	0	0	0	0	0	0	0	0	0%

Kaiser Permanente

Emergency Management

Summary For - Enter name of hospital

ALERT TYPE	OCCURRENCE
Command Center Activation	0
Patient Care Impacts	0
Business / Operational Impacts	0
Structural Impacts	0
Resource Request	0
Recovery Plan Activated	0
AAR	0
Total Alert	0



0

TOP 10 HVA	RANK	OCCURRENCE
Fire	1	0
Internal Fire	2	0
#NAME?	3	#NAME?
Trauma	4	0
Communication / TelephonyFailure	5	0
Epidemic	6	0
Inclement Weather	7	0
Pandemic	8	0
Power Outage	9	0
Suicide	10	0

0

TOP 10 ACTUAL ALERTS	OCCURRENCE	HVA RANK
	0	

Appendix B - Memoranda of Understanding

Attachment A – ICS Assignment List and Activation Instructions

ICS ROLE	DESCRIPTION	PRIMARY STAFF ASSIGNED	SECONDARY STAFF ASSIGNED
Incident Commander			
Public Information Officer			
Liaison Officer			
Safety Officer			
Operations Section Chief			
Planning Section Chief			
Logistics Section Chief			
Finance and Administration Section Chief			
Other			

Authority to Activate

The CEO or designee have the authority to activate ICS and will serve as the Incident Commander until relieved, or ICS deactivation.

Activation

Upon notification of an incident, the CEO or designee conducts a rapid assessment of the situation, considering the following decision factors for ICS activation:

- The impact of the incident on operations, patients, staff, and resources.
- The anticipated duration of the incident.

When the ICS is activated, a formal announcement is made, at a minimum, to all staff via email. Those assigned to an ICS role are to report to the Command Center, or EOC, located at a location that is included in the announcement.

Deactivation

Prior to deactivation, the IC will make an assessment of the situation, considering the ongoing impact on operations. Based on the factors considered and ability to return to normal operations, the IC will determine when to formally deactivate ICS. When the decision has been made to deactivate ICS, a formal announcement will be made via email, at a minimum, to all involved parties, which could include staff, patients, community partners, or the public at large.

Attachment B - Job Action Sheet

Immediate Response (0-2 hours)

Section	Branch	Time	Action
Command	Chief Executive Officer		Activate Emergency Operations Plan, the severe weather plan, the facility incident management team. Shelter-in-place, and site abandonment plan, as needed.
			Notify Board of Directors, and other appropriate internal and external official of situation status.
			Establish operational periods, objectives, and regular briefing schedule. Consider using the incident action plan Quick Start for initial documentation of incident.
			Determine timeline and criteria for discontinuation of nonessential services and procedures.
			Inform patients, staff, and families of situation status and provide regular updates.
			Monitor media outlets for updates on the incident and possible impacts on the facilities, Communicate information via regular briefings to Section Chiefs
			Notify HMCC in accordance with local policies and procedures to determine incident details, community status, and establish contacts for requesting supplies, equipment, or personal.
			Obtain the most current and projected weather information from local and national sources
	Chief Financial Officer		Advise the infrastructure branch regarding facilities hardening and protective measures
			Recommend safe areas for immediate shelter-in-place to protect life
			Monitor for the safe shelter of patients, staff and visitors.
			Initiate HICS215A to Assign, direct, and ensure safety actions are adhered to and completed.
	Chief Clinical and Community Service Officer		Evaluate safety issues related to current patient care services, and operational considerations for next 24 hours

Immediate Response (0-2 hours)

Section	Branch	Time	Action
Operations	Chief Financial Officer		Review evacuation policy and procedures and determine whether identified evacuation of storm, transportation routes, and resources for movement
			At the storm's onset, evacuate any patients, staff and visitors from impacted areas to safety
			Implement emergency plans and procedure as needed (heating, ventilation and air conditioning, utilities, communications, etc.).
			Oversee the immediate stabilization of the facilities infrastructure and initiate protective measures.
			Maintain utilities and communications with service providers, activating alternate systems as needed.
			Implement emergency support procedures to sustain critical services (i.e., power, water, medical gases and communication).
			Secure the facility and implement restricted access procedures.
			Initiate Business Continuity Plans and Procedures
Planning	Chief Financial Officer		Assess the community impact to the storm to determine direct and indirect effects on staff, transportation and power, etc.
Logistic	Chief Financial Officer		Refer to the action sheet for appropriate tasks
			Implement emergency support procedures to sustain communications and information technology.
Operations	Chief Clinical and Community Service Officer		Determine if personnel and resources are available to successfully complete the incident action plan. If not, contact logistics for additional personnel or resources.
			Assess patients for risk and prioritize care and resources, as appropriate.
			Assess the impact of the storm on continued outpatient's services; determine the need for cancellations or rescheduling.

Intermediate and Extended Response (2to greater than 12 hours)

Section	Officer	Time	Action	Initials
Command	Incident Commander		Conduct briefing to patients, staff, and persons seeking shelter as well as the media to provide updates on storm and facility status.	
			Address social media issues as warranted; use social media for messaging as situation dictates	
			Maintain contact with HMCC. Relay status and critical needs and receive storm and community updates.	
	Chief Financial Officer		Maintain the safety of patients, staff, families and individuals seeking shelter to the best possible extent.	
			Update the HICS 215A as required	
	Chief Clinical and Community Service Officer		Communicate potentially unsafe conditions to the Incident Commander for evaluation for continuation of care or closure.	

Intermediate and Extended Response (2to greater than 12 hours)

Section	Officer	Time	Action	Initials
Operations	Chief Executive Officer		Ensure the demobilization Plan is being readied.	
	Chief Financial Officer		Ensure that all documentation, including damage assessments, repair costs and tracking materials are submitted to the Planning Section	
			Conduct regular facility and infrastructure evaluations and assessments and respond immediately to damage or problems.	
			Continue facility security and maintain restricted access; determine the need for expansion.	
	Chief Clinical and Community Services Officer		Monitor patients and visitors for adverse effects on health and for psychological stress.	

Intermediate and Extended Response (2to greater than 12 hours)

Section	Officer	Time	Action	Initials
Logistics	Chief Financial Officer		Provide for continuing communication systems and information technology functionality	
			Continue to obtain need supplies, equipment, and medications, Route request for additional resources not available in the facility thru outside agencies; HMCC.	
	Chief Clinical and Community Service Officer		Monitor, report, follow up on, and document staff or patient injuries.	

Intermediate and Extended Response (2to greater than 12 hours)

Section	Officer	Time	Action	Initials
Finance/ Administration	Chief Financial Officer		Implement establish pay codes for personnel to track hours associated with the storm.	
			Continue to track hours associated with the emergency response.	
			Facilitate procurements of supplies, etc., in cooperation with HMCC	
			Begin to collect, when safe, documentation of structural and infrastructure damage and initiate reimbursement and claims procedures.	
			Track and monitor all expenditures, response, storm damage, and repair costs.	
			Track estimates of lost revenue due to facility storm damage and response.	

Demobilization/System Recovery

Section	Officer	Time	Action	Initials
Command	Chief Executive Officer		Determine facility's status and declare termination of incident.	
			Approve the Demobilization Plan	
			Conduct a final media briefing and assist with updating patients and staff.	
			Communicate the final facility's status and termination of incident to HMCC.	
	Chief Financial Officer		Monitor and maintain a safe environment during the return to normal operations.	
			Ensure applicable regulatory agencies are notified of alterations in life safety, safe workplace issues, or environment of care issues	
Operations	Chief Financial Officer		Monitor the fire doors and alarms are in working order	
			Conduct or continue damage assessment surveys	
			Ensure completion of facility's repair.	
			Monitor that entry and exits points are open and functioning.	

Demobilization/System Recovery

Section	Officer	Time	Action	Initials
Operations	Chief Clinical and Community Service Officer		Reschedule canceled Patients	
			Provide behavioral health services and information about community services to patients and staff as need.	
			If record keeping included use of paper based records, ensure all clinical information is entered into electronic medical records.	
Planning	Chief Executive Officer		Conduct debriefings and hot wash with: Command Staff, Administrative personal and Staff	
			Write an After Action Report or Corrective Action. Improvement Plan Summary of incident Summary of action taken Actions that could be improved Recommendations for future	
			response actions Collect, collate, file, and secure completed documentation of actions, decisions, and activities.	
	Chief Clinical Community Service Officer		Ensure that issues impacting clinical and support operations are relayed to appropriate sections for resolutions.	

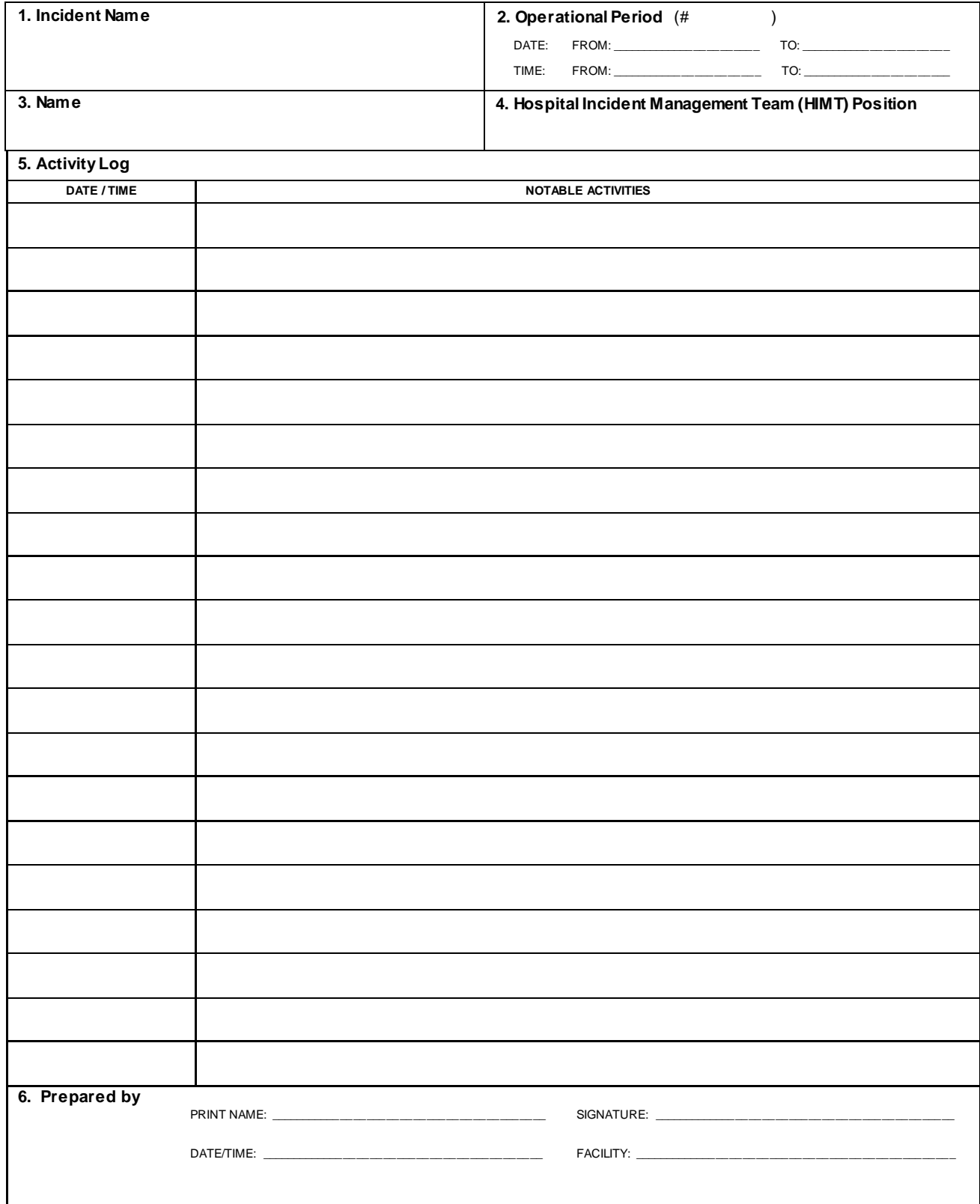
Demobilization/System Recovery

Section	Officer	Time	Action	Initials
Logistics	Chief Financial Officer		Monitor and assist with restoration of communications and information technology services.	
			Restock supplies, equipment, medications, and water to pre-incident inventories.	
			Complete documentation and follow up of personnel injury or line-of-duty death as appropriate	
Finance/ Administration	Chief Financial Officer		Review the summary of final response and recovery costs.	
			Contact insurance carriers to initiate reimbursement and claims procedures.	
			Compile a final summary of response and recovery cost, expenditures, and estimate lost revenues.	

