Hilltown Community Health Center

Administrative Offices
58 Old North Road
Worthington, MA 01098
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www.hchcweb.org

BOARD MEETING
May 2, 2019
HUNTINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the April 4, 2019 Meeting Minutes (Vote Needed)

3. Executive Session

4. Finance Committee Report for April (Vote Needed)

5. Committee Reports (as needed) (Vote Needed)
    - Executive Committee
    - Quality Improvement
    - Fundraising
    - Credentialing/ Privileging-(Vote Needed)
        1. New Employee:
            - Stephanie Williams, LPN
        2. Preceptorship:
            - Barbara Saykin, FNP Preceptor
        3. Recredentialing:
            - Leah King
            - Aaron Riverwood
            - Melissa Castro (termed 2/28/2019)
            - Stefanie Sudyka
            - Alice Rudin
            - Jillian McBride, LICSW
            - Elizabeth Spooner
            - Karen Rowe
            - Jonathan Liebman, ANP
            -
    - Personnel
    - Facilities
    - Recruiting, Orientation, and Nominating (RON)
    - Strategic Planning
    - Corporate Compliance

6. Chief Executive Officer / Senior Manager Reports

7. Old Business
    - New Access Point Application-Informational Only (Located on Board Portal)

- Budget 2019 Follow-Up

8. New Business
    - Annual Auditing Firm Report
    - Policies (Vote Needed)
        - Credentialing and Privileging Policy
        - Dental/ Oral Health Policies:
            1. Early Childhood Caries (ECC) Patient w/ High and Medium Risk
            2. Hygiene Exam Policy
            3. Oral Health- Dental Infection Control
    - Next Meeting-Annual Meeting; Where and When?

9. Adjourn

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 04/04/2019 5:30pm
Worthington Health Center

MEMBERS: John Follet, President; Nancy Brenner, Vice President; Kathryn Jensen, Clerk, Lee Manchester; Matt Bannister; Kate Albright-Hanna; Alan Gaitenby
STAFF: Eliza Lake, CEO; Michael Purdy, CCCSO; Frank Mertes, CFO; Tabitha Griswold, Executive Assistant
ABSENT: Maya Bachman; Seth Gemme
GUEST: Dr. Beth Coates

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 02/07/2019 and 03/07/2019	John Follet called the meeting to order at 5:38pm. The former Board member referenced in the previous month's minutes was Tim Walter, and the Board felt that his name should be added to the last bullet on the second page in the February 7th minutes. The location of the March 7th meeting was correct to reflect Huntington Health Center. Board Member, Alan Gaitenby was added to the absent list. **Nancy Brenner moved to approve the February and March Board minutes with amendments. Alan Gaitenby seconded the motion, which was approved by those present.**	February 7, 2019 Board minutes with corrections and March 7, 2019 Board minutes pending correction were approved by all present
Finance Committee	• Frank Mertes, CFO reported on the January and February finances. Each month does not show a big difference in terms of loss in comparison to last year's numbers, although it is slightly higher. The cumulative operating loss of approximately $14k more loss than last year. In this year, HCHC has much more depreciation due to the Amherst site. Driving the loss in operating margin, the Medical Department continues to lose money, and has lost more	Finance Committee report was approved.

than $30,000 more than last year at this time. However, the Dental Department is doing $28K better in revenue than last year for first two months for FY 2019. There are 11 days of cash on-hand at the end of February. HCHC's ability to pay bills is starting to get tighter but the beginning of March is starting to see a slight increase in revenue. For the Community Programs, the revenue seen there is all grant revenue. HCHC covers the management costs for the community programs.

- The FY 2019 Budget will be discussed later in the agenda.
- Updates:
  - The MassHealth $300K advance- a $50k grant was received from Mass General Hospital (MGH), previously referred to as Partners. Senior Management has decided to use the $50k to mitigate the holdback put on MassHealth's payments to HCHC over the next approximately two months. This will give time for Senior Management to decide how to pay back the $250K remaining balance. There is several options to paying back the remaining MassHealth $250K cash advance. Frank expressed his uneasiness with the option of MGH backing a local bank loan. A more promising possibility is renegotiating with MassHealth about payback terms. Other possibilities, which are not appealing, are to use the investments (gains are projected) or using the line of credit.
  - Musante lease with town of Amherst- Frank reported that the new proposal for payment terms has been verbally approved by the Town Manager, but we have not received a signed agreement yet. The terms have been renegotiated so that the town is assuming $110K of the $160K in additional construction costs, and HCHC will increased the rent payments over a longer period of time.
  - Annual fiscal audit update-Frank reported that the audit is ongoing and will be ready in May for review.
  - Ware, MA-The New Access Point (NAP) opportunity is being referred to as the Quaboag Hills Health Center project. The application is on schedule to be submitted on time. All letters of support have been received, except for Baystate Medical Center (BMC). This may be

	due to more political reasons as they are providing Caring Health Centers with space in the hospital and Caring is a part of their ACO. They will likely give support in the event that HCHC receives the NAP instead of Caring. This will be outlined in the application as to why they will not give a letter of support. A final copy of the application will be provided in May. **Wendy Long moved to approve the Finance Committee report. Nancy Brenner seconded the motion, which was approved by those present.**	
CEO Report	• Eliza Lake reported on a recent day-long C3 Board retreat. C3 is exploring a number of possible shared services, including a shared Electronic Health Record (EHR). After meetings in January, Frank Mertes is scheduled to meet again with consultants regarding the EHR and the issues that the HCHC continues to experience. Eliza explained that HCHC's EHR is considered a "failed implementation" with eCW, and there is a general appeal to starting a new system with more support. The cost of a new system implementation is unknown, but will likely be prohibitive. C3 may help mitigate the costs of this potential change, on the front end. There is hope that the new system will enable dental and medical systems to overlap. There was also a discussion of potential large scale savings to be had if all health centers utilize the same eomployee medical insurance. There was also conversations with C3 about the crisis of limited Medical Assistants, across the state. C3 has identified this shortage as a real issue and are exploring how they can help. Unfortunately, help at this level is not a quick fix but more long term solutions. • Eliza accepted the position of Chair of the Baystate Noble Hospital's Community Benefits Advisory Board. The IRS requires all hospitals have these councils that monitors money used for community engagement. Noble has a specific need to enhance this engagement with the community. • Eliza reported on marketing efforts for the Amherst site. MassHealth is not informing the majority of its members that their Plan Selection period starts in March and April,	

so there is ongoing work to market the Amherst site as best as possible. This includes gathering ideas for Spanish speaking marketing outlets, and how to appeal to the target population through our marketing images. The latest patient data is that 45% of the medical patient population has MassHealth and 22% of the patients are uninsured. As expected, 70% of the dental patients have MassHealth coverage. Eliza continues to build relationships with Amherst community organizations to improve outreach, including the Center for New Americans and Amherst Survival Center.

- Eliza reported on a HRSA dental infrastructure grant opportunity, which would provide $300K HRSA grant available to provide improvements to dental infrastructure – dental staff are assessing possible capital needs and will determine if HCHC would be a compelling candidate for this grant.
- There continues to be an ongoing struggle with staffing, although it seems that RN staffing is under control with two recent hires. In response to the staffing shortage, meetings with Dawn Flatt, Frank Mertes, Cynthia Magrath, Michael Purdy, Jon Liebman and Miranda Balkin are occurring weekly to set up appropriate schedules for providers. Michael noted that with the short staffing there becomes a cascade of risk issues, and having to develop workarounds. There continues to be vigorous efforts in recruitment for MAs and providers, with a potential MD and NP in conversations with Medical leadership. Frank explained that in these management meetings, various solutions to the staffing shortage are being discussed, given the possible delays in hiring. These solutions are categorized by each department, expectations of outcomes and then fall back plans. The staffing issue is very serious and taken very seriously by senior management. Michael commends the providers and staff for being flexible during these times.
- Eliza discussed political efforts for assisting with financial stability in a recent letter to Mindy Domb, outlining rural and small community needs. This will hopefully lead to a possible earmark into the state budget. Eliza explained

	that $100K is the most a health center can request in that earmark. • Eliza reported that although HCHC would like to join NACHC, for many reasons, the fee for membership is substantial. Eliza will be reaching out to NACHC directly to attempt renegotiation of a more reasonable membership rate. • Eliza reported on the recent Washington visit for NACHC visits to Capitol Hill. Eliza met with Congressman Richard Neal, Congressman McGovern's staff, and Senator Warren's staff to discuss health centers' federal legislative priorities. She felt that he was very attentive and supportive to the legislative priorities expressed by those in attendance.	
Executive Committee	• John Follet reported that Lee Manchester has stepped forward as listed interim treasurer. A potential new Board candidate would be interested in Finance Committee. **Wendy Long moved to approve the appointment of Lee Manchester as the Interim Treasurer. Nancy Brenner seconded the motion, which was approved by those present.**	Appointment of Lee Manchester as Interim Treasurer was approved.
Recruitment, Orientation & Nominating (RON) Committee	• Wendy Long reported that the committee has drafted and outlined a screening process for onboarding new members. Questions that the committee asks the candidate being forwarded to the CEO and President for their consideration in their meeting with the candidate. This will help mitigate duplication of questions to new board members during the various interviews. The committee has recently utilized this new system with a potential new Board member. The potential new Board member is a CPA, former CFO, and is a nonprofit CEO, currently. The next step will be the interview with Eliza and John. Wendy noted that the committee is seeking another current Board member to join the committee. Nancy Brenner offered to help on the committee. Eliza and Marie Burkart recently met with a potential candidate, but the interviewee declined to join the Board. Eliza noted that the there is a need for new members that are patients of the Musante Health Center	

	and live in the Valley, to fulfil the HRSA requirements. She and Marie will work with staff to identify possible candidates.	
Corporate Compliance Committee	• Eliza Lake reported that she met with Daniel Worpek, IT Manager to review all of HCHC's HIPAA policies, in order to ensure that we remain compliant with federal HIPPA requirements – these policies are before the Board at this meeting. The Emergency Management Plan has been updated, and an updated training schedule is being developed. In May, Senior Management will begin intensive preparation for HRSA's November Operational Site Visit. John noted that during a recent webinar regarding the Board's involvement with the HRSA visit, it was discussed that the Board is to have an active role with the sliding fee scale and determining the reasonable nominal fee. John also reported that it was discussed that certain policies only need to be renewed every three years. Eliza noted that Mary Ellen Driscoll from MassLeague is willing to do a training on the 18 program requirements of HRSA Compliance. The Board asked that Eliza schedule this training for September.	
Credentialing/ Privileging Committee	• John Follet, on behalf of the Credentialing/ Privileging Committee, presented new employee Carlos Coppin, Dental Assistant. **Wendy Long moved to credential this practitioner. Lee Manchester seconded the motion.** • John on behalf of the Credentialing/Privileging Committee, presents the following employees for re-credentialing. **Wendy Long moved that the following members be re-credentialed. Lee Manchester seconded the motion. The measure was approved by those present.** ▪ Michael Purdy, OD ▪ Timothy Gearin, DMD ▪ Andrew J. Adams, DDS ▪ Alice Rudin, DDS ▪ Julie Cowles ▪ Marylou Stewart, DDS ▪ Ellen Wright ▪ Rossie Feldman, LICSW	Credentialing was approved for Carlos Coppin. Re-credentialing was approved for the employees listed. Bridget Rida to notify employee of the granted credentials.