Attachment C – Incident Action Plan Quick Start and Activity Log

- PURPOSE:** The Activity Log records details of notable activities for any Incident Command Team (ICT) position. These logs provide basic documentation of incident activity, and a reference for any After Action Report (AAR). Personnel should document how relevant incident activities are occurring and progressing, or any notable activities, actions taken and decisions made.
- ORIGINATION:** Initiated and maintained by personnel in HIMT positions as it is needed or appropriate.
- COPIES TO:** A completed HICS 214 must be submitted to the Documentation Unit Leader. Individuals may retain a copy for their own records.
- NOTES:** Multiple pages can be used if needed. If additional pages are needed, use a blank HICS 214 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Name	Print the name of the person for whom the activities are being documented.
4	HIMT Position	Enter the Hospital Incident Management Team (HIMT) position for which the activities are being documented.
5	Activity Log	<p>Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date (m/d/y), as well as if the operational period covers more than one day.</p> <p>Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, information received, etc.</p> <p>This block can also be used to track personal work activities by adding columns such as "Action Required," "Delegated To," "Status," etc.</p>
6	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.



- PURPOSE:** The HICS 214 - Activity Log records details of notable activities for any Hospital Incident Management Team (HIMT) position. These logs provide basic documentation of incident activity, and a reference for any After Action Report (AAR). Personnel should document how relevant incident activities are occurring and progressing, or any notable activities, actions taken and decisions made.
- ORIGINATION:** Initiated and maintained by personnel in HIMT positions as it is needed or appropriate.
- COPIES TO:** A completed HICS 214 must be submitted to the Documentation Unit Leader. Individuals may retain a copy for their own records.
- NOTES:** Multiple pages can be used if needed. If additional pages are needed, use a blank HICS 214 and repaginate as needed. Additions may be made to the form to meet the organization's needs.

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1	Incident Name	Enter the name assigned to the incident.
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5	Activity Log	<p>Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date (m/d/y), as well as if the operational period covers more than one day.</p> <p>Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, information received, etc.</p> <p>This block can also be used to track personal work activities by adding columns such as "Action Required," "Delegated To," "Status," etc.</p>
6	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.



1. Incident Name	2. Operational Period (#) DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____
3. Situation Summary — HICS 201 —	
4. Current Hospital Incident Management Team (fill in additional positions as appropriate) — HICS 201, 203 —	
<div style="display: flex; justify-content: space-around; align-items: center;"><div style="text-align: center;"><div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Public Information Officer</div><div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Liaison Officer</div><div style="border: 1px solid black; padding: 5px;">Safety Officer</div></div><div style="text-align: center;"><div style="border: 1px solid black; padding: 10px; width: 200px;">Incident Commander</div></div><div style="text-align: center;"><div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">Medical-Technical Specialists</div></div></div> <div style="display: flex; justify-content: center; margin-top: 20px;"><div style="width: 80%; border-top: 1px solid black; position: relative;"><div style="position: absolute; top: -10px; left: 50%; transform: translateX(-50%); border-left: 1px solid black; border-right: 1px solid black; height: 10px;"></div><div style="display: flex; justify-content: space-between; width: 100%; margin-top: 10px;"><div style="width: 22%; text-align: center; border: 1px solid black; padding: 5px;">Operations Section Chief</div><div style="width: 22%; text-align: center; border: 1px solid black; padding: 5px;">Planning Section Chief</div><div style="width: 22%; text-align: center; border: 1px solid black; padding: 5px;">Logistics Section Chief</div><div style="width: 22%; text-align: center; border: 1px solid black; padding: 5px;">Finance / Administration Section Chief</div></div></div></div>	

5. Health and Safety Briefing Identify potential incident health and safety hazards and develop necessary measures (remove hazard, provide personal protective equipment, warn people of the hazard) to protect responders from those hazards. — HICS 202, 215A —

6. Incident Objectives — HICS 202, 204 —

6a. OBJECTIVES	6b. STRATEGIES / TACTICS	6c. RESOURCES REQUIRED	6d. ASSIGNED TO

7. Prepared by PRINT NAME: _____ SIGNATURE: _____
DATE/TIME: _____ FACILITY: _____

PURPOSE: The Incident Action Plan (IAP) Quick Start is a short form combining HICS Forms 201, 202, 203, 204 and 215A. It can be used in place of the full forms to document initial actions taken or during a short incident. Incident management can expand to the full forms as needed.

ORIGINATION: Prepared by the Incident Commander or Planning Section Chief.

COPIES TO: Duplicated and distributed to Command and General staff positions activated. All completed original forms must be given to the Documentation Unit Leader.

NOTES: If additional pages are needed for any form page, use a blank HICS IAP Quick Start and repaginate as needed. Additions may be made to the form to meet the organization's needs.

NUMBER	TITLE	INSTRUCTIONS
1	Incident Name	Enter the name assigned to the incident.
2	Operational Period	Enter the start date (m/d/y) and time (24-hour clock) and end date and time for the operational period to which the form applies.
3	Situation Summary	Enter brief situation summary.
4	Current Hospital Incident Management Team	Enter the names of the individuals assigned to each position on the Hospital Incident Management Team (HIMT) chart. Modify the chart as necessary, and add any lines/spaces needed for Command staff assistants, agency representatives, and the organization of each of the General staff sections.
5	Health and Safety Briefing	Summary of health and safety issues and instructions.
6	Incident Objectives	
	6a. Objectives	Enter each objective separately. Adjust objectives for each operational period as needed.
	6b. Strategies / Tactics	For each objective, document the strategy/tactic to accomplish that objective.
	6c. Resources Required	For each strategy/tactic, document the resources required to accomplish that objective.
	6d. Assigned to	For each strategy/tactic, document the Branch or Unit assigned to that strategy/tactic.
7	Prepared by	Enter the name and signature of the person preparing the form. Enter date (m/d/y), time prepared (24-hour clock), and facility.

Attachment D – Management Emergency Contacts

CRITICAL TEAM MEMBERS

CEO	Eliza Lake	617-413-8604 (cell)
CFAO	Frank Mertes	413-474-8434 (cell)
CCCSO	Michael Purdy	937-243-3148 (cell)
Medical	Jon Liebman	413-320-7706 (cell)
Dental	Mary Lou Stuart	413-584-0202 (home)
Behavioral Health	Franny Huberman	413-854-8662 (cell)
Optometry	Michael Purdy	937-243-3148 (cell)
Community	Kim Savery	413-329-8129 (cell)
Practice Manager	Cynthia Magrath	973-953-3717 (cell)
Clinical Operations	Dawn Flatt	413-214-2892 (cell)
Reception	Patti Igel	413-977-6615 (cell)
Maintenance	Russ Jordan	413-992-7021 (cell)

Attachment E – Partner Contact List

Attachment E – Partner Contact List

HEALTH CENTER NAME	ADDRESS	WEBSITE	CONTACT NUMBER
Caring Health Center	1049 Main Street Springfield, MA 01103	www.caringhealth.org	413-739-1100
CHP Community Health Center	444 Stockbridge Road Great Barrington, MA 01230	www.hhcinc.org	413-528-8580
Community Health Center of Franklin County	489 Bernardston Road Greenfield, MA-1301	www.chcfc.org	413-325-8500
Holyoke Health Center	230 Maple Street Holyoke, MA 01040	www.hhcinc.org	413-420-2200
Community Health Center of Franklin County (dental services only)	338 Montague city Road Turners Falls, MA 01376	www.chcfc.org	413-774-2615
COALITIONS	ADDRESS	WEBSITE	CONTACT NUMBER
Health and Medical Coordinating Coalition	12 Olive Street, Suite 2 Greenfield, MA 01301	www.frcog.org/program-services/emergency-preparedness/region-1-health-medical-coordinating-coalition/	413-774-3167
Hampshire Public Health Preparedness Coalition c/o Northampton Health Department	212 Main St. Northampton, MA 01060		(413) 587-1314
HOSPITALS	ADDRESS	WEBSITE	CONTACT NUMBER

Attachment E – Partner Contact List

Cooley Dickinson Hospital	30 Locust Street Northampton, MA 01060	www.cooleydickinson.org	413-586-8400
Baystate Noble Hospital	115 West Silver Street Westfield, MA 01085	www.baystatehealth.org/locations/noble-hospital	413-568-2811
Berkshire Medical Center	725 North Street Pittsfield, MA 01201	www.berkshirehealthsystems.org	413-447-2000
SCHOOL DISTRICTS	ADDRESS	WEBSITE	CONTACT NUMBER
Gateway Regional School District	12 Littleville Road Huntington, MA 01050	www.grsd.org	413-685-1003
Hampshire Regional School District	19 Stage Road Westhampton, MA 01027	http://www.edline.net/pages/Hampshire_RegionalSD	413-527-7200

Attachment F –Emergency Notifications and Activation Messaging

Hilltown Community Health Centers, Inc.

Emergency Management Plan

All Departments and Programs

HCHC Emergency Messages

NOTE: In the event of a true emergency, any staff person must use the HCHC public address system to make an announcement, which will be broadcast to all phones in the facility. When a staff person hears this message, they must loudly repeat the message in their hallway as they take the appropriate steps to ensure their own safety and that of patients and visitors around them. This verbal repetition is crucial to ensure that all individuals in the facility, regardless of proximity to a phone, are alerted to the situation.

ARMED INTRUDER

This is an EMERGENCY. There is a man/woman with a weapon in the building. Last seen [location]. Please go into lock-down mode at this time. **THIS IS NOT A DRILL!** Wait for the all clear notification from local authorities. [Repeat message]

BOMB THREAT

This is an EMERGENCY alert. We have received a bomb threat that we deem credible. Evacuate the building. **THIS IS NOT A DRILL.** Follow instructions from authorities, [Repeat Message]

EXPLOSION

This is an EMERGENCY. There has been an explosion in the building. If you are in the building and it is safe to do so you should evacuate immediately. Follow instructions from local authorities. **THIS IS NOT A DRILL.** [Repeat message]

FLOODING

This is an Emergency. The Health Center is currently flooding. Seek higher ground immediately. Wait for authorities. **THIS IS NOT A DRILL.** [Repeat Message]

GAS LEAK

This is an EMERGENCY. There is a gas leak in the building. It poses a threat of fire from accidental ignition. Immediately extinguish any burners or other flames and evacuate building. Follow instructions of local authorities. THIS IS NOT A DRILL. [Repeat message]

HAZARDOUS MATERIALS IN BUILDING

This is an EMERGENCY. There has been a [spill/release] of a hazardous material in the building. Evacuate immediately. Follow instructions of local authorities. THIS IS NOT A DRILL. [Repeat message]

HAZARDOUS MATERIALS OUTSIDE BUILDING

This is an EMERGENCY. There has been a [spill/release] of a hazardous material outside the building. Stay in the building. Close all doors and windows. Follow instructions of local authorities. THIS IS NOT A DRILL. [Repeat message]

SUSPICIOUS PACKAGE

This is an EMERGENCY. A suspicious package has been found on site. Evacuate immediately. Follow instructions from local authorities. THIS IS NOT A DRILL. [Repeat message]

TORNADO

This is an Emergency. A tornado warning has been issued until [time] today. A tornado warning means that a tornado has been sighted on the ground and you should take immediate cover. Proceed to the basement and follow our emergency procedures. THIS IS NOT A DRILL. [Repeat message]

Attachment G – Emergency Shut-Off Sheets

EMERGENCY UTILITY SHUT-OFF LOCATIONS
Worthington Health Center
58 Old North Road, Worthington

UTILITY	SHUT-OFF LOCATION	ACCESS INSTRUCTIONS	METHOD TO SHUT OFF
Water	Go to the basement, off of the Eye Care Department. Go straight back into the furnace room.	Once inside go to the back right wall and look for the sign that reads WATER MAIN SHUT OFF behind the valve.	Turn the valve handle 90 degrees - it will stop when completely closed. The handle will be perpendicular to the pipe when it is off.
Natural Gas / Propane	Go to the basement, off of the Eye Care Department. Go straight back into the furnace room.	Once inside go to the back right wall and look for the sign that reads GAS SHUT OFF behind the valve.	
Electric – Main feeds to areas of the building	The main electrical panel is located in the server room next to the lunch room.	Once located, open panel door to access breakers.	Switch main breaker to off position.
Emergency Generators			
HVAC	N/A		

EMERGENCY UTILITY SHUT-OFF LOCATIONS
Huntington Health Center
73 Russell Road, Huntington, MA

UTILITY	SHUT-OFF LOCATION	ACCESS INSTRUCTIONS	METHOD TO SHUT OFF
Water	Go to the new basement (door next to Med Room) and go into the furnace room on your left when entering the new basement.	Go to the back of the furnace room (watch your head under the ductwork), and you will see, coming into the building, is the main water line. You will see a sign on the wall above the valve that reads WATER MAIN SHUT OFF.	Turn the valve handle 90 degrees - it will stop when completely closed. The handle will be perpendicular to the pipe when it is off.
Natural Gas / Propane	N/A		
Electric – Main feeds to areas of the building	The main electrical pane is located in the server room	Once located, open panel door to access breakers	Switch main breaker to off position.
Emergency Generators	N/A		
HVAC	N/A		

EMERGENCY UTILITY SHUT-OFF LOCATIONS
Hilltown Community Center
9 Russell Road, Huntington

UTILITY	SHUT-OFF LOCATION	ACCESS INSTRUCTIONS	METHOD TO SHUT OFF
Water	Go to the basement, through bulkhead located outside near playground area.	Once inside go to the back wall and look for the sign that reads WATER MAIN SHUT OFF behind the valve.	Turn the valve handle 90 degrees - it will stop when completely closed. The handle will be perpendicular to the pipe when it is off.
Natural Gas / Propane	There are three furnaces located in the attic, crawl space on second floor and in the cellar. Gas tanks are located outside next to each other.	Gas valves are located beside each tank outside.	
Electric – Main feeds to areas of the building	Go to the basement, through bulk head located outside near playground area.	Once inside go to the back wall and look for electrical panel.	Switch main breaker to off position.
Emergency Generators	N/A		
HVAC	N/A		

EMERGENCY UTILITY SHUT-OFF LOCATIONS

John P. Musante
70 Boltwood Walk, Amherst

UTILITY	SHUT-OFF LOCATION	ACCESS INSTRUCTIONS	METHOD TO SHUT OFF
Water	Located in the mechanical room of the Bangs Center with key for all staff to access it		
Natural Gas / Propane	N/A		
Electric – Main feeds to areas of the building	Located in the mechanical room of the Bangs Center with key for all staff to access it	Once inside go to the back wall and look for electrical panel.	Switch main breaker to off position.
Emergency Generators	N/A		
HVAC	N/A		

Attachment H – Vendor Contact List

VENDOR NAME	DESCRIPTION	CONTACT PERSON	PHONE/ EMAIL	CONTRACT/ ACCOUNT #	LOGIN/ PASSWORD
Baystate Elevator	Elevator maintenance		800-809-5410		
New England Security	Alarm system		413-467-3784		
Great White Cleaning	Cleaning company	Scott Texiera	413-478-4447		
Mike O'Melia Electrical	Electrician	Mike O'Melia	413-354-6531		
Western MA Climate	Heating/AC	Mike Crow	413-568-7770		
Ryan Rida Plumbing	Plumber	Ryan Rida	413-695-5218		
George Propane	Propane service	Mike George	800-464-2053		
Sunset Oil	Oil service		413-374-4132		
Lafond Septic	Septic service		413-667-3622		
Clean Harbor	Tight tank water testing		413-789-9018		
Steve Kidrick Snow	Plowing	Steve Kidrick	413-667-3268		
Donnie Bisbee Plowing	Plowing	Donnie Bisbee	413-296-0180		
Sullivan Schein Dental	Dental equipment / flu	Ryan Archambault	413- 330-3698		
Stericycle	Biohazard, sharps, fixer &		800-633-9278		
Aladco	Lab coats		413-534-7391	12401	
Mckesson	Medical supplies	Andrew Aronson	800-866-9243	W 467722 / H 467749	DAVIDMOR/ salad549
Mass Surgical	Medical supplies	DJ O'Connor	413-532-1401		
GlaxoSmithKline	Vaccines	Phil Hoar	802-375-0078	W 782705 / H 819014	
Henry Schein Medical Division	Vaccines	Claudia Brown	413-772-4346 x7112		
Vaccineshoppe.com	Vaccines			W 70023948 / H 70023949	W: hchcw/ Hilltown H: HCHCH/ COFFEE
Merck	Vaccines		877-829-6372	18542	Hilltown/ Community
Novartis/Chiron	Rabies Post Exposure IG vaccine		800-244-7668	W 55923 / H 74326	
Bayer	Mirena IUD		866-647-3646	142268	
Paragard	IUDs		800-322-4966		

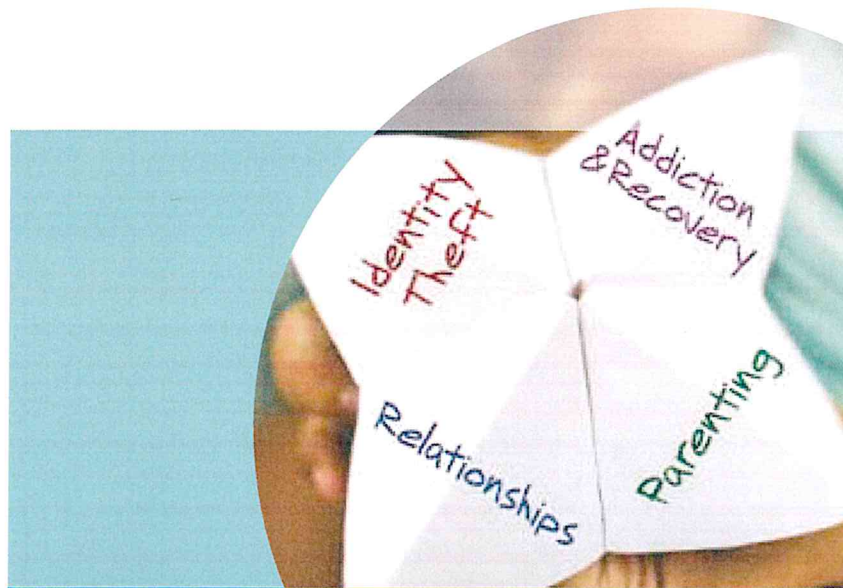
	AED supplies		800-442-1142	13819201	
Cooper Surgical	diaphragms		800-243-2974	10165590	
Office Depot	Office supplies		Ordered online		
WB Mason	Office supplies		Ordered online		
Staples	Office supplies		Ordered online		

Attachment I - Multi-year Training and Exercise Plan

YEAR- 2019

SITE	JAN	APR	MAY	JUNE	SEP	OCT	DEC
<i>WHC</i>	Comm. Drill			Fire Drill	Lock Down		
<i>HHC</i>	Comm. Drill			Fire Drill	Lock Down		
<i>CHC</i>	Comm. Drill			Fire Drill	Lock Down		
<i>JPMHC</i>	Comm. Drill			Fire Drill			

Attachment J – Employee Assistance Program Resources



Life's stresses aren't a game

Real solutions are close at hand

unum.com
MK-1516 (11-12)

Work-life balance employee assistance program

Toll-free, 24-hour access

- 1-800-854-1446: English
- 1-877-858-2147: Spanish
- 1-800-999-3004: TTY/TDD

Online access

www.lifebalance.net; user ID and password: lifebalance

Your work-life balance employee assistance program — provided at no additional charge through your company's insurance benefit plan — can help you find solutions for the everyday challenges of work and home as well as for more serious issues involving emotional and physical well-being.

- Childcare and/or eldercare referrals
- Personal relationship information
- Health information and online tools
- Legal consultations with licensed attorneys
- Financial planning assistance
- Stress management
- Career development

Help is easy to access

- **Telephone consultations:** Speak confidentially with a master's level consultant to clarify your need, evaluate options and create an action plan.
- **Face-to-face meeting:** Meet with a local consultant up to three times per issue for short-term problem resolution.*
- **Educational materials:** Receive information through our online library of downloadable materials and interactive tools.

To learn more, please visit www.lifebalance.net;
user ID and password: lifebalance

Work-life balance employee assistance program services are provided by Ceridian Corporation and are available with selected Unum insurance offerings. Exclusions, limitations and prior notice requirements may apply, and service features, terms and eligibility criteria are subject to change. The services are not valid after termination of coverage and may be withdrawn at any time. Please contact your plan administrator for full details.

*In California and Nevada, you may confer with a local consultant up to three times in a six-month time period.

Insurance products underwritten by the subsidiaries of Unum Group.
unum.com

© 2012 Unum Group. All rights reserved. Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

MK-1516 (11-12) FOR EMPLOYEES



This is not a medical insurance card.

Keep this card with you at all times. It gives you immediate access to a full range of confidential work-life balance services for you and your family. If you need additional cards, contact your workplace plan administrator.

Annex A –Continuity of Operations Plan (COOP)



Hilltown Community Health Centers, Inc.

Administrative

SUBJECT: CONTINUITY OF OPERATIONS PLAN

REGULATORY REFERENCE: HRSA PIN 2007-15 Health Center Emergency Management Program Expectations; CMS Final Rule for Emergency Preparedness 491.12(a)(3)

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this plan to have a formal documented process for carrying out primary functions in the event of a catastrophic reduction of clinical staff due to biological illness, i.e. a pandemic of some sort.

Policy:

1. HCHC will follow the procedures outlined in this policy in the event of a significant reduction in staffing.
2. Business interruptions will be handled in coordination with local (town, hospital) emergency preparedness plans.
3. The Incident Commander will be the CEO, and in his or her absence or unavailability of the Chief Financial and Administrative Officer or other designated Incident Commander.
4. Issues that would arise were there a physical impact on the health center infrastructure such as a prolonged loss of energy, disruption in water supply, fire, earthquake, or other natural or intentional disaster are addressed in the Emergency Management Plan.