	▪ Eleanor Smith ▪ Jillian McBride, LICSW ▪ Susan Hedges ▪ Amanpreet Gill, DMD ▪ Elizabeth Coates, MD ▪ Brenda Chaloux, FNP	
Facilities Committee	Alan Gaitenby reported that although the committee has not met, there have been several facility upgrades. Automatic door openers were installed in both Worthington and Huntington, funded by a Community Foundation grant. Using the same funding, we will be installing ADA compliant door knobs in the administrative wing in Worthington. The windblown siding on the front of the building in Huntington will be fixed following a bidding process. The generator in Huntington has a cracked manifold. The generator is about 10 yrs. old and that particular manifold is not made any more. However, the generator company believe they can fix it by the beginning of next week. Any excess vaccines from Huntington have been moved to Worthington until generator has been fixed.	
Personnel Committee	John Follet reported that this committee has not met.	
Strategic Planning	Nancy Brenner reported that the committee was able to review the updated Strategic Plan. Nancy requested Eliza point out any significant adjustments. Eliza reported that the significant adjustments were made in regards to the Ware expansion, and the increased priority of telehealth.	
Fundraising Committee (ad hoc)	Nancy Brenner reported that the committee is working through the messaging words. A survey went out to staff, and received a helpful 42 responses to help with the messaging. The committee drafted a letter for the general appeal. The committee proposes to include the annual report with the annual appeal. The committee will beginning working on the annual report and determining what that will look like. The committee will be working on choosing testimonies from staff and putting together perhaps a general story. The annual report and annual letter are due to go out together in June. The quote for the mailing is about $6k for about 16k mailings. Those mailings are target for all Hilltown residents and then Hadley, Amherst and Northampton residents, 45 years old or	

	older, with an income of $50k or more. Matt Bannister offered that Peoples Bank may provide direct pay option for fundraising expenses as a grant opportunity. HCHC also received $5k in grant money from Easthampton Savings Bank for the JPMHC.	
Quality Improve-ment/Risk Managemen t Committee	Kathryn Jensen reported on the last two meetings. In the February meeting, there were risk management incidents of falls in the parking lot due to icing. Now that the risk is mitigated with improving weather, it is something to address for next winter season. Kathryn reported that during recent meetings the understaffing continues to be an issue. The understaffing is also a concern for possible incidents due to lack of staffing in risk management systems. The Board felt that the email to staff included in Eliza's previous CEO Report was very helpful. Kathryn reported on a concern in eye care regarding an automated list for peer review.	
Committee Reports	**Nancy Brenner moved that the committee reports be approved. Kathryn Jensen seconded the motion. The committee reports were approved by those present.**	Committee reports presented at this meeting were approved.
Old Business	• New Access Point (NAP) update was discussed in the CEO report. **Nancy Brenner moved to approve the application submission. Matt Bannister seconded.** • The change in the July meeting was forwarded by Eliza to all members. Without any dispute, the meeting has changed to July 11th. • John will be reaching out to Maya Bachman, to gauge her continued interest and level of participation.	The submission of the application as approved by those present.
New Business	• FY 2019 Budget: o Frank Mertes reported on the FY 19 Budget. This budget is as realistic as possible for the entire 12 months, including the two months that just passed. A summary of the budget is included. The budget was built with the following assumptions: ▪ Fully staffed with support medical staff ▪ A new provider by September 2019 ▪ Visits by provider that are comparable to last year	

	▪ Reimbursement rates that are compatible to last year's The budget is broken down by month, department and location. Even with the School Based program making money (due to grant funding) there is still an overall $420k revenue loss across the three other sites. Frank noted that even without the depreciation factor HCHC would not have a profit. The Dental Department has the opportunity to be able to change fast, as demonstrated by the results compared to last year. The Medical Department, on the other hand, has greater expenses then revenue, because it is so labor intensive, and will require more time and effort to correct. o Frank reported that meetings are set up with department heads to generate options to achieve financial stability. These meetings are designed to mitigate the projected results of this budget. Under the current projections, HCHC will run out of cash on hand in November, and then would be forced to use its line of credit or investments. The good news, however, is that the situation can be addressed, and with improved communication and regular meetings, improvement is a hopeful result. With the two months' time bought by the $50K grant from MGH, these meetings are critical to generate creditable ideas to present to the Board such as changes to hours, or services provided. Of course, management will be considering the effect of any changes on staff and patients as well as implications on revenue both short term and long term. **Matt Bannister moved to approve the FY 2019 budget. Alan Gaitenby seconded the motion.** • Policies: o From the March 7th meeting policies were presented: ▪ Sliding Fee Scale 2019 ▪ Credit and Collection Policy	FY 2019 Budget was approved.

	o The Credentialing and Privileging Policy will be presented at the May 2nd meeting. o The following new policies were reviewed. ▪ The Emergency Management Plan (EMP) ▪ HIPPA Security Policies ▪ HIPPA Privacy Policies **Matt Bannister made a motion to approve the above policies, which was approved by those present.**	Sliding Fee Scale 2019 and Credit & Collection Policy, EMP, and HIPPA Policies were approved.
Next Meeting	**Kathryn Jensen moved the meeting be adjourned. Nancy Brenner seconded the motion, which was approved by those present.** **The meeting was adjourned at 8:10 pm.** The next scheduled meeting will be on May 2, 2019 at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

Hilltown CHC
Dashboard And Summary Financial Results
March 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 Mar. 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	0.73	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	33	30	34	39	42	39	36	36	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	56	94	64	58	30	30	29	33	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%	-9.1%	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%	-8.7%	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%	38.0%	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	4,638			
Net Medical Revenue per Visit	$ 134.56	$ 144.39	$ 144.02	$ 144.38	$ 146.08	$ 143.80	$ 143.59	$ 140.35			
Dental Visits	14,880	3,512	7,426	11,454	12,953	14,318	15,537	4,272			
Net Dental Revenue per Visit	$ 113.60	$ 109.03	$ 115.98	$ 116.41	$ 116.88	$ 114.52	$ 112.76	$ 114.63			
Behavioral Health Visits	3,809	1,002	2,120	3,129	3,586	3,916	4,306	1,089			
Net BH Revenue per Visit	$ 95.70	$ 85.29	$ 89.42	$ 91.01	$ 88.72	$ 85.15	$ 87.74	$ 78.93			
Optometry Visits	2,329	523	1,124	1,726	1,973	2,156	2,381	592			
Net Optometry Revenue per Visit	$ 79.61	$ 91.60	$ 85.75	$ 87.29	$ 88.73	$ 87.01	$ 86.40	$ 83.62			

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Mar. 2019

	Mar. 2019 Actual	Mar. 2019 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Over (Under) Cur. v. PY YTD
OPERATING ACTIVITIES								
Revenue								
Patient Services - Medical	222,153	218,000	4,153	650,949	646,796	4,153	631,119	19,830
Visits	1,523	1,510	13	4,638	4,625	13	4,371	267
Revenue/Visit	$ 145.87	$ 144.37	$ 1.49	$ 140.35	$ 139.85	$ 0.50	$ 144.39	$ (4.04)
Patient Services - Dental	178,894	166,369	12,525	489,704	477,180	12,524	382,901	106,803
Visits	1,481	1,453	28	4,272	4,244	28	3,512	760
Revenue/Visit	$ 120.79	$ 114.50	$ 6.29	$ 114.63	$ 112.44	$ 2.19	$ 109.03	$ 5.60
Patient Services - Beh. Health	27,300	27,405	(105)	85,957	86,062	(105)	85,459	498
Visits	353	315	38	1,089	1,051	38	1,002	87
Revenue/Visit	$ 77.34	$ 87.00	$ (9.66)	$ 78.93	$ 81.89	$ (2.95)	$ 85.29	$ (6.36)
Patient Services - Optometry	18,189	23,693	(5,504)	49,502	55,006	(5,504)	47,908	1,594
Visits	197	195	2	592	590	2	523	69
Revenue/Visit	$ 92.33	$ 121.50	$ (29.17)	$ 83.62	$ 93.23	$ (9.61)	$ 91.60	$ (7.98)
Patient Services - Optometry Hardware	9,873		9,873	26,036	16,163	9,873	17,927	8,109
Patient Services - Pharmacy	14,767	16,000	(1,233)	18,484	19,717	(1,233)	31,719	(13,235)
Quality & Other Incentives	117	276	(159)	757	916	(159)	9,363	(8,606)
HRSA 330 Grant	128,601	126,160	2,441	379,859	377,418	2,441	371,760	8,099
Other Grants & Contracts	87,893	81,626	6,267	196,230	189,963	6,267	185,654	10,576
Int., Dividends Gain /(Loss) Investments	4,184	2,380	1,804	31,394	29,590	1,804	163	31,231
Rental & Misc. Income	2,486	2,466	20	7,429	7,409	20	9,727	(2,298)
Total Operating Revenue	694,457	664,375	30,082	1,936,301	1,906,220	30,081	1,773,700	162,601
Compensation and related expenses								
Salaries and wages	459,724	449,383	10,341	1,420,974	1,410,632	10,342	1,403,466	17,508
Payroll taxes	39,003	34,378	4,625	115,427	110,802	4,625	105,790	9,637
Fringe benefits	33,943	41,433	(7,490)	116,065	123,556	(7,491)	115,061	1,004
Total Compensation & related expenses	532,670	525,194	7,476	1,652,466	1,644,990	7,476	1,624,317	28,149
No . of week days	21	21	-	64	64	-	65	-
Staff cost per week day	$ 25,365	$ 25,009	$ 356	$ 25,820	$ 25,703	$ 117	$ 24,989	$ 830