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

Originally Drafted: MAR 2006

Reviewed or Revised: APR 2019

Approved by Board of Directors, Date: _____

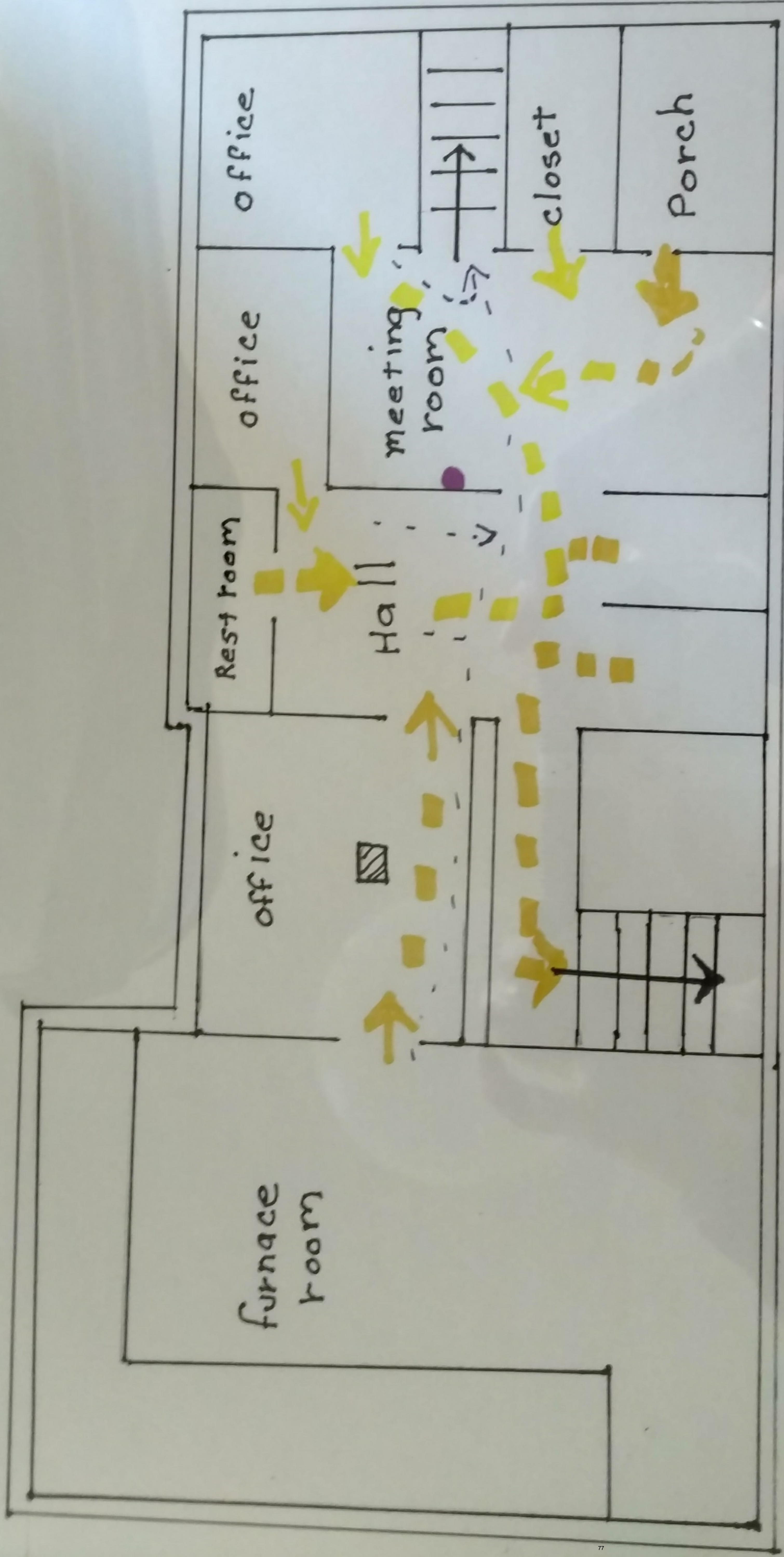
Approved by:

Eliza B. Lake
CEO, HCHC

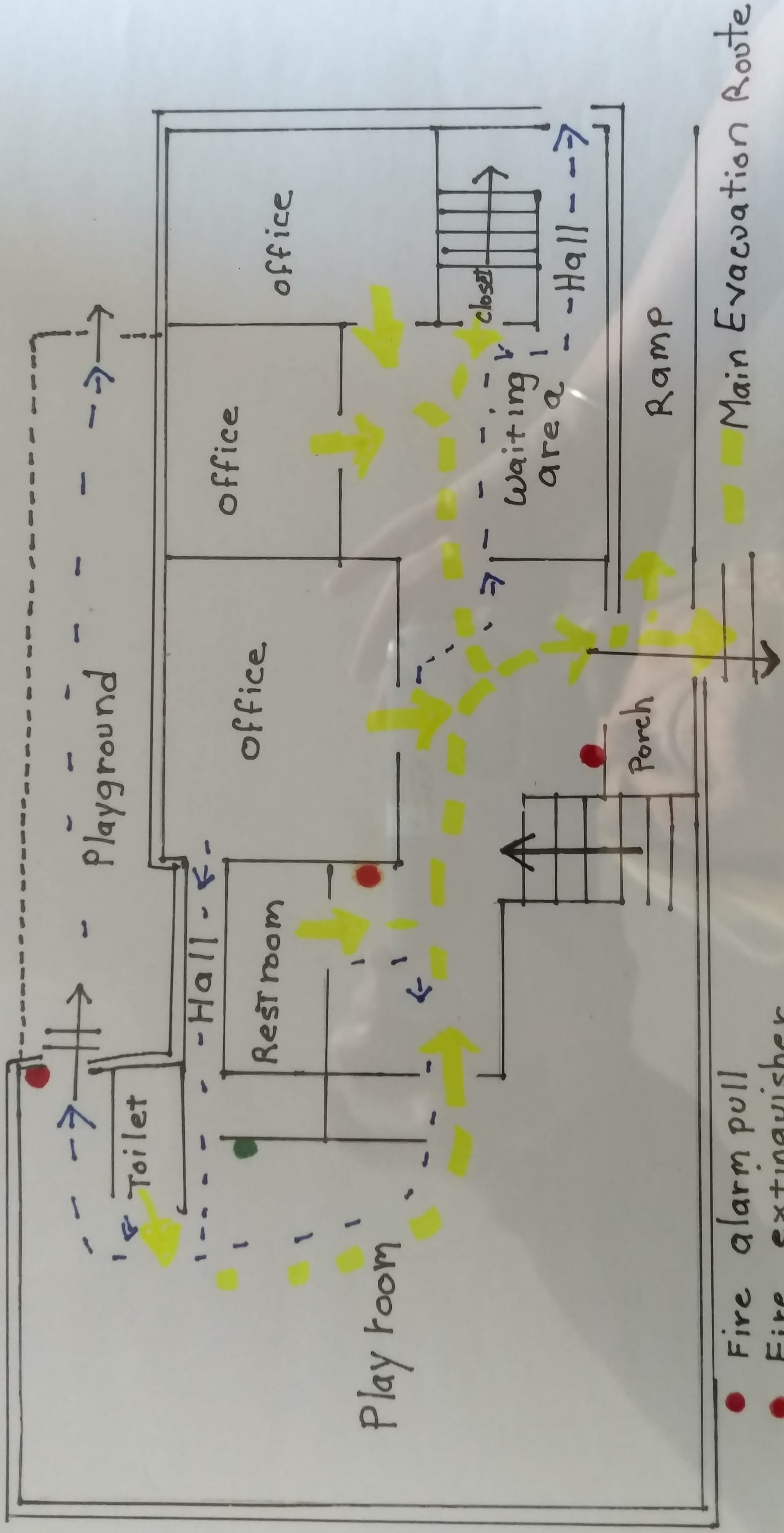
Date: _____

John Follet, MD
President, HCHC Board of Directors

Annex B – Evacuation Plans



9 Russell Road 2nd floor



- Fire alarm pull
- Fire extinguisher
- First Aid kit

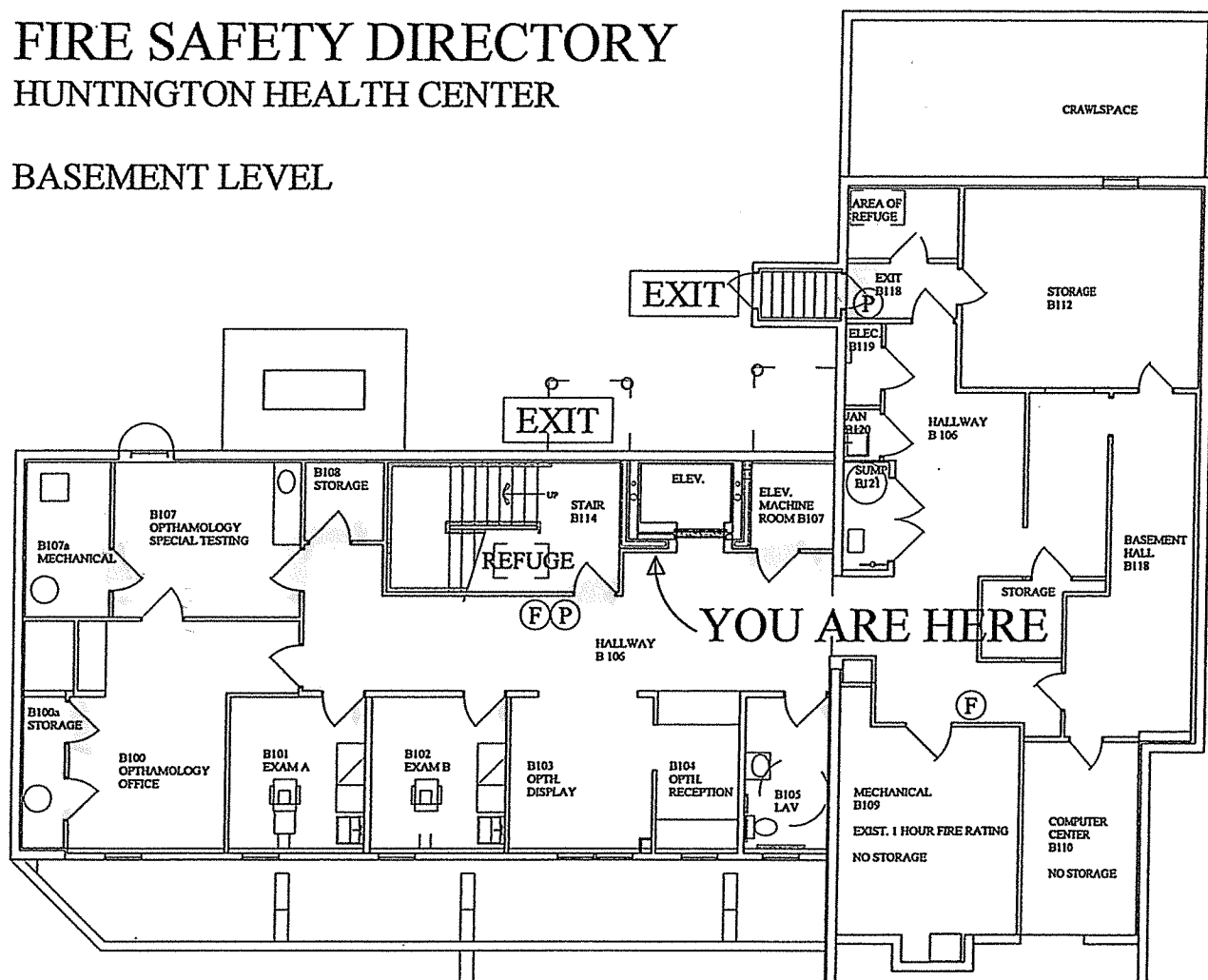
----- Alternate Route

● You are Here

FIRE SAFETY DIRECTORY

HUNTINGTON HEALTH CENTER

BASEMENT LEVEL



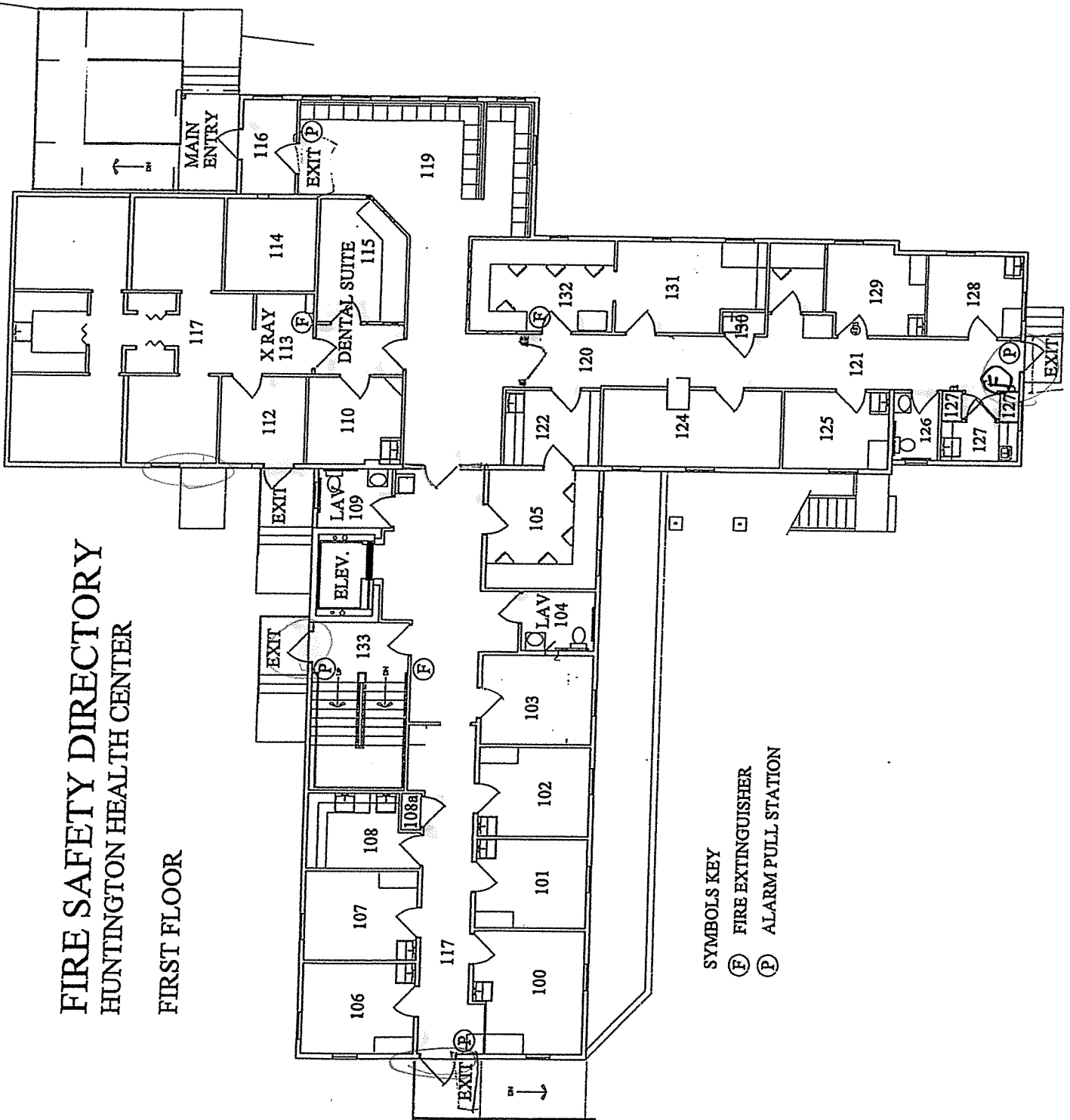
SYMBOLS KEY

- REFUGE AREA OF REFUGE
- (F) FIRE EXTINGUISHER
- (P) ALARM PULL STATION
- EXIT EXIT

RED STRIPE INDICATES PATH TO EXIT

FIRE SAFETY DIRECTORY HUNTINGTON HEALTH CENTER

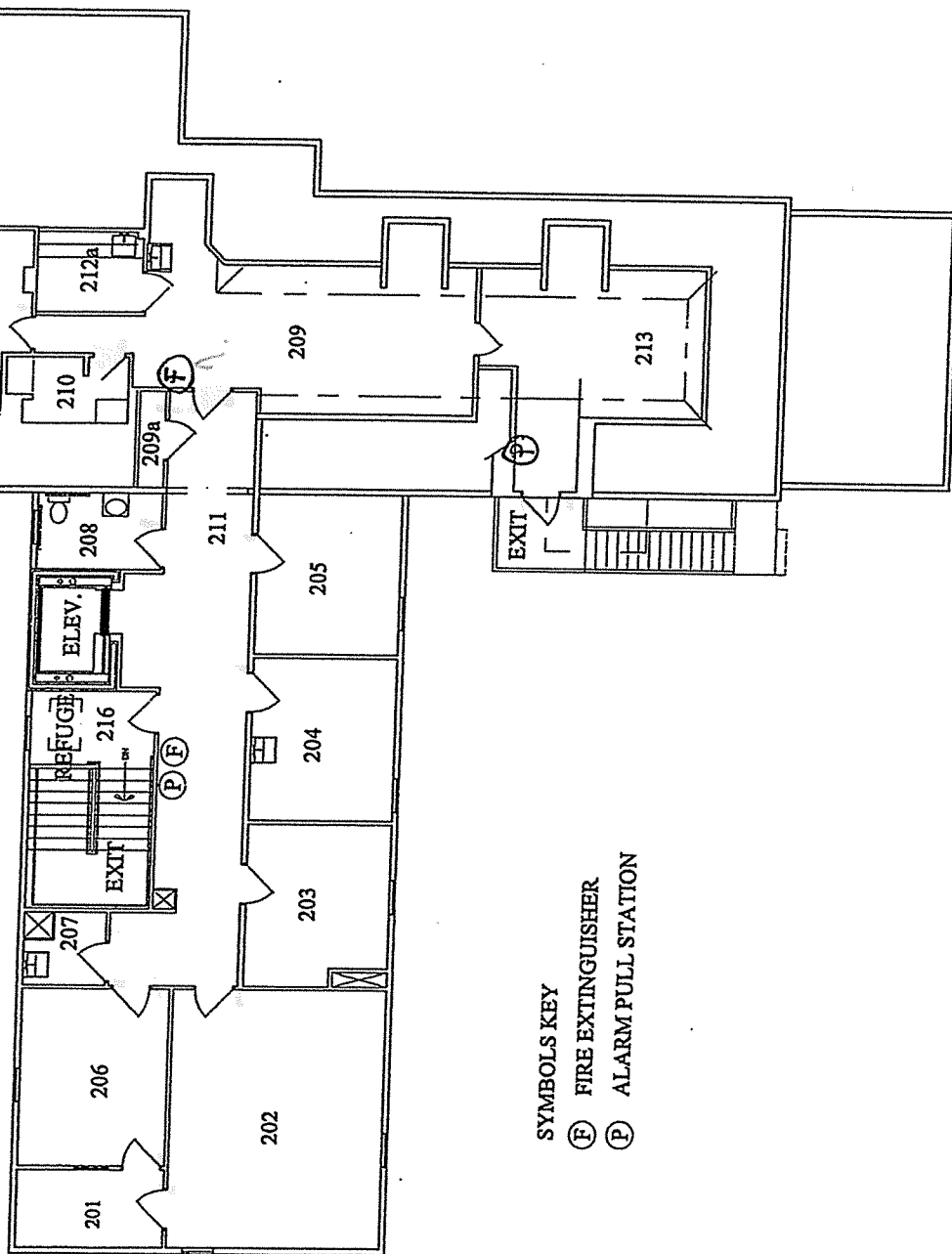
FIRST FLOOR



SYMBOLS KEY
(F) FIRE EXTINGUISHER
(P) ALARM PULL STATION

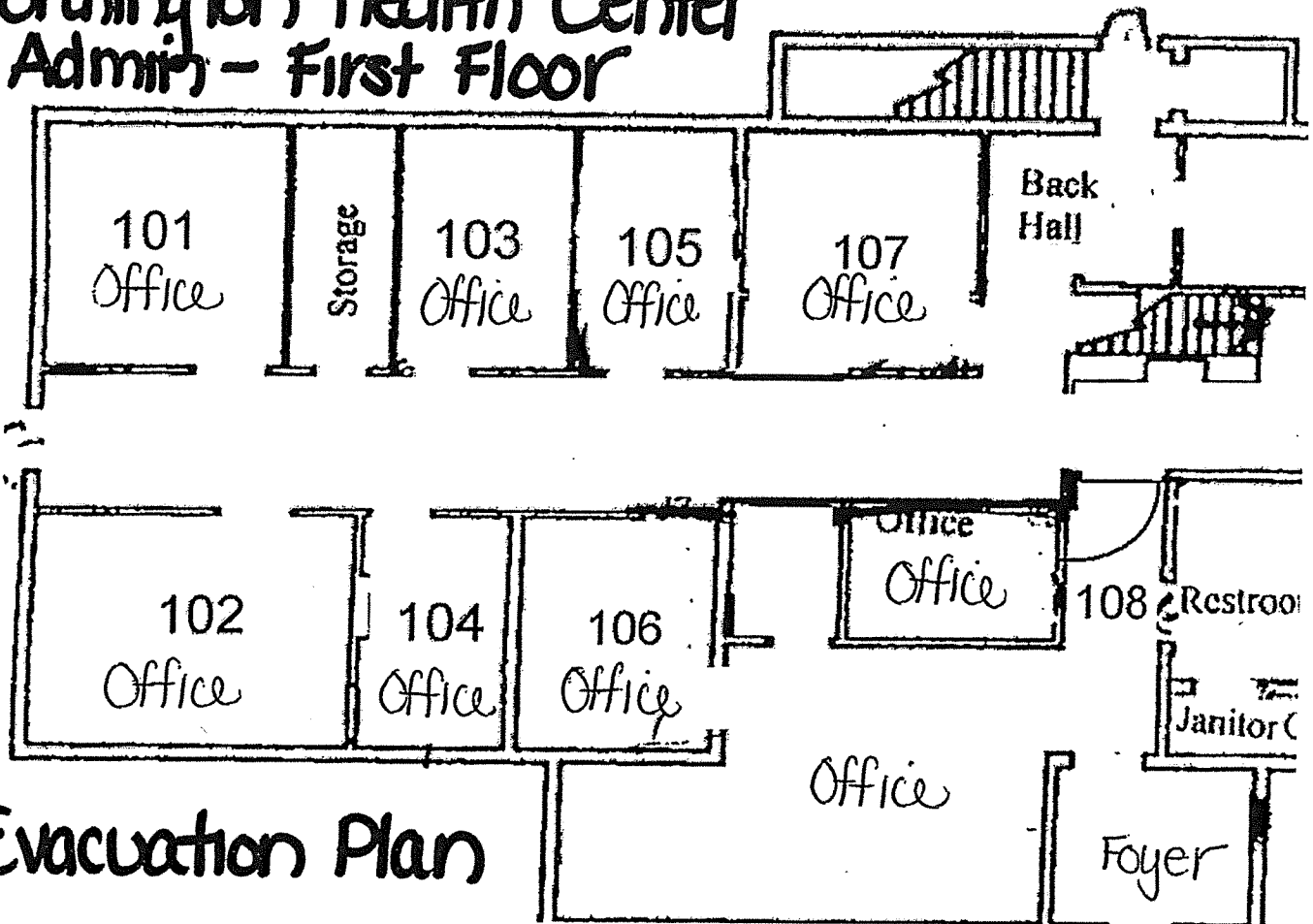
FIRE SAFETY DIRECTORY HUNTINGTON HEALTH CENTER

SECOND FLOOR

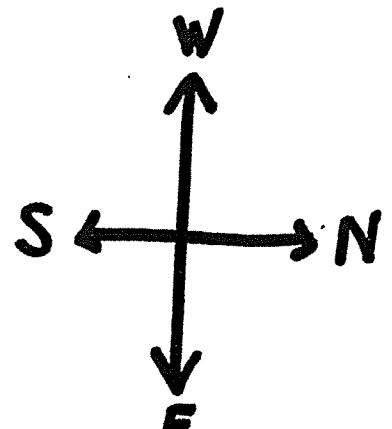


- SYMBOLS KEY
- (F) FIRE EXTINGUISHER
 - (P) ALARM PULL STATION

Worthington Health Center Admin - First Floor

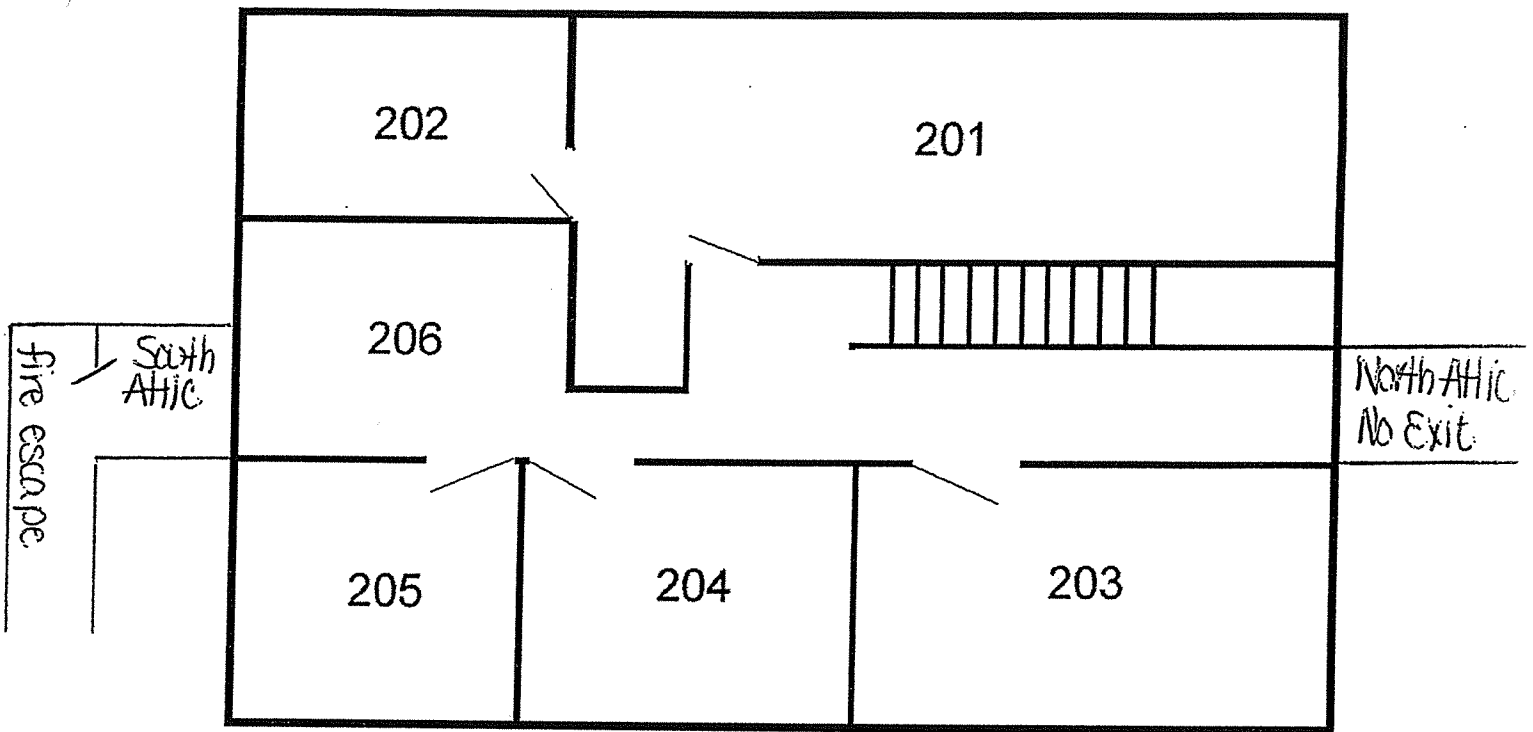


You Are Here
Fire Alarm Pull
Fire Extinguisher
Main Exit Route
Alternate Route

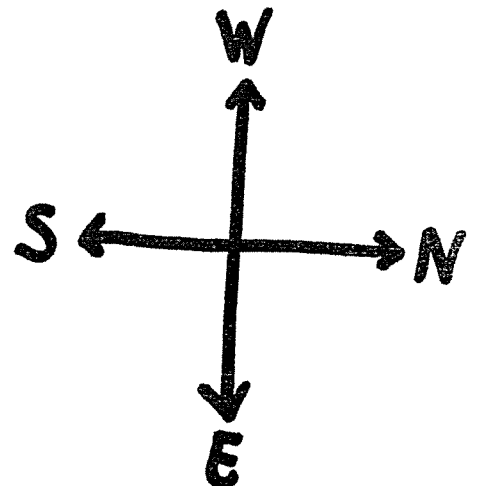


Worthington Health Center

Second Floor Evacuation Plan



You Are Here
Fire Alarm Pull
Fire Extinguisher
Main Exit Route
Alternate Route



EVACUATION PLAN

WORTHINGTON HEALTH CENTER

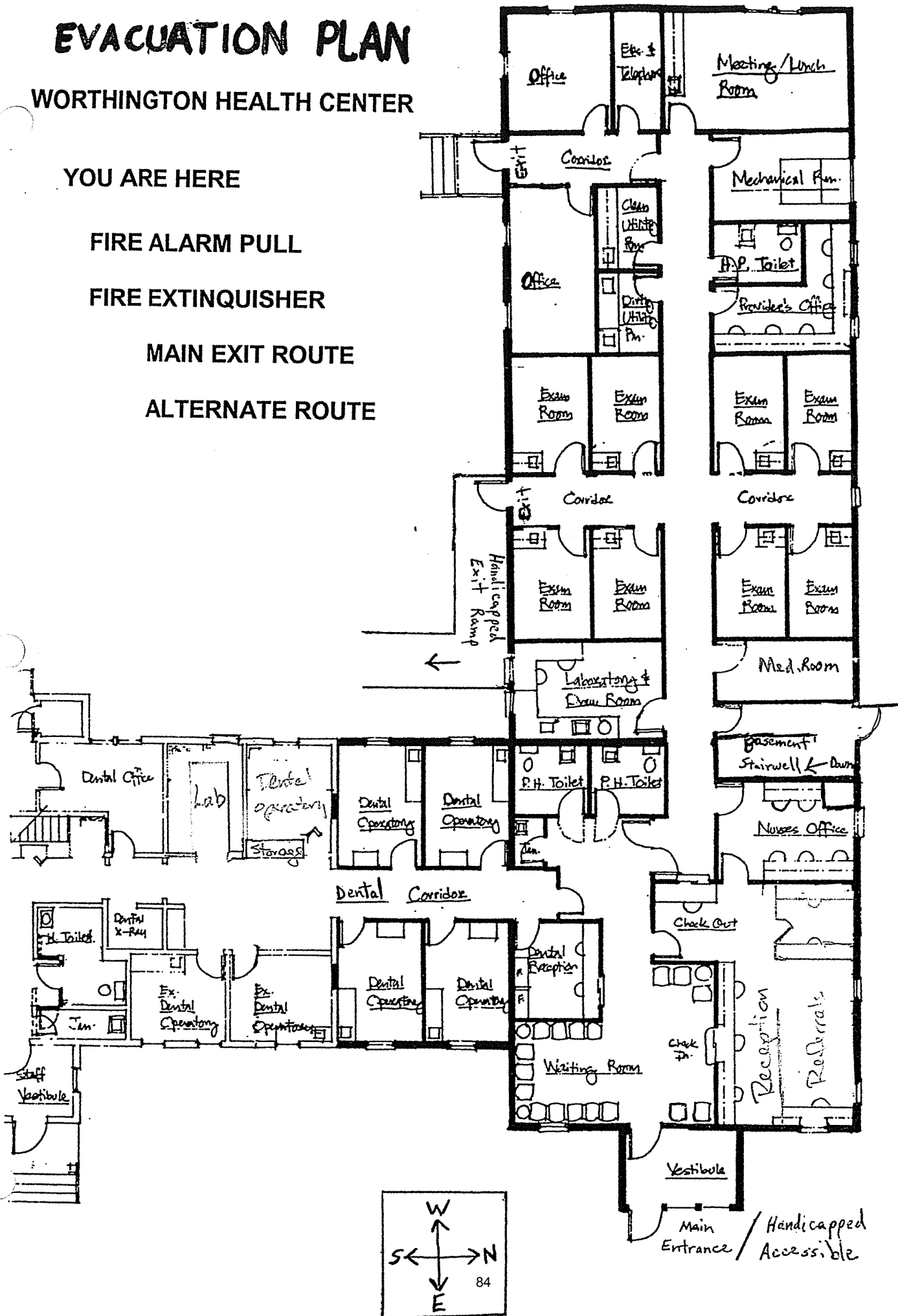
YOU ARE HERE

FIRE ALARM PULL

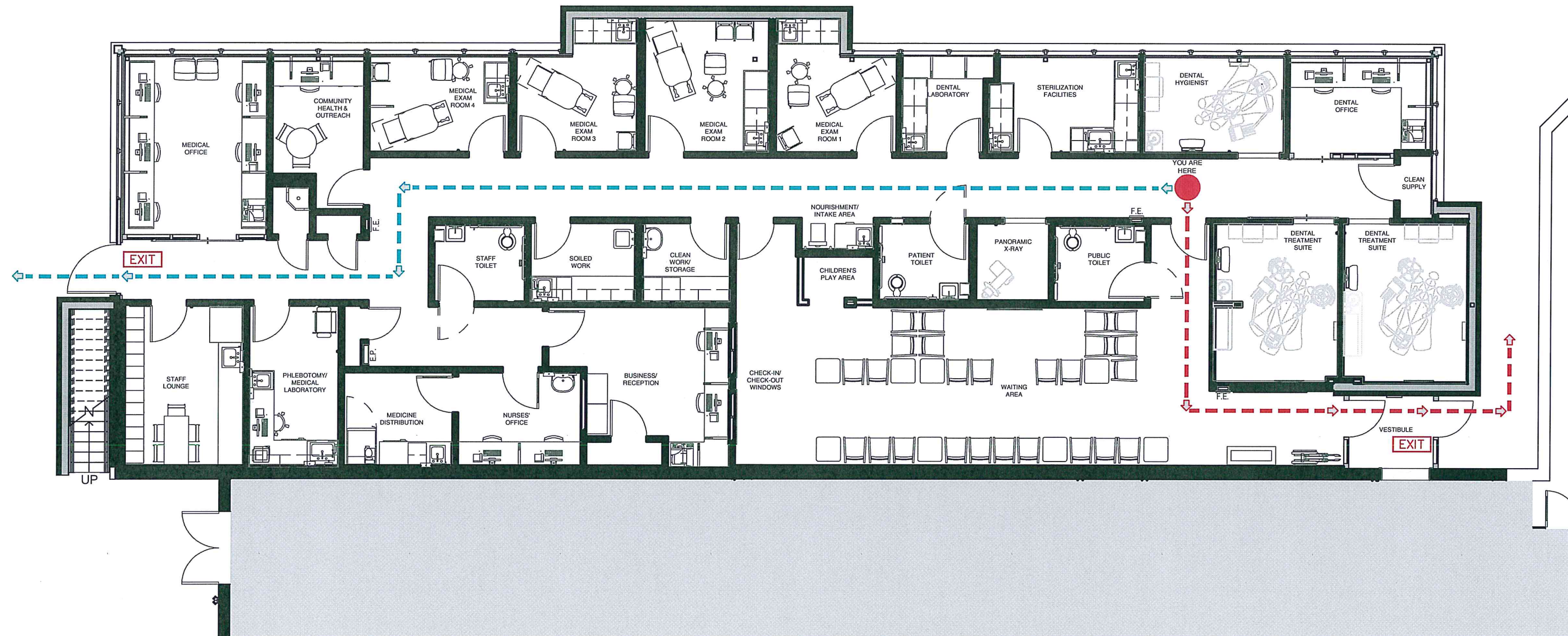
FIRE EXTINGUISHER

MAIN EXIT ROUTE




ALTERNATE ROUTE



70 Boltwood Walk, John P. Musante Health Center Emergency Evacuation Diagram



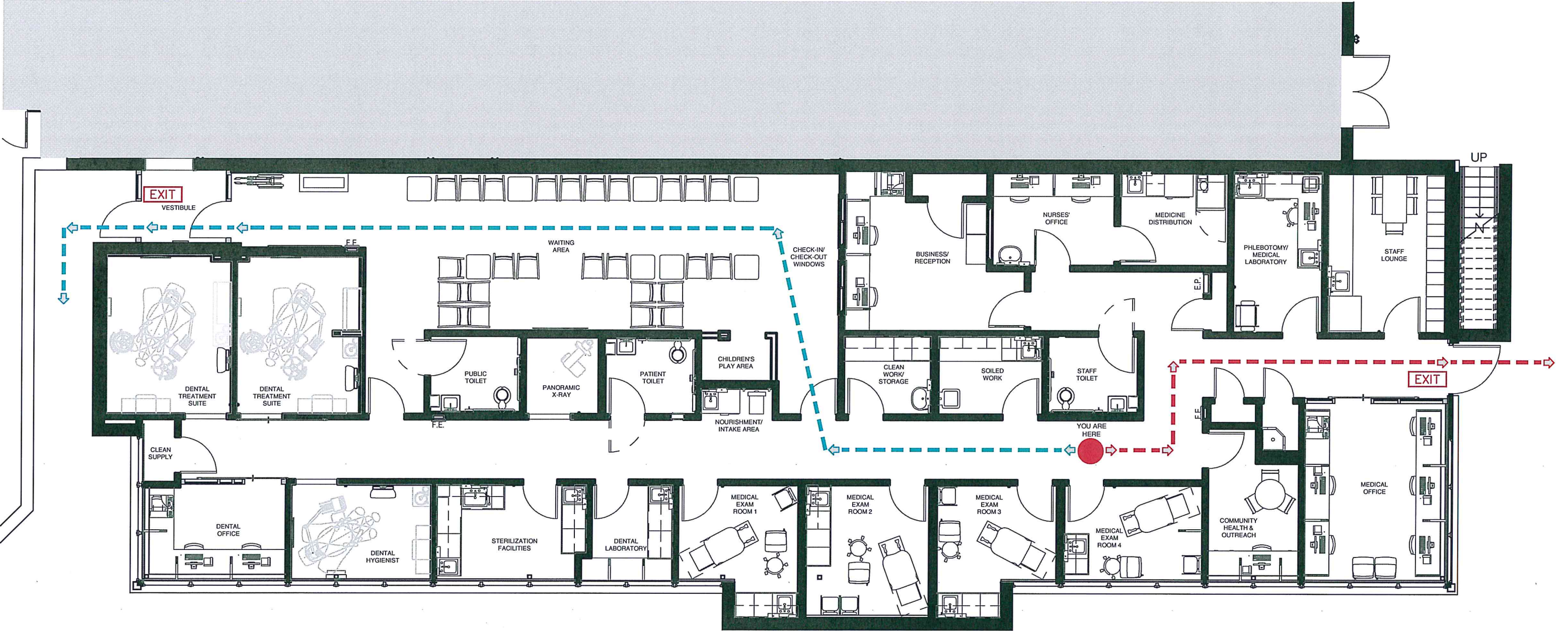
70 BOLTWOOD WALK
JOHN P. MUSANTE HEALTH CENTER @
BANGS COMMUNITY CENTER

LEGEND	
 YOU ARE HERE	CURRENT LOCATION
	PRIMARY EVACUATION PATH
	SECONDARY EVACUATION PATH




IN CASE OF FIRE OR OTHER
EMERGENCY REQUIRING
EVACUATION, IMMEDIATELY
LEAVE THE BUILDING AND
CONTACT EMERGENCY
RESPONSE PERSONNEL AT

911

70 Boltwood Walk, John P. Musante Health Center Emergency Evacuation Diagram



70 BOLTWOOD WALK
JOHN P. MUSANTE HEALTH CENTER @
BANGS COMMUNITY CENTER

LEGEND	
 YOU ARE HERE	CURRENT LOCATION
	PRIMARY EVACUATION PATH
	SECONDARY EVACUATION PATH

IN CASE OF FIRE OR OTHER
EMERGENCY REQUIRING
EVACUATION, IMMEDIATELY
LEAVE THE BUILDING AND
CONTACT EMERGENCY
RESPONSE PERSONNEL AT

911

Annex C – Fire Safety Plan

Hilltown Community Health Centers, Inc.

Emergency Management Plan

All Departments and Programs

SUBJECT: Fire Safety/Response

REGULATORY REFERENCE: 42 CFR Parts 403, 416, 418, 441, and 494 and CMS Final Rule re: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; HRSA PIN 2007-15.

Purpose:

The objective of this plan is to provide guidance in the event of a fire in order to prevent injury to staff, patients and visitors. The attached Plan outlines the requirements to be met by public health facilities in relation to fire safety.

Plan:

1. All HCHC facilities will have a fire inspection completed by the local official(s) on an annual basis.
2. Facilities will be equipped with fire extinguishers which are conspicuously marked and inspected annually.
3. All HCHC facilities will conduct fire drills at least two times per year.
4. All HCHC personnel will be familiar with the evacuation routes of their assigned facility. Those employees working in multiple facilities will be familiar with the evacuation plans peculiar to those facilities.

Procedure:

All HCHC facilities will have a fire inspection completed by the local official(s) on an annual basis.

1. The annual inspection will be scheduled by the Facilities Manager with the appropriate local agency.
2. The inspection will be conducted in accordance with local requirements.
3. The inspection report will be filed as follows:
 - a. A copy to the Department of Health (DPH)
 - b. A copy retained by the facilities manager
 - c. A copy posted conspicuously in the lobby area of the facility

Facilities will be equipped with fire extinguishers which are conspicuously marked and inspected annually.

1. The Huntington Facility has fire extinguishers located:
 - a. **Basement** (3) – Optometry exit door, outside the furnace room, inside the IT room
 - b. **1st floor** (5) – Exit door, Knightville Wing, outside the stairwell door, inside reception door, exit door, Littleville Wing, in dental by the Pano
 - c. **2nd floor** – staff lunch room, hallway by stairs, exit door from dietary office
2. The Worthington facility has fire extinguishers located:
 - a. **Basement** (2) – By the entry door in both basements
 - b. **1st floor** (8) – Dental by the Pano, Physical Therapy office, exit door in the Admin wing, on the wall by the entrance to medical reception, Medical wing between exam rooms 7& 8, lunchroom, by the exit near the provider office, in the server room
 - c. **2nd floor** (2) – On the wall to the right of the Finance office, on the wall in the copy machine room
3. The John P. Musante Health Center has fire extinguishers located:
 - a. **Main Hall** (2) – On the wall to the right of the Emergency Exit next to the Dental Operatories and on the wall to the left of the Community Health and Outreach Office.

All HCHC facilities will conduct fire drills at least two times per year.

1. All fire drills will be coordinated through the facilities manager
2. Drills will be pre-announced to staff to ensure they know a drill is taking place
3. Hallway doors should be closed prior to exit when possible
4. Staff will follow the evacuation plan listed below

All HCHC personnel will be familiar with the evacuation routes of their assigned facility. Those employees working in multiple facilities will be familiar with the evacuation plans peculiar to those facilities.

1. Staff will exit the building using the closest exit and rendezvous at a designated location
 - a. HHC – the west end of the parking lot near the dumpster