Hilltown Community Health Centers
Income Statement - All Departments
Period Ending Mar. 2019

	Mar. 2019 Actual	Mar. 2019 Budget	Over (Under) Budget	YTD Total Actual	YTD Total Budget	Over (Under) Budget	YTD PY Actual	Over (Under) Cur. v. PY YTD
Other Operating Expenses								
Advertising and marketing	2,360	4,650	(2,290)	3,363	5,653	(2,290)	746	2,617
Bad debt	8,898	5,075	3,823	33,494	29,672	3,822	38,066	(4,572)
Computer support	9,699	6,537	3,162	22,454	19,292	3,162	22,109	345
Conference and meetings	183	405	(222)	672	894	(222)	1,378	(706)
Continuing education	6,820	3,401	3,419	10,598	7,179	3,419	6,227	4,371
Contracts and consulting	3,596	3,470	126	8,699	8,573	126	6,910	1,789
Depreciation and amortization	27,651	27,651	0	82,952	82,952	0	35,176	47,776
Dues and membership	1,743	3,134	(1,391)	6,696	8,086	(1,390)	5,519	1,177
Equipment leases	2,484	2,107	377	6,659	6,282	377	6,033	626
Insurance	2,119	2,119	0	6,349	6,349	0	5,408	941
Interest	1,256	1,392	(136)	4,065	4,201	(136)	4,535	(470)
Legal and accounting	2,188	2,888	(700)	6,563	7,263	(700)	9,970	(3,407)
Licenses and fees	5,783	4,660	1,123	13,166	12,043	1,123	13,739	(573)
Medical & dental lab and supplies	13,868	12,100	1,768	33,307	31,539	1,768	24,001	9,306
Merchant CC Fees	1,452	1,515	(63)	4,450	4,513	(63)	3,776	674
Office supplies and printing	2,740	3,586	(846)	7,905	8,751	(846)	12,066	(4,161)
Postage	2,162	2,075	87	4,258	4,171	87	4,535	(277)
Program supplies and materials	18,850	19,450	(600)	55,401	56,001	(600)	46,427	8,974
Pharmacy & Optometry COGS	4,446	10,340	(5,894)	21,228	27,122	(5,894)	17,453	3,775
Recruitment	2,455	225	2,230	2,455	225	2,230	284	2,171
Rent	7,088	5,538	1,550	19,616	18,066	1,550	9,420	10,196
Repairs and maintenance	17,635	14,064	3,571	40,532	36,962	3,570	52,503	(11,971)
Small equipment purchases	1,780	175	1,605	2,729	1,124	1,605	3,466	(737)
Telephone/Internet	13,582	13,696	(114)	40,897	41,012	(115)	25,660	15,237
Travel	2,437	2,280	157	4,931	4,774	157	4,194	737
Utilities	4,635	4,500	135	15,675	15,539	136	17,700	(2,025)
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	167,910	157,032	10,878	459,114	448,237	10,877	377,301	81,813
Net Operating Surplus (Deficit)	**(6,123)**	**(17,851)**	**11,728**	**(175,279)**	**(187,007)**	**11,728**	**(227,918)**	**52,639**
NON-OPERATING ACTIVITIES								
Donations, Pledges & Contributions	200	-	200	629	430	199	22,501	(21,872)
Loan Forgiveness	-	-	-	-	-	-	-	-
Capital Grants	5,713	12,348	(6,635)	5,713	12,348	(6,635)	158,878	(153,165)
Net Non-operating Surplus (Deficit)	**5,913**	**12,348**	**(6,435)**	**6,342**	**12,778**	**(6,436)**	**181,379**	**(175,037)**
NET SURPLUS/(DEFICIT)	**(210)**	**(5,503)**	**5,293**	**(168,937)**	**(174,229)**	**5,292**	**(46,539)**	**(122,398)**

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

	Mar. 2019	Mar. Budget	Over (Under) Budget	YTD	YTD Budget	Over (Under) Budget	PY YTD	Cur. v. PY YTD
Operating								
Medical	$ (7,647)	$ (4,681)	$ (2,966)	$ (99,646)	$ (96,679)	$ (2,967)	$ (110,410)	$ 10,764
Dental	(3,086)	(13,426)	10,340	(45,467)	(55,807)	10,340	(105,099)	$ 59,632
Behavioral Health	3,571	2,813	758	1,012	254	758	(11,092)	$ 12,104
Optometry	3,413	(1,341)	4,754	(9,578)	(14,332)	4,754	(9,793)	$ 215
Pharmacy	15,975	14,859	1,116	19,049	17,933	1,116	26,695	$ (7,646)
Community	(4,925)	(1,710)	(3,215)	(18,450)	(15,235)	(3,215)	117	$ (18,567)
Fundraising	(4,463)	(5,270)	807	(13,621)	(14,428)	807	(19,344)	$ 5,723
Admin. & OH	(8,961)	(9,095)	134	(8,578)	(8,714)	136	1,008	$ (9,586)
Net Operating Results	**$ (6,123)**	**$ (17,851)**	**$ 11,728**	**$ (175,279)**	**$ (187,008)**	**$ 11,729**	**$ (227,918)**	**$ 52,639**
Non Operating								
Donations	$ 200	$ -	$ 200	$ 629	$ 430	$ 199	$ 22,501	$ (21,872)
Capital Project Revenue	5,713	12,348	(6,635)	5,713	12,348	(6,635)	158,878	$ (153,165)
Total	**$ 5,913**	**$ 12,348**	**$ (6,435)**	**$ 6,342**	**$ 12,778**	**$ (6,436)**	**$ 181,379**	**$ (175,037)**
Net	**$ (210)**	**$ (5,503)**	**$ 5,293**	**$ (168,937)**	**$ (174,230)**	**$ 5,293**	**$ (46,539)**	**$ (122,398)**

Hilltown Community Health Centers

Balance Sheet - Monthly Trend	Actual Dec 2018	Actual Jan 2019	Actual Feb 2019	Actual Mar 2019	Budget Mar 2019	Over (Under) Mar 2019
Assets						
Current Assets						
Cash - Operating Fund	$ 197,997	$ 233,851	$ 252,962	$ 242,277	$ 217,075	$ 25,202
Cash - Restricted (Amherst Donations)	6,152	1,051	12,402	12,404	11,902	502
Patient Receivables	945,217	1,032,027	970,729	1,013,085	1,000,000	13,085
Less Allow. for Doubtful Accounts	(109,786)	(118,366)	(128,973)	(133,664)	(120,000)	(13,664)
Less Allow. for Contractual Allowances	(317,200)	(374,895)	(344,593)	(351,978)	(325,000)	(26,978)
A/R 340B-Pharmacist	32,188	7,390	(1,455)	11,707	5,000	6,707
A/R 340B-State	1,827	1,827	1,827	1,827	1,827	-
Contracts & Grants Receivable	69,673	62,015	65,280	63,523	65,000	(1,477)
Prepaid Expenses	14,866	16,298	20,021	20,962	18,521	2,441
A/R Pledges Receivable	28,828	26,328	15,360	15,360	15,360	-
Total Current Assets	869,761	887,526	863,561	895,504	889,686	5,818
Property & Equipment						
Land	204,506	204,506	204,506	204,506	204,506	-
Buildings	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	-
Improvements	911,848	911,848	911,848	929,483	911,848	17,635
Leaehold Improvements	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	1,293,868	1,288,156	5,713
Construction in Progress (Amherst)	-	-	12,348	-	12,348	(12,348)
Total Property and Equipment	6,952,096	6,952,096	6,964,444	6,975,444	6,964,444	11,000
Less Accumulated Depreciation	(2,430,365)	(2,458,016)	(2,485,666)	(2,513,317)	(2,513,317)	-
Net Property & Equipment	4,521,731	4,494,080	4,478,778	4,462,127	4,451,127	11,000
Other Assets						
Restricted Cash	53,713	53,713	53,712	53,721	53,712	9
Pharmacy 340B and Optometry Inventory	11,811	12,249	11,909	13,494	11,909	1,585
Investments Restricted	6,661	6,661	6,661	7,446	6,661	785
Investment - Vanguard	227,889	247,383	255,060	258,439	257,440	999
Total Other Assets	300,074	320,006	327,342	333,100	329,722	3,378
Total Assets	**$ 5,691,566**	**$ 5,701,613**	**$ 5,669,681**	**$ 5,690,731**	**$ 5,670,535**	**$ 20,196**
Liabilities & Fund Balance						
Current & Long Term Liabilities						
Current Liabilities						
Accounts Payable	$ 164,918	$ 180,932	$ 225,470	$ 208,209	$ 225,000	$ (16,791)
Notes Payable	300,000	300,000	300,000	300,000	300,000	-
Sales Tax Payable	56	23	39	44	-	44
Accrued Expenses	60,334	61,951	46,717	51,693	50,000	1,693
Accrued Payroll Expenses	386,764	481,414	480,774	511,383	488,000	23,383
Payroll Liabilities	20,702	17,285	15,242	13,947	16,000	(2,053)
Unemployment Escrow	826	826	826	826	826	-
Line of Credit	-	-	-	-	-	-
Deferred Contract Revenue	120,296	124,247	136,693	143,579	134,693	8,886
Total Current Liabilities	1,053,896	1,166,677	1,205,760	1,229,681	1,214,519	15,163
Long Term Liabilities						
Mortgage Payable United Bank	167,900	166,455	165,007	163,512	163,607	(95)
Mortgages Payable USDA Huntington	176,837	175,775	174,707	173,542	173,707	(165)
Total Long Term Liabilities	344,737	342,230	339,714	337,054	337,314	(260)
Total Liabilities	**1,398,633**	**1,508,907**	**1,545,474**	**1,566,735**	**1,551,832**	**14,903**
Fund Balance / Equity						
Fund Balance Prior Period	4,292,933	4,192,706	4,124,206	4,123,996	4,118,703	5,293
Total Fund Balance / Equity	4,292,933	4,192,706	4,124,206	4,123,996	4,118,703	5,293
Total Liabilities & Fund Balance	**$ 5,691,566**	**$ 5,701,613**	**$ 5,669,681**	**$ 5,690,731**	**$ 5,670,535**	**$ 20,196**
Current Ratio	**0.83**	**0.76**	**0.72**	**0.73**	**0.73**	

Hilltown Community Health Centers, Inc.

Administrative Policy

SUBJECT: CREDENTIALING AND PRIVILEGING POLICY

REGULATORY REFERENCE: HCHC Corporate Compliance Plan, Annex 7, Public Health Service Act, Section 330(a)(1), (b)(1)-(2), (k)(3)(C), and (k)(3)(I), BPHC Health Center Program Compliance Manual c. 5, 258 CMR 12.00, M.G.L. c. 13, § 84 and 258 CMR 8.05, 234 CMR 2.00 and M.G.L. c.112, § 45 and § 80B, 244 CMR 3.05(4) and (5), 246 CMR 3.00: M.G.L. c. 112, § 67.

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to ensure the patients of HCHC receive the highest level of clinical care possible and to have a formal documented process to follow regarding credentialing and privileging of practitioners with whom it contracts or who it employs to provide medical, oral health, vision or behavioral health care to its patients.

Policy:

1. All HCHC practitioners will be credentialed and privileged according to procedures established in the HCHC Corporate Compliance Plan, Annex 7: Credentialing and Privileging Program.
2. Documents contained in a practitioner's confidential credentialing file will be kept current. Practitioners must agree to immediately report any changes in the information contained in his/her credentialing file.
3. HCHC will re-privilege and re-credential all practitioners every two (2) years on the anniversary date of his/her start of employment. Such renewal of privileges shall contain a documented review of credentialing and privileging materials as required by Annex 7 of the HCHC Corporate Compliance Plan and applicable regulatory guidance.

Questions regarding this policy or any related procedure should be directed to the Chief Clinical and Community Services Officer at 413-667-3009 ext. 270.

Originally Drafted: AUG 2012 Reviewed or Revised: April 2019

Approved by Board of Directors, Date: _____

Approved by:

_____ Date: _____

Eliza B. Lake
Chief Executive Officer, HCHC

_____ Date: _____

John Follet, MD
Chair, HCHC Board of Directors

Annex 7: HCHC Credentialing and Privileging Program

I. Introduction and History

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

II. Authority

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

III. Definitions

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

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

Licensed or Certified Health Care Practitioner: an individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists, and registered dieticians. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners. As such, the credentialing and privileging requirements of these two groups may vary.

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

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

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

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

Other Clinical Staff: An individual who is not licensed, certified or registered but participates in part of the care process. Examples include, but are not limited to, medical assistants who are not certified, and community health staff.
The HCHC Credentialing program includes in this category the following:

1. Medical Assistants (not certified)
2. Community Health Workers

Resident, Intern, or Shadow:

1. Resident- A qualified physician or dentist who has earned their respective degree and practices medicine under direct or indirect supervision of senior clinician registered in that specialty.
2. Intern- A Student or trainee who will gain work experience by practicing in that specialty.
3. Shadow- a student or trainee who will observe practices by following a professional in the desired specialty.

Primary Source Verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of primary source verification include, but are not limited to, direct correspondence, telephone verification, internet verification, and reports from credentials verification organizations. The Education Commission for Foreign Medical Graduates (ECFMG®), the American Board of Medical Specialties, the American Osteopathic Association Physician Database, or the American Medical Association (AMA) Master file can be used to

verify education and training. The use of credentials verification organizations (CVOs) or hospitals that meet JCAHO's "Principles for CVOs" is also an acceptable method of primary source verification. Verification for some items must be obtained from primary sources and should be in writing from the primary source, although oral verification can be done. In the unlikely event that only oral verification is obtained, a dated and signed note in the credentialing file stating who at the primary source verified the item, the date of verification, and how it was verified is required.

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

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

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

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

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

IV. Credentialing

A. Initial Credentialing Requirements

1. Primary Source Verification

a) Initial credentialing of LIPs requires primary source verification of the following:
(1) Current licensure;
(2) Relevant education, training, or experience;
(3) Current competence, defined as verification of current competence based on a statement from the applicant regarding disciplinary/other actions, peer recommendations, results of the interview and screening process, and a complete review of the provider's file for inconsistencies, gaps, disciplinary actions, etc.; and
(4) Health fitness, or the ability to perform the requested privileges, will be determined by a completed HCHC Health Attestation Form from the individual, and is confirmed by both the supervisor and HCHC's designated physician.

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

2. Secondary Source Verification

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

3. National Practitioner Data Bank

a) HCHC must also query the NPDB (as applicable) for LIPs and other licensed or certified health care professionals as part of the initial credentialing process.

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

The following table lists the minimum required activities identified in the BPHC Health Center Program Compliance Manual c. 5. Section c. for credentialing both LIPs and Other licensed or certified practitioners.

4. Advanced Practice Clinician Supervision Agreements

Advanced Practice Clinicians and physicians must have a signed Advanced Practice Clinician Supervision Agreement that complies with applicable laws and regulations. HCHC will maintain an agreement for all Nurse Practitioners and Physician Assistants, and will renew every 2 years.

5. Credentialing Requirements for Medical Residents

a) Proof of Professional Liability insurance in the amount $1M/$3M required

b) Signed contract with the school or other training facility permitting students to train at the health center

c) CORI check completed with no findings

d) Letter from the student stating ability to perform requested privileges

e) Current unrestricted license to practice in the State of Massachusetts (if applicable)

f) Current DEA certificate (if applicable)

g) Current MA Controlled Substance certificate (if applicable)

h) Government issued Photo I.D.

i) Proof of Immunizations/Titers as described in the Personnel Handbook

j) Name of HCHC's supervising provider

k) Release of Liability

l) Attestation

6. Credentialing Requirements for Interns and Shadows

a) Proof of Professional Liability insurance in the amount $1M/$3M, if applicable

b) Signed contract with the school or other training facility permitting students or trainees to train at the health center, if applicable

c) CORI check completed with no findings

d) Letter from the student stating ability to perform requested privileges, if applicable

e) Government issued Photo I.D.

f) Proof of Immunizations/Titers as described in the Personnel Handbook

g) Name of HCHC's supervising provider

h) Release of Liability

i) Attestation

Verification of Credentialing and Privileging Activity			
	Licensed or Certified Practitioner		Non-licensed/Certified/Registered Clinical Staff*
Examples of Staff	*Physicians, dentists, nurse practitioners, physician assistants, LICSW, LMHC, optometrists*	*RN, LPN, certified medical assistant, registered dietitians/nutritionist, LCSW, dental hygienists, dental assistants*	*Medical assistants, community health workers*
Initial Credentialing Activities[1]	Verification Method		
Licensure, registration, certification	Primary source	Primary source	Not applicable
Education and training/ graduation verification	Primary source**	Secondary source[2]	Secondary source*
National Practitioner Data Bank (NPDB) query	Copy of NPDB report or documentation that the health center is signed up for NPDB continuous query	Copy of NPDB report or documentation that the health center is signed up for NPDB continuous query (Not applicable for some OLCHPs)	Not applicable
Government-issued picture identification	Secondary source	Secondary source	Secondary source*
Immunizations as required[3]	Secondary source	Secondary source	Secondary source*
Life support training	Secondary source	Secondary source	Secondary source*
Drug Enforcement Administration registration[4]	Secondary source	Not applicable	Not applicable
Malpractice insurance coverage	Secondary source	Secondary source	Not applicable
Massachusetts Controlled Substance Registration (MCSR)	Secondary source, if applicable	Not applicable	Not applicable
Work History	Secondary Source- at least 5 years of professional work history	Secondary source, if applicable	Secondary source, if applicable
Certification	Secondary source, if applicable	Secondary source, if applicable	Secondary source, if applicable

*This item has changed from previous guidance and practices.

** In states in which the licensing agency, specialty board, or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.

[1] The health center determines who has approval authority for credentialing and privileging of clinical staff

[2] For reasons of quality and safety, primary source verification is preferable

[3] See state recommendations or standards for provider immunization and communicable disease screening or Centers for Disease Control and Prevention recommendations at http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html

[4] Some professionals may also have a Controlled Dangerous Substance registration

B. **Types of Verification**

1. Primary Source Verification

a) Current License or Certification as Appropriate to the Discipline: Verification of current Massachusetts license must be obtained by direct confirmation from the applicable Massachusetts licensing board. Online licensure verification is accepted.

b) Board Certification (if applicable): Board certification is verified from ABMS for physicians, or other appropriate certifying board for non-physicians. Online verification is accepted.

c) Verification of Graduation from Medical School or Training Program: Written verification will be requested directly from medical school or training program or through the AMA Master Profile or through DegreeVerify.com. If the provider is a graduate of a Foreign Medical School, he/she must present evidence of certification by the Education Commission for Foreign Medical Graduates (ECFMG). This information is then verified with ECFMG.

d) Verification of Completion of Residency Training (if applicable): Verification of completion of residency training is obtained from the institution(s) where the post-graduate medical training was completed or through the AMA Master Profile.

e) Professional Liability Claims History: Verification of claims history must be obtained from the current and/or previous carriers if the provider has been insured with the present carrier for less than five (5) years.

2. Secondary Source Verification

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

a) Government-issued photo ID
b) Proof of Immunizations/titers
c) Malpractice Insurance Coverage (if applicable)
d) Current DEA Certificate (if applicable)
e) Current MA Controlled Substance Registration (if applicable)
f) Hospital Privileges from the Applicant's Primary Admitting Facility (if applicable)
g) Verification of clinical privileges in good standing at the hospital designated by HCHC as its primary admitting facility must be confirmed in writing and must include the date of the appointment, scope of privileges, disciplinary actions, restrictions and recommendations.
h) Certification (if applicable)
i) Work History (if applicable)
j) At least five (5) years of professional work history must be included in the file. Providers will be asked to explain any gap greater than one (1) year in his/her professional work history.

3. Other Verification

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

b) Ability to Perform Requested Privileges: For new providers, verification of ability to perform requested privileges will be based on 1) a completed Health Attestation Form, and 2) appropriate education/training to perform requested procedures.