 - b. WHC – the north end of the front (patient) parking lot
 - c. JPMHC – in front of the Clark House Main Entrance across the lawn from the Center

In the event of a fire, the fire alarm system should be activated, alerting all individuals in the building to the hazard.

1. The Staff members and Administrators on site will be guided by the following steps:
 - a. **Rescue** - Remove all patients and visitors in immediate danger.
 - b. **Alarm** - Activate the nearest fire alarm pull box.
 - c. **Contain** - Isolate the fire, close door, windows, fire doors beginning with those nearest the fire areas.
 - d. **Extinguish/Evacuate** - Extinguish fire with the appropriate fire extinguisher, as safe and appropriate.
2. Staff will also be instructed not to use elevators, as fire involving the control panel of the elevator or the electrical system of the building can cut power in the building and cause individuals to be between floors.
3. Reception staff will notify and assist patients in the waiting rooms or public restrooms. Reception staff will also take the RED evacuation clipboard containing a staff list, a patient list and the evacuation plan and proceed to the designated rendezvous location.
4. Clinical staff will ensure they assist any patients in the exam rooms, both ambulatory and non-ambulatory, with leaving the clinical area and will be responsible for ensuring that they evacuate the building.
5. Reception will ensure that all staff sign in upon arriving at the rendezvous location. Patients should be checked against the patient list.
6. Staff will remain in the rendezvous area until given the All Clear by the On Scene commander of the responding agencies.
7. The staff will fight the fire **ONLY** if:
 - a. The fire department has been notified of the fire, **AND**
 - b. There is a way out and staff can fight the fire with their back to the exit, **AND**
 - c. There is a proper extinguisher, in good working order, **AND**
 - d. Staff have been trained to do so.
8. If staff utilize the fire extinguisher, the designated individual will choose appropriate fire extinguisher as per classification of fire as follows:
 - a. **ORDINARY COMBUSTIBLES** (e.g., paper, grease, paint)
 - b. **FLAMMABLE LIQUIDS** (e.g., gasoline, grease paint)
 - c. **ELECTRICAL EQUIPMENT** (e.g., wiring, overheated fuse boxes) Note: C extinguisher (dry chemical) is an all-purpose extinguisher and can be used on Class A, B, C fires.
 - d. Once proper extinguisher has been chosen, extinguish as follows:
 - 1) Remove the extinguisher from the wall unit.
 - 2) **P** - Pull the pin.
 - 3) **A** - Aim the nozzle at the base of the fire.
 - 4) **S** - Squeeze or press the handle.
 - 5) **S** - Sweep side to side at the base of the fire until the fire is extinguished.
9. Upon deactivation of the emergency, the Senior Administrator will ensure the replacement of the fire extinguisher.