4. Database Queries

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

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

C. Credentialing Process

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

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

The Credentialing process will proceed as follows:

- The Credentialing Specialist will request and collect all the necessary documentation.
- Once all the necessary documents have been received and the file is completed, a Credentialing Review Sheet will be placed on top of the provider's application.
- The Credentialing / Privileging Specialist will sign off that a satisfactory review has been conducted
- The supervisor or his/her designee will review all applications and sign off on the Review Sheet.
- The Credentialing Specialist will present the provider's application to the Credentialing and Privileging Committee, which will review all items in the application and sign off on the Review Sheet if approved
- If the Committee approves the application, it will issue a recommendation to HCHC's Board of Directors for approval or denial. Approval or denial by the Board of Directors will be obtained within ninety (90) days of employment.
- In some cases, the supervisor and the Credentialing Specialist may agree to submit an incomplete application to the Committee for approval on a Pending status, noting the reason for this action in the blank section of the Credentialing Review Form. The Committee may approve the pending application with the requirement that the application be completed within 30 days.

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

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

D. Other

1. Right to Review Credentialing File

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

2. Orientation

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

E. HCHC Re-Verification Process

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

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

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

V. Privileging

A. Privileging Requirements

BPHC Health Center Program Compliance Manual c. 5. Section d requires privileging of each licensed or certified health care practitioner specific to the services being provided at each of HCHC's care delivery settings.

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

B. Privileging of Licensed Independent Practitioners

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

Verification of Credentialing and Privileging Activity			
	Licensed or Certified Practitioner		Non-licensed/Certified/Registered Clinical Staff*
Initial Privileging Activities[1]	Verification Method		
Clinical Competence	Primary source (training, education, references)	Primary source (training, education, references)*	Primary source (training, education, references)*
Fitness for Duty	Secondary source*	Secondary Source	Secondary source*
Hospital Admitting Privileges	Secondary source	Not applicable	Not applicable
Verification of clinical privileges according to job description	Secondary source, if applicable	Secondary source, if applicable	Secondary source, if applicable*

*This item has changed from previous guidance and practices.
** In states in which the licensing agency, specialty board, or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.
[1] The health center determines who has approval authority for credentialing and privileging of clinical staff
[2] For reasons of quality and safety, primary source verification is preferable
[3] See state recommendations or standards for provider immunization and communicable disease screening or Centers for Disease Control and Prevention recommendations at http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
[4] Some professionals may also have a Controlled Dangerous Substance registration

1. *Medical Practitioners*

a) Family Practice Physicians

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

Clinical Competencies for Family Practice Physicians		
Skin procedures	**Gynecology procedures**	**Orthopedic procedures**
Punch biopsy	IUD insertion and removal	Injection of knee
Shave biopsy	Endometrial biopsy	Injection of shoulder
Excisional biopsy		Injection of hip
Cryotherapy		Other joint injection
Suturing		
Incision and drainage		
Toenail removal		
Cyst removal		

b) Medicine/Pediatrics, Internal Medicine and Pediatric Physicians

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

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

Initial privileging to perform IUD insertion and/or endometrial biopsy requires proof of appropriate training in residency, or training in a post-graduate CME program, or specific on-site training by a privileged clinician and observation and approval by a privileged clinician.

Maintenance of privileging requires competent insertion of a device or performance of an endometrial biopsy at least five (5) times per year.

c) Nurse Practitioners

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

Clinical Competencies for Nurse Practitioners, Physician Assistants	
Skin procedures	**Orthopedic procedures**
Punch biopsy	Injection of knee
Shave biopsy	Injection of shoulder
Excisional biopsy	Injection of hip
Cryotherapy	Other joint injection
Suturing	
Incision and drainage	
Toenail removal	
Cyst removal	

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

d) Applicable to All Medical LIPs

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

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

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

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

2. ***Behavioral Health Practitioners***
   a) Licensed Independent Clinical Social Workers and Licensed Mental Health Clinicians

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

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

3. ***Dental/Oral Health Practitioners***
   a) Licensed Dentists

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

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

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

Clinical Competencies for Licensed Dentists		
Perform clinical and regional oral exams including oral cancer screening	Perform patient medical and dental history	Perform oral diagnosis
Develop comprehensive treatment plans with full explanation of risks and alternatives	Order and interpret radiology tests	Order and interpret laboratory tests
Refer to diagnostic medical or dental providers when necessary	Provide consultation services	Prescribe medications for patients
Prescribe anxiolytic medications and narcotics for patients using the Mass reference system	Administer IM/SC injections	Restorative care including amalgams, composites, crowns, and implant restorations
Root canals – anterior teeth	Root canals – posterior teeth	Periodontics – gingivectomies
Prosthodontics – removable/fixed full dentures, removable/fixed partial dentures, full/partial overdentures	Palliative treatment	Simple extractions
Surgical extractions	Tissue impacted teeth extractions	Abscess incision and drainage
Frenectomies	Local anesthesia	

4. ***Eye Care Practitioners***
   a) Optometrists

The minimum training requirements for privileging for Optometrists consist of

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

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

C. Other Licensed or Certified Practitioners

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

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

1. ***Medical Practitioners***

a) Medical Auxiliaries

(1) Registered Nurses

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

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

(2) Licensed Practical Nurses

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

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

(3) Medical Assistants

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

2. ***Behavioral Health Practitioners***

a) Licensed Clinical Social Workers

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

3. Dental/Oral Health Practitioners

a) Dental Auxiliaries

Dental auxiliaries include the following positions:

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

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

- General supervision (G) - Supervision of dental procedures based on instructions given by a licensed dentist but not requiring the physical presence of a supervising dentist during the performance of those procedures.

- Direct Supervision (D) - Supervision of dental procedures based on instructions given by a licensed dentist who remains in the dental facility while the procedures are being performed by the auxiliary.

- Immediate Supervision (I) - Supervision of dental procedures by a licensed dentist who remains in the dental facility, personally diagnoses the condition to be treated, personally authorizes the procedures, and before dismissal of the patient, evaluates the performance of the auxiliary.

Clinical Competencies for Hygienists and Dental Assistants				
Delegated Procedure	Appropriate Supervision			
	RDH	**CDA**	**FTA**	**OJT**
Give oral health instruction	G	G	G	G
Perform dietary analysis for dental disease control	G	G	G	G
Take and record vital signs	G	G	G	G
Chart dental restorations and record lesions	G	D	D	D
Take intra-oral photographs	G	G	G	G
Retract lips, cheek, tongue and other oral tissue parts	G	G	G	G
Place temporary restorations	G	D	D	I
Irrigate and aspirate the oral cavity	G	D	D	D
Isolate the operative field	G	G	G	D
Take impressions for study casts, athletic mouth guards, custom trays	G	G	G	I
Take wax bite registrations for identification purposes	G	G	G	D
Apply topical anesthetic agents	G	I	I	I
Take oral cytologic smears	D			
Remove sutures	G	G	G	D
Place and remove periodontal dressings	G	G	G	D
D Place and remove rubber dam	G	G	G	D
Irrigate and dry root canals	I	I	I	
Expose radiographs	G	G	D	D
Remove gingival retraction cord	D	D	D	D
Apply cavity varnish	I	I	I	I
Remove temporary restorations with hand instruments	G	I	I	N/A
Place and remove wedges	G	D	D	I
Place and remove matrix bands	G	D	D	I
Place gingival retraction cord	D	D	D	D
Cement and remove temporary crowns and bridges	G	G	G	I
Insert and/or perform minor adjustment of athletic mouth guards and custom fluoride trays	G	G	G	I
Polish teeth after dentist or dental hygienist has determined that teeth are free of calculus	G	G	G	N/A
Apply anti-cariogenic agents	G	G	G	D
Remove surgical dressings	G	G	G	N/A
Apply dental sealants	G	I	I	N/A
Place surgical dressings	G	G	G	N/A
Perform pulp testing	D	N/A	N/A	N/A
Select and try stainless steel crowns or other pre- formed crown for insertion by dentist	I	I	I	I
Perform periodontal charting	G			
Conduct dental screenings	G			
Perform preliminary examination to determine needed dental hygiene services	G			
Perform sub-gingival and supra-gingival scaling	G			
Perform root planing and curettage	G			
Polish amalgam restorations	G			
Apply identification microdisks	G			
Perform minor emergency denture adjustments to eliminate pain and discomfort in nursing homes and other long term care facilities	G			

Table obtained from 234 CMR-2.04

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

D. Privileging Revision or Renewal Requirements

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

1. The revision or renewal of privileges of other licensed or certified health care practitioners should occur at a minimum of every 2 years. Verification is by:
    a. supervisory evaluation of performance that assures that the individual is competent to perform the duties described in the job description based on the following:
        i. for LIPs: Primary source based on peer review and/or performance
        ii. improvement data.
        iii. for Other Licensed or Certified Practitioners: Supervisory evaluation per job description
    b. verification of current licensure, registration, or certification through primary source

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

3. For Nurse Practitioners and Physician Assistants, Advanced Practice Clinician Supervision Agreement is to be reviewed and signed by all required parties every 2 years.

Verification of Credentialing and Privileging Activity			
	Licensed or Certified Practitioner		Non-licensed/Certified/Registered Clinical Staff*
Renewal or Revision of Privileges[1]	Verification Method		
Current licensure, registration, certification	Primary source*	Primary source*	Primary source*
New (additional) privileges according to Health Center scope	Secondary source	Secondary	Not applicable
Current clinician competence	Primary source (peer review, supervisory performance review)	Primary source (peer review, supervisory performance review)	Primary source* (peer review, supervisory performance review)
National Practitioner Data Bank (NPDB) query	Secondary source	Secondary source	Not applicable
Frequency	Ongoing basis- at least every 2 years	Ongoing basis- at least every 2 years	Ongoing basis*- at least every 2 years

*This item has changed from previous guidance and practices.
** In states in which the licensing agency, specialty board, or registry conducts primary source verification of education and training, the health center would not be required to duplicate primary source verification when completing the credentialing process.
[1] The health center determines who has approval authority for credentialing and privileging of clinical staff
[2] For reasons of quality and safety, primary source verification is preferable
[3] See state recommendations or standards for provider immunization and communicable disease screening or Centers for Disease Control and Prevention recommendations at http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
[4] Some professionals may also have a Controlled Dangerous Substance registration

Temporary Privileging

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

1. To fulfill an important patient care need

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

a) a situation where a physician becomes ill or takes a leave of absence and an LIP would need to cover his/her practice until he/she returns (locum tenens)
b) a specific LIP has the necessary skills to provide care to a patient that an LIP currently privileged does not possess

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

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

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

- there is verification of
  - current licensure
  - relevant training or experience
  - current competence as defined above
  - ability to perform the privileges requested
  - other criteria required by medical staff bylaws

- the results of the National Practitioner Data Bank query have been obtained and evaluated

- the applicant has:
  - a complete application
  - no current or previously successful challenge to licensure or registration
  - not been subject to involuntary termination of medical staff membership at another organization
  - not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges

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

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

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

Hilltown Community Health Centers, Inc.

Clinical Policy
Oral Health/Dental Department

SUBJECT: HYGIENE EXAM
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for providing hygiene exams for patients.

Policy:

All hygienists will follow the attached procedure for hygiene exams.

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

Originally Drafted: FEB 2017 Reviewed or Revised: APR 2019

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

Exam:

1. Review medical History – make sure form is filled out in its entirety (front and back), record changes in chart/computer and add alerts
2. List medications and reason for each
3. Medical history update (pink paper) to be placed in front of most recent health history (blue paper) providers need to sign and date
4. If patient is new, take blood pressure
5. Chief complaint noted (may be recall only)
6. OCS results: negative note, if positive note: size, location and description. Flag if in house suspicion and place on tracking list. If referred, copy referral for chart and place on tracking list.
7. New patients record all existing restorations
8. Perio charting:
    - Perio diagnosis based on charting (include probing, bleeding points, furcation involvement, mobility recession, OH)
    - History of: SCPR, periodontist referral, 3-4 month recalls
    - Current recommendations: SCRP, referral, 3-4 month recalls
9. Radiographs: last FMS, last bitewings problematic teeth requiring PA, crown requiring PA
10. Watches / follow up concerns
11. Note: recommended mouth guards, fillings that are incomplete, incipient caries
12. If patient needs prescriptions (including 5000+), have them ready to sign

Following the completion of exam:

13. Check that the updated medical health history is signed, record prescriptions given
14. If a crown is treatment planned, lab work to be done, fill out PA insurance form and add x-ray and give to receptionist, have patient sign a crown consent form and give them a copy
15. Record any referrals given in computer chart and place copy in chart
16. Check to make sure correct doctor is in computer for exam
17. Note treatment to be performed next visit. Print treatment plan and have patient sign.
18. Set up next prophy and exam.
19. Fill out slip for reception, next visits to be scheduled including information as: Number of visits, time for each , which provider to see patient
20. Note in computer that treatment plan was given

Exam for a patient with an implant:

1. Make a recall for 1 year
2. Take a periapical x-ray to check bone loss, calculus, and cement
3. Occlusion check with shimpaper, slightly out of occlusion
4. Check: Inflammation, pocketing, mobility
5. Occlusal guard check: is there evidence of bruxism?

Exam for a patient with an Over denture:

1. Make a recall for 1 year
2. Check retention
3. Perio for implant abutments
4. Periapical x-rays
5. Check tissue health
6. Balanced occlusion check with articulating paper
7. Make sure no cleaner is used inside denture (affects rubber rings inside)

Hilltown Community Health Centers, Inc.

Clinical Policy
Oral Health/Dental Department

SUBJECT: ORAL HEALTH-DENTAL INFECTION CONTROL
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for infection control and measures within the department.

Policy:

Infection control standards are in effect and uniform for the protection of all patients and staff. All staff will follow the following protocols to meet quality standards.

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

Originally Drafted: FEB 2017 Reviewed or Revised: APR 2019

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

CLEANING ROOM

1. Throw away all used products on tray i.e. 2x2's, cotton rolls, dry angles, articulating paper, micro-brush, curing light sleeve, tip-a-dilly, used etch tip, floss, tray cover, patient napkin, etc.
2. Wipe instruments that may have debris, i.e. composite instrument, dycal instrument, ball burnisher, beaver tail, dappen dish, etc.
3. Load instruments in basket for transport to lab.
4. Make sure to leave cord packers, spatulas, scissors, syringes, oral surgery instruments, tighteners, clamps, etc. out of the basket.
5. Syringes should have needle and carpule(s) removed in operatory and disposed of in sharps container.
6. Any one-use burs should be disposed of in the sharps container.
7. The high speed handpiece should be run for 20 seconds without a bur. This procedure is intended to physically flush out patient material that might have entered the turbine, air or waterlines.
8. Remove all barrier covers i.e. handle covers, headrest covers, tape on control pads, tape on x-ray control, tape on mouse, etc.
9. Spray all impressions, partials, dentures and models before leaving the room. Bringing untreated items into the lab increases chances for cross infection.
10. Remove tray to lab and place in the receiving area, i.e. next to the ultrasonic.
11. Remove gloves and return to room.
12. We are no longer spraying the Cavicide to disinfectant the room. Using the Cavicide wipes, wipe once to clean and again to disinfect. Be sure to wipe all surfaces – cart, cart drawer handles, chair, light and light handles, patient glasses, assistant glasses, bib clip, Amtel, delivery system, X-ray unit, curing light, amalgamator, bur blocks, floss container, countertop, composite gun and carpules, etch, impression guns, Ionosit, patient mirror, key board, etc.
13. Dress room – headrest cover, light handle covers, tray cover, tape on any controls and X-ray control pad/buttons and curing light sleeve.
14. Using Cavicide wipe patient glasses, assistant glasses, handheld mirror and orange shield. Rinse with water and dry so there is no Cavicide residue left on them.
15. When taking x-rays, remove dirty bib before placing the lead apron on the patient.

HAZARDOUS WASTE PROTOCOL

Amalgam:

1. Leftover amalgam should be removed from the carrier before it hardens and put in the amalgam well. Once it gets to the lab, it should be placed in the Amalgam Safe. When the safe is full it gets mailed out in the box with the prepaid label it came with.

2. On a monthly basis we clean out the chairside traps connected with the suction and empty any amalgam collected into the Amalgam Safe.
3. We have an amalgam separator in the basement which removes amalgam waste particles from the dental wastewater so that it does not end up in wastewater treatment plants. We check it monthly. When it is full we seal it off and mail it to a mercury recycler. When they receive it they issue a Certificate of Receipt.
4. Extracted teeth with amalgam in them should be placed in the Amalgam Safe.

Lead:

1. Lead backing from film is collected by our hazardous waste collection facility.
2. Old lead aprons are collected in a purchased bucket and mailed off.

Fixer:

1. Fixer is collected and picked up by our hazardous waste collection facility.

Medical Waste:

1. Blood soaked gauze is placed in a leak-resistant biohazard bag. When full they are secured and placed in a medical waste box in the basement where it is picked up by our hazardous waste collection facility.
2. OSHA considers extracted teeth to be potentially infectious material that should be disposed of in the leak-resistant biohazard bag. However, extracted teeth can be returned to patients on request. Extracted teeth with amalgam in them must go in the Amalgam Safe.
3. Needles, burs, and scalpels are disposed of in sharps containers which are closed and then placed in the medical waste box in the basement.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. Masks and eyewear should be worn to protect mucous membranes of the eyes, nose and mouth during procedures. Be sure mask is worn over nose not under.
2. Change masks between patients or during patient treatment if the mask becomes wet.
3. Wear lab coat – long sleeves and closed at neck. Change if it becomes visibly soiled.
4. New gloves should be worn with every patient and removed if leaving the room.
5. Masks, gloves and eyewear should not be worn when at the front desk or in the office.
6. Gloves that are torn or punctured should be removed and hands should be disinfected before regloving.
7. The effectiveness of double gloving in preventing disease transmission has not been demonstrated.
8. Utility gloves should be worn when handling instruments in the lab as well as mask and eyewear.
9. Perform hand hygiene with either a non-antimicrobial or antimicrobial soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material. If hands are not visibly soiled, an alcohol-based hand rub can also be used.

10. Hands should be cleaned before and after every patient and before regloving during a procedure.
11. Store liquid soap in either disposable closed containers or closed containers that can be washed and dried before refilling. Do not add soap to a partially empty dispenser.
12. The eye wash station(s) should be tested weekly by letting water flow for at least 3 minutes and recorded. All employees should be trained in use.

STERILIZATION PROTOCOL

1. The instrument processing area should be divided as much as possible into distinct areas for 1) receiving, cleaning and decontamination; 2) preparation and packaging; 3) sterilization; and 4) storage. Do not store instruments in an area where contaminated instruments are held or cleaned.
2. Dirty instruments should be in baskets when brought into lab and baskets should be placed in the ultrasonic. Extra instruments should be placed in baskets and put in ultrasonic. Ultrasonic lid should be used when in use.
3. All handpieces should be run through the Quattrocare, dried and bagged.
4. Burs should be placed in bur blocks to be cleaned and transferred to pouches for sterilization. Check burs for debris or rust and dispose of if they will not come clean.
5. Tray should be sprayed.
6. Wear heavy-duty utility gloves for instrument cleaning and decontamination.
7. Appropriate PPE should be worn when spraying/splashing is anticipated.
8. After ultrasonic is finished, remove baskets and rinse well. Instruments and baskets must be dry before placing in pouches. Use paper towels or laundry towels to accomplish this. Be aware of items such as sensor holders that have small openings on the side that can hold water. If the last sterilizer run of the day has happened, baskets for the next day can be left out to air dry overnight and packaged the following morning.
9. Hinged instruments should be processed open and unlocked.
10. Place pouches loosely in sterilizer. Handpieces should be sterilized in the Statim. Bagged instruments should be paper side down. Putting the instruments in paper side down allows water to “wick” out through the paper and speeds drying time. In the Statim 5000 using the wire pouch rack or Stat-Dri plates can speed up the drying process. Do NOT overfill sterilizers – overfilling will prevent pouches from fully drying and will necessitate rerunning the sterilizer.
11. Sterilizers should run all the way through the drying cycle. Hot packs should not be touched until they are cool and dry because hot packs act as wicks, absorbing moisture, and hence, bacteria from hands.
12. The pouches we use have internal and external indicators to monitor sterilization. We also use weekly spore tests for each sterilizer.
13. Pouches should be stamped with the date on the end on the paper side. When writing on the pouches use a permanent marker on the plastic side.
14. Pouches should be folded on the fold line only.