10. The Behavioral Health providers or Employee Assistance Program will be made available to provide support to the affected family members and staff.

Annex D—Hazard-Specific Plans

Hilltown Community Health Centers, Inc.

Emergency Management Plan

All Departments

SUBJECT: Armed Intruder

REGULATORY REFERENCE: 42 CFR Parts 403, 416, 418, 441, and 494 and CMS Final Rule re: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

PLAN:

It is the plan of Hilltown Community Health Center to provide an emergency response plan to alert Health Center staff and patients that an armed intruder or active shooter appears to be actively engaged in attempting to injure people in the Health Center or on the Health Center Grounds.

PURPOSE:

The objective of this plan is to provide guidance in the event an individual is actively shooting persons in the health center or on the grounds.

DEFINITIONS:

For purposes of this Plan:

An armed intruder/active shooter is defined as a person or persons who appear to be actively engaged in killing or attempting to kill people in the Health Center or on the Health Center grounds. In most cases, active shooters use a firearm(s) and display no pattern or method for selection of their victims. In some cases, armed intruder use other weapons.

RESPONSE PROCEDURE:

Notification Procedure:

- 1) The intent of most armed intruders is to kill as many people as quickly as possible. Traditional law enforcement response will include the concept of "surround and contain" in order to minimize the number of victims. In order to save lives, the law enforcement agency having jurisdiction will initiate an immediate response.
- 2) Upon discovery of an armed intruder situation, as soon as possible and when safe to do so, provide overhead announcement of "Armed Intruder" and his/her location through the PA system, which broadcasts to every phone in the building. In order to use the PA system:
 - In Huntington Health Center, dial *461
 - In Worthington Health Center, dial *462
 - In Community Center (9 Russell Road), dial *462

- These numbers are on a sticker on every phone
 - Do NOT use these numbers except in the case of an emergency!
- 3) Notify law enforcement by pushing emergency button or calling (911).
- The phone call to 911 (from the area where the caller is safely concealed) should provide the following information
 - i) Description of suspect and possible location
 - ii) Number and types of weapons.
 - iii) Suspect's direction of travel.
 - iv) Location and condition of any victims
- 4) Incident Commander (usually a member of the Administration) will meet and guide law enforcement officers if possible and as appropriate. The goal of law enforcement is to locate, isolate, and neutralize the shooter as quickly as possible to prevent additional deaths or injuries.

Employee Response:

When an HCHC employee become aware of an Armed Intruder on the premises, they should use their judgement to assess which of the following responses is most appropriate and will result in the greatest degree of safety.

a) Lock Down

- Find the safest place to hide, where the armed intruder is less likely to find you. In most cases, this will mean staying in the room in which you already are and securing the room.
- If possible, choose the nearest location that has another means of exit (another door, a window that is not high up, etc).
- Direct other staff, patients and visitors into adjacent rooms, close and lock the door and attempt to barricade the door.
 - Most HCHC rooms/office have locking doors – lock the door immediately.
 - If you are in a room that does not lock (exam room, operatory, etc), there is a bag in the upper shelf of the cabinet closest to the door that contains the means to secure the door. Please familiarize yourself with this location of this bag for the rooms in which you frequently work. The bag will contain the following:
 - A wedge to place on the floor under the handle-end of the door. Kick it in as hard as you can.¹
 - If there is moveable furniture, barricade the door as well as you can.
- Once door is locked do not open for anyone until you hear the "All Clear" signal.

¹ Additional security measures for non-locking rooms will likely be added, and this plan revised.

- Your hiding place should:
 - Be out of the active shooter's view
 - Provide protection if shots are fired in your direction. Behind locked door, behind furniture or stay as low to the floor as possible and remain quiet and still.
 - Avoid areas which do not provide barriers or restrict your options for movement if possible.
- To prevent an active shooter from trying to enter your hiding place:
 - Silence your cell phone; use on text mode only for communication
 - Turn off any source of noise (i.e., radios, televisions)
 - Turn off any lights, including computer screens, etc.
 - Hide behind large items (i.e., cabinets, desks)
 - Prepare to use counter measures if necessary
 - Remain quiet
- Identify items that can be used for self-defense, should the intruder begin to come into the room. Any object can work, but look for harder, sharper, and/or heavier objects if possible.

b) Evacuate

- If there is an accessible escape path, and locking down is not safe or possible, attempt to evacuate the Premises. Be sure to:
 - Have your escape route and plan in mind
 - Evacuate regardless of whether others agree to follow
 - Leave your belongings behind
 - Help patients and visitors evacuate. If patient unable to evacuate, lockdown and barricade.
 - Prevent individuals from entering an area where the active shooter may be.
 - Keep your hands up palms facing forward so that police offices can see them clearly as you exit the building.
- At Huntington Health Center, use nearest exit and, depending on your location in the building:
 - Exit east end (Russell side) of the Huntington Health Center and proceed to the rendezvous point (heading down Rte. 20) to rest area on river side of the road
 - Exit west end (Huntington side) of building and proceed to rendezvous point located in the parking lot of Gateway Farm and Pet store
- At Worthington Health Center, use nearest exit and, depending on location:
 - Exit south end of the Worthington Health Center (toward the Maples) and proceed to the rendezvous point (heading down Rte. 143) to the lawn beside Worthington Historical Society at the light
 - Exit north end of building (toward Listons) and proceed to rendezvous point located at the intersection of Route 143 and Cummington Road

- At the Hilltown Community Center/9 Russell Road, use the nearing exit and, depending on the safest direction to proceed, gather at rendezvous points
 - in the parking lot of United Bank, up Route 20 to the east toward the middle of town, or
 - in the parking lot of the Water Department, across Route 20 and the railroad tracks, on Upper Russell Road.
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe

c) **Targeted Aggressive Response**

- As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:
 - Acting as aggressively as possible against him/her.
 - Throwing items and improvising weapons
 - Yelling
 - Using the "Swarm" technique – all employees present physically attack the intruder, focusing on the arm holding the weapon
 - Committing to your actions

d) If Lock Down, Evacuation, or Targeted Aggressive Response is not possible:

- Remain calm
- Dial 911, if possible, to alert police to the armed intruder's location
- If you cannot speak, leave the line open and allow the dispatcher to listen

- 5) Remain in your secure location until a Law Enforcement Official has released you after they have determined that the scene is safe.

RECOVERY:

All HCHC employees that are able will assist law enforcement/emergency responders in the recovery immediately after the incident, and will follow their instructions.

After any armed intruder incident, the Emergency Management Committee will conduct a "hot wash" or assessment of the incident, with the cooperation of all employees present during the event, as appropriate and able. This process will identify risks and potential improvements to the response plan, and develop a plan for the mitigation of future risks. The Emergency Management Committee will be responsible to implement this plan, including any amendments or additions to staff training/drills.

After any incident, the HCHC Behavioral Health providers or the Employee Assistance Program's counseling program will be made available to provide mental health support to the affected staff and family members.

Hilltown Community Health Centers, Inc.

Emergency Management Plan

All Departments and Programs

SUBJECT: Inclement Weather/Facility Closure

REGULATORY REFERENCE: 42 CFR Parts 403, 416, 418, 441, and 494 and CMS Final Rule re: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for actions required when the health center experiences an inclement weather event that necessitates closure. The same procedure will be followed if facility(ies) must close for any other reason, as well.

Plan:

1. Unscheduled closures and/or delayed openings will be disseminated to employees using the Snow Line and All Staff email.
2. Early closures for inclement weather will be disseminated to employees by All Staff email and telephone.
3. Closures will be passed along to the answering service.
4. Closures will be noted on both the HCHC website and Facebook pages.
5. Closures will be reported to the Region One HMCC Duty Officer, the Mass League of Community Health Centers, and other state or local entities as needed.
6. In the event of an unforeseen closure related to a natural occurrence, employees will be paid for their normal work day unless time off has already been scheduled

Procedure:

Unscheduled closures and/or delayed openings will be disseminated to employees using the Snow Line and All Staff email.

1. The Chief Executive Officer (CEO), in conjunction with the Facilities Manager and the Practice Manager will make the decision to close the health center prior to the start of the workday, or during the . The decisions shall be based upon weather forecasts, on-the-ground observations, MEMA/DPH advisories, and any other source of information required to ensure a prudent decision. When the Governor of Massachusetts closes state agencies, releases state employees from work, or restricts road travel due to weather conditions, the

Health Center will take this information into consideration/conform to this directive as appropriate.

2. Once the decision has been made:
 - a. The Facilities Manager will post the announcement on the Snow Line (**413-238-4110**) prior to 6:15 a.m. on the affected day.
 - b. Employees should call the Snow Line after 6:15am to be informed of the health center's status.
 - c. The CEO will send out an All Staff email echoing the announcement on the Snow Line.
3. The CEO, in conjunction with the Facilities Manager and the Practice Manager will make the decision to have a delayed opening of the health center.
 - a. In the event of a delayed opening, employees will consult the Snow Line for updated information **1 ½ hours** prior to the delayed opening time.
 - b. If the health center opening is delayed, staff will be expected to show up at their usual time if that time is any time after the delayed opening. *For example*, if the health center is opening at 10:00 AM, anyone whose usual work schedule calls for them to work at 10:00 AM or after will report to work on-time.

Early closures for inclement weather will be disseminated to employees by All Staff email and telephone.

1. The CEO, in consultation with the Facilities Manager and Practice Manager, will make the decision to close the health center early in the event of inclement weather.
2. The CEO will send an All Staff email stating the reason for the early closure and the time of the closure.
3. Reception in both health centers will be responsible for spreading the word to all employees.

Notification of closures to the patients/public will be accomplished through a variety of methods.

1. If there is an identified possibility of a delayed opening/closure, due to weather forecasts, the Reception Supervisor and Practice Manager will ensure that all patients with appointments that could be affected by a delay/closure are contacted by phone and/or other means to ask them to check HCHC's website and/or call the phone line prior to coming to their appointment to ensure that the site is open.
2. Once the delay/closure decision is made, the Reception Supervisor and Practice Manager will ensure that all patients with appointments that will be affected by the closure are contacted by phone and/or other means.
3. All closures will be passed along to the answering service. Upon receipt of a closure, early closure or delayed opening, the Reception Supervisor will contact the answering service and ensure the following:

- a. The phones are rolled to the service
 - b. The status of the health center is conveyed to the service with the understanding that the closure message will be automated for the patients or other people calling the health center.
 - c. Patients having an emergency will be instructed by the service to either call 911 or the service will contact the on-call provider.
 - d. The Reception Supervisor and/or Practice Manager will inform the IT Manager by phone or text that the outgoing phone message at the health center should be changed to the Inclement Weather Message. He will then manually change the outgoing messages, which will then inform callers of the closure, in the event that they punch through and don't get the answering service. The message will include the information that closure notices are available on both the website and the Snow Line, and it will give that phone number.
 - e. In the event the Reception Supervisor is unavailable, these duties will roll up to the Practice Manager.
4. Closures will be noted on both the HCHC website and Facebook pages. The Executive Assistant or administrator will ensure that both the HCHC web site and the HCHC Facebook page are updated with the current status of the health center.
 5. The Emergency Management Manager or CEO will inform the HMCC Duty Officer and the Mass League, and will respond to any survey requests from the League as needed.
 6. Closures will be conveyed to local media. The Executive Assistant will contact the WGGB-40 television station and put the announcement on their closure list.