15. Sterile packages should be inspected for integrity and compromised packages must be reprocessed prior to use.
16. Sterilized packages should be stored in closed or covered cabinets and drawers, if possible.

Hilltown Community Health Centers, Inc.

Clinical Policy
Oral Health/Dental Department

SUBJECT: EARLY CHILDHOOD CARIES (ECC) PATIENT WITH HIGH or MEDIUM RISK
REGULATORY REFERENCE: None

Purpose:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for providing assessment and treatment for patients with early childhood caries (ECC) with high risk.

Policy:

When an ECC patient is identified with high or medium risk, the attached procedure is followed.

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

Originally Drafted: FEB 2017 Reviewed or Revised: APR 2019

Approved by Board of Directors, Date: _____

Approved by:

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

_____
John Follet, MD
Chair, HCHC Board of Directors

Procedure:

New patient Exam/ Recall Exam:

1. Caries risk assessment questionnaire.
2. Comprehensive or periodic exam by dentist.
3. Appropriate prophy if cooperative (scaling as needed, rubber cup or toothbrush prophy).
4. BWS if indicated.
5. Fluoride varnish
6. ***Toothbrush instruction***
7. ***Nutritional evaluation and instruction***
8. ***Self management goal:***

Disease management recall 3 months

1. Review tooth brushing
2. Review nutritional goal
3. ***Fluoride varnish***
4. ***Self management goal:*** *set new goal or reemphasize previous goal for next visit.*

Disease management recall 6 month

1. Evaluate OHI and goals
2. Evaluate risk classification (if no new decay and good OH reclassify to lower risk grade)
3. Evaluate recall frequency and varnish frequency
4. Periodic exam by dentist
5. Prophy
6. Fluoride varnish

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

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

Community Care Cooperative (C3) ACO:

This month has been a quiet one in our interactions with C3, although we are facing a new challenge: Janet Dimock, one of our Community Health Workers, had taken on the unfunded mandate (from MassHealth) that ACOs, and therefore health centers, conduct extensive coordination with the Behavioral Health Community Partners on our MassHealth members. A few weeks ago, Janet announced that she was retiring at the end of April, and the Medical and Community Programs leadership haven't been able to figure out any staff person who has the capacity to take this responsibility on. The implications of this are unclear, and certainly there is great concern across the state, and the ACOs, about this additional burden that was not made clear at the beginning of the program implementation.

C3 is continuing to explore a number of other projects/expansions. One is the shared EHR that we have discussed before, and another is partnering with another entity to become a part of the One Care system, which is the state program for individuals age 18-64 dually eligible for Medicare and MassHealth. HCHC has never been very involved in this program, as we have only a few patients enrolled with the current provider in the area, Commonwealth Care Alliance. This is all very preliminary, but C3 sees this as a way of expanding its model at health centers from just the MassHealth population.

Hospital Engagement:

Frank had a call with the **Mass General Hospital** staff to talk about the possible further support that they could give to HCHC, potentially in form of a loan guarantee. The call did not go well – the financial person that Frank spoke with had not been briefed prior to the call by our prior contacts about the situation, and was dismissive of the idea. We are therefore now focused on the renegotiation with MassHealth, to change the terms of the payback. I am having lunch next week with our primary contact at Partners, as both of us will be at a conference on the Cape, and perhaps we will come up with some other ideas.

We are in very early and very tentative conversation with a local hospital about how we can collaborate around a primary care office that they currently own, but which we might find a way to work together to serve that community. I am hoping to meet with Jackie Leifer, a lawyer who is a national expert on health center law, next week on the Cape, to see what possible models of collaboration between hospitals and health centers are, within the requirements of HRSA.

Goal 2: HCHC Expansion

John P. Musante Health Center (JPMHC): Outreach is continuing, and in fact one of the Musante Center's dentist's son is helping design and beta test Facebook ads, *pro bono*. We have given more tours to Center for New Americans classes, and I am cultivating some new connections with the subsidized housing projects in Northampton, which is an area that we have not yet explored.

Unfortunately, Sophal Lom, NP, has given notice – her family will be moving to Boston this summer, and she will no longer be a PCP in Amherst. This is, of course, a blow, but given the patient volume at that site, it will allow the remaining providers there to spend more time in Amherst, potentially reducing the need for them to work in Huntington. That will, in turn, exacerbate the provider problems in the Hilltowns, which I will address below.

Telehealth: Michael Purdy and I attended a two-day conference for community health centers on telehealth in April, and found it very helpful. It is clear that there are many possible models for using telehealth – provider to specialist consultation, patient to specialist consultation, patients and providers consulting with a provider at another health center site, or even patients at one site having a visit at another health center site. The latter would be most helpful in situations where a site is understaffed, but the first and second model is the most feasible and helpful for HCHC.

As I mentioned last month, we are going to looking at telespychiatry first, and the leadership of the Medical and Behavioral Health departments are working with Marie to write the HRSA grant that is due in mid-May. We are exploring the options for possible partnership with local BH providers, including hospitals, to see if we can contract for a few hours of psychiatry a month, which would make a psychiatrist available for either PCPs or therapists, and potentially for patients who need a direct consultation. We are also looking at hiring someone to be a BH Care Coordinator and/or dedicated CHW, to address no shows and other supports BH patients might need. The funding is on-going, and therefore spending it on staffing makes the most sense. We will send you a copy of the application directly after it is submitted, but would like a vote this week to authorize us to submit the application. I will try to give more details tomorrow.

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:

As we will discuss during the Finance Committee presentation, March was not a terrible month. In April we lost a medical provider, so things are not likely to continue in this vein, but if they did we would not be unhappy. We continue to struggle with staffing, although the nursing department is now fully staffed. The leadership team has developed a plan for increasing the front desk capacity as a way of

mitigating the lack of medical assistants, but now we are having difficulty finding receptionists, as well. The efforts to address this continue.

I am happy to report that State Representative Mindy Domb was successful in getting a $25,000 earmark in the House budget, and she has told me that there will be an effort to get a higher number in the Senate budget, which will be debated in May. I am spending the day at the State House tomorrow, and will talk with Senators Comerford and Hinds about this in our meetings. I will also talk with Comerford's staff about next week's hearing on the bill that would increase dental rates for health centers; I will submit written testimony (because there won't be a chance to testify in person), and may be asked to go back to meet with committee staff to make the case. As noted before, this increase would have resulted in a $115,000 increase in revenue in 2018, had it been in place.

Other Reports

State and National Activities:

- After the successful meeting with Congressman Neal in Washington, I was somewhat surprised to receive a call a few weeks ago informing me that the Congressman would like to visit our health center the week of April 21st. He did come for a brief visit on April 25th, and talked with Jon, Frank, and me about the challenges of serving rural areas and how current funding and health care system structures doesn't adequately support community health centers specifically, and public health in general. There was a *Springfield Republican* reporter present, but he did not write about the visit, focusing instead on Neal's role in the current political activity in Washington. As quiet as it may have been, I think the visit was an important opportunity to develop a stronger relationship with a powerful Congressman. The League is talking with NACHC about whether Neal's seemingly sudden interest in health centers is something that they would like to cultivate – I of course said I would be happy to help in any way I can advocate for health centers' interests.
- Although 40 state representatives co-sponsored an amendment to the state budget that would have created the Health Center Transformation Fund as an immediate source of support for Massachusetts CHCs, the amendment was not adopted. Tomorrow I will learn more about what the current state legislative priorities are, which I will convey to our delegation.

PROGRAM NARRATIVE
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PROGRAM NARRATIVE

Hilltown Community Health Centers, Inc. (HCHC) has been a federal qualified health center (FQHC) since 2000. In 2018, HCHC served 8,571 patients in 43,694 visits (all types).

HCHC operates four health center sites and a family support facility: the Huntington Health Center serving the southern Hilltowns; the Worthington Health Center serving the northern Hilltowns; the John P. Musante Health Center in Amherst serving central Hampshire County and Pioneer Valley; the School-Based Health Center in the Gateway Regional Middle/High School serving the students in the Gateway Regional School District; and the Hilltown Community Center in Huntington that provides both on-site and community-based health education programs, health insurance assistance, social service support and services, family education and support, and domestic violence advocacy and safety planning.

A. NEED

1. Proposed Service Area

a. Service Area Boundaries

The Quaboag Hills Health Center (QHHC) will serve the low-income population of west-central Massachusetts that is unable to access affordable primary and preventative medical care services. Located in downtown Ware, the QHHC will be a new access point for HCHC, which is a NCQA-certified FQHC serving the hilltowns of western Hampshire and Hampden Counties and the central Pioneer Valley region of both counties. The service area of the QHHC will expand HCHC's reach to include all of Hampshire County, the eastern towns of Hampden County, and the western area of Worcester County. All of these communities do not currently have easy access to primary care for low-income individuals.

The service area for the proposed Quaboag Hills Health Center, in which at least 75% of patients will reside, includes nine communities located in the Hampshire, Hampden and Worcester counties in west-central Massachusetts. The nine communities include: 1) Brookfield, 2) East Brookfield, 3) Hardwick (including the villages of Gilbertville and Wheelwright), 4) New Braintree, 5) North Brookfield, 6) Palmer (including the villages of Bondsville, Thorndike and Three Rivers), 7) Ware, 8) Warren, and 9) West Brookfield.

Table 1. Community Characteristics

	2017 Population Estimate*	Percentage of Population Living Below Federal Poverty Level*	Percentage of Population Living Below 200% of Federal Poverty Level*	Percentage of Low Income CHC Penetration* *
Hampshire County				
Ware	10,612	14.3%	26%	3.5%
Worcester County				
Brookfield	3,386	9.2%	20%	1.54%
East Brookfield	2,259	4.8%	19%	0%
Hardwick	2,294	12%	30%	1.82%

New Braintree	1,106	8.3%	17%	0%
North Brookfield	4,761	6.5%	20%	1.98%
Warren	4,339	11.3%	32%	1.17%
West Brookfield	4,606	6.5%	20%	1.41%
Hampden County				
Palmer	12,253	14.1%	31%	3.6%
Total Service Area	**45,616**	**10%**	**24%**	**2.27%**
Massachusetts	**6,742155**	**11%**	**24%**	**47.14%**

* US Census, American Community Survey 2014-2017
** UDS Mapper, Population Total 2012-2016

The communities comprise the area known regionally and statewide as the Quaboag Hills Region. The total population of the service area is 45,616. Seven of the nine communities are located in Worcester County, one is in Hampshire County and one is in Hampden County. This group of communities, all on the fringes of counties that are centered either to the west or east of this region, have come together to form local coalitions and organizations to address their needs, which are often neglected by the entities that serve the rest of their counties. For instance, the Quaboag Valley Community Development Corporation and the Quaboag Hills Community Coalition are specifically focused on the economic development and social services needs of the region. Baystate Health, a large tertiary care health system based in city of Springfield, MA, has defined this area as its Eastern Region, served by one hospital and an outpatient center. And finally, the state Department of Public Health and its Office of Rural Health, in recognition of the inadequacy of using only counties as a unit of measurement and analysis, has designated these communities as being part of the "Quaboag Rural Cluster." The communities cluster around MA Route 9 as the central east/west route and MA Route 32 as the north/south route. See Attachment 1 for the Quaboag Hills Service Area Map.

b. How Service Area Matches Where Proposed Patients Reside

The Quaboag Hills Health Center service area communities were chosen due to their lack of access to primary care medical services. The Massachusetts Department of Public Health (MDPH) has determined that six of the nine communities in the service area meet the HRSA definition of a primary care professional shortage area. Three of those communities have no physicians, and three have 3500+ residents per PCP. Of the remaining communities, two have 1500-3499 residents per PCP and one has 750-1499 residents per PCP.[1] Additionally, all nine communities in the service area are identified by HRSA as "hot spots" as each have unmet need score of over 35 and none have a federally qualified health centers located in their community.

With only 2.27 percent of the total low-income population of the service area utilizing a FQHC, it would appear that the population of the proposed service area is unserved by a health center and would frequent a new health center located within the service area. The downtown Ware site for the QHHC was chosen due to its central location to all service area towns and walkability to the largest concentration of low-income residents, including two low-income rental developments in downtown Ware, which collectively contain 191 units of low-income housing.

[1] MA DPH Data Brief: Health Professions Data Series-Physicians 2014

c. Health Center Penetration of Proposed Service Area

According to UDS Mapper, the proposed service area is currently served by four federally qualified community health centers (FQHC), none of which is closer than 20 miles from downtown Ware. These include Community Health Center of Franklin County (29 miles), Caring Health Center (27 miles), Holyoke Health Center (23 miles), and Family Health Center of Worcester, Inc. (21 miles). HCHC's Musante Health Center in Amherst is the closest FQHC site, at 19 miles from the proposed Ware site. These distances are large, particularly given the extremely limited public transportation available, and are reflected in the very low penetration rate. Of the total low-income population (12,144), only 276 individuals are patients at an FQHC, for a **penetration rate of 2.27%**. Of the total population of the service area (45,616), only 0.61% are patients of an FQHC.

2. Current Unmet Health Care Needs

a. Service by Other Primary Care Providers

The Massachusetts Primary Care Office, which is housed at the MDPH, lists only four practices as serving the Quaboag Hills service area: two in Palmer, one in Ware and one in West Brookfield. Taken together the four practices employ seven primary care providers. One of the practices in Palmer is located at the Baystate Wing Hospital and the practice in Ware is located at Mary Lane Outpatient Center – both of these sites now comprise Baystate Health's Eastern Region system.[2]

b. Factors Associated with Access to Care and Health Care Utilization

The QHHC service area is characterized by geographic isolation, lack of public transportation, and a substantial low-income population.

Geography

The communities in the QHHC service area fall between the cities of Worcester and Springfield and are comprised of densely populated former mill villages surrounded by rural areas and developing commuter neighborhoods. Seven of the nine towns have populations of less than 5,000 and all nine communities meet the state definition of rural defined as "a municipality in which there are fewer than 500 people per square mile".[3] Some of the communities have strong mixed-use town centers but the majority have town centers that have historical and civic significance but little commercial or neighborhood development.

Transportation

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[2] NB: In 2016, Baystate Health closed Mary Lane Hospital and transitioned it into an Outpatient Center, and created the Eastern Region system, which is comprised of Wing Hospital and Mary Lane. In 2016, the two hospitals each had their own CHNA, but the data presented in both was identical. We therefore refer to the 2016 CHNA as being that of the entire Eastern Region.

[3] Improving State-Sponsored Services in Massachusetts in Rural Communities, Rural Access Commission Report, EOHS, August 2013, pg. 5

None of the Quaboag Hills communities has direct access to the region's major interstate highways, I-90, I-84, I-90 or Route 2 with the exception of Palmer (I-90 access) – otherwise there are only two lane paved roads and dirt roads in the region. The service area is on the eastern periphery of the Pioneer Valley Transit Authority's (PVTA) service area and on the western periphery of the Worcester Regional Transit Authority's (WRTA) service area. The PVTA has a single route, the Ware-Palmer Express that goes from Ware to Springfield twice a day and takes nearly an hour to go between the two locations. The WRTA has one route that services just two communities in the service area, Brookfield and East Brookfield. The route takes an hour to go from Brookfield to downtown Worcester. With only two public transportation routes out of the region, regional public health officials interviewed for the 2016 Baystate Eastern Region Community Health Needs Assessment (CHNA) identified increased transportation options as an overall community need for the region. Individuals who do not own a vehicle face difficulties accessing educational and employment options; community-based programs that promote health, such as exercise and nutrition programs; and other activities that promote social connection. In addition, lack of accessible transportation has an impact on health for low-income or elderly populations living in rural areas, where public transportation may have limited routes and frequency of service.[4] Lack of transportation is a particular concern in Ware and Palmer where 8% of households do not have vehicles (ACS, 2013-17).

In the last two years, the community has come together to develop a non-fixed route van system called the Quaboag Connector, but the priority for this program are trips related to employment and education. These are reserved on a first-come, first-served basis; rides to work, job training programs & other job-related destinations take first priority. Requests for other purposes such as medical or shopping are put on a waiting list and are confirmed or re-booked 1 days prior to the ride. All rides cost $2 each way. This is an important development for the community, but has not significantly impacted patients' ability to access care, if they do not have a car.

Income Characteristics

In the QHHC service area, a substantial percentage of residents struggle with poverty and low levels of income. The connections between poor health and poverty, low levels of income, and access to fewer resources are well established. Low-income individuals are more likely to be negatively impacted by the chronic stress associated with challenges in securing basic necessities that impact health such as housing, food, and access to physical activity.

The average unemployment rate in the QHHC service area is significantly higher at 5% than the state versus 3.6% statewide.[5] Unemployment rates in the towns of Ware, Palmer and West Brookfield were 50% higher than the state average. The overall poverty rate in the service area is 10% and some communities are even higher including areas of Ware and Palmer whose poverty rates were over 14% (Table 1) (ACS 2013-2017). The federal poverty level (FPL) is extremely low and omits a sizeable portion of the population that is struggling economically. The percent of the population living below 200% of the federal poverty level offers a better glimpse of individuals who are low income and may lack resources to meet basic needs. In particular, families that live below 200% of the poverty line likely do not have the resources they need to be

[4] Pioneer Valley Regional Non-Transit User Study, Pioneer Valley Planning Commission, 2011
[5] January 2019 Statistics, Massachusetts Executive Office of Labor and Workforce Development

economically self-sufficient. Approximately 24% of residents in the service area live in households with incomes below 200% the federal poverty level. The highest levels are in Hardwick, Palmer and Warren, over 30% of the population lived in households at or below 200% of federal poverty level (ACS 2013-2017).

Regional public health officials identified housing insecurity and homelessness as key contributors to poor health. Housing insecurity was identified as a health need in the 2013 CHNA and continues to impact Baystate Eastern Region service area residents. Thirty percent of the population in the QHHC service area is housing cost burdened, with the highest rates of housing burden in the towns of Ware (40%) and Hardwick (35%) (ACS 2013-17).

Lack of affordable housing can contribute to homelessness and housing instability, which leads to increased stress and can often force families to prioritize housing costs over factors that can influence health, such as purchasing healthy foods and medications. Poor housing conditions also impact the health of residents. Older housing combined with limited resources for maintenance can lead to problems (e.g. mold, pest/rodent exposure) that affect asthma and other respiratory illnesses; exposure to environmental contaminants such as lead paint, asbestos, and lead pipes; and safety and accessibility issues for children, elderly or disabled populations. The QHHC service area has a large older housing stock, with approximately 29% of occupied housing units in Hampden, Hampshire, and Worcester Counties built before 1940 (ACS 2013-2017).

In 2016, the Town of Ware designated the entire downtown business district and surrounding residential streets a slum and blight area. According to a study prepared for the town by the Pioneer Valley Planning Commission prior to the town determination, 146 of the 354 homes (41%) in the designated area were either in substandard condition or abandoned.[6]

Vulnerable Populations

According to the Baystate Eastern Region 2016 CHNA, children and youth, older adults, and some communities of color, particularly Latinos, experience disproportionately high rates of some health conditions or associated morbidities when compared to that of the general population in the Baystate Eastern Region service area.

- Children/youth experienced high rates of asthma and are impacted by obesity and mental health issues. In addition, substance use among young people can have lifelong consequences, making youth a particularly vulnerable population.
- Older adults had higher rates of heart disease, hypertension, and depression.
- Latinos experienced higher rates of ER visits due to some chronic diseases, including asthma and COPD.

Individuals with low-income levels, those living in poverty (especially children and some communities of color), and those that are homeless are also disproportionately impacted by

[6] Slum and Blight Inventory for Ware, MA Town Center, Pioneer Valley Planning Commission, October, 2016

poor health. Although data was not available for health conditions by income/poverty level, these health determinants have been consistently documented with adverse health outcomes.

c. Most Significant Causes of Morbidity and Mortality

Health statistics in Massachusetts are collected by the Massachusetts Department of Public Health (MDPH). The analysis below utilizes 2014 and 2015 (the most current available) age-adjusted hospitalization and emergency room data from MDHP from their Public Health Information Tool (PHIT) as well as data from the Center for Disease Control's (CDC) Behavioral Risk Factor Surveillance System (BRFSS), the Robert Wood Johnson County Health Rankings and Roadmap and the Tufts Foundation Healthy Aging Report. While all of these data sources provide some insight into the health data for the region, there are significant limitations to this data. Almost all of it is available at the county level, but since the Quaboag Hills regions contains small parts of three counties, and the population centers of those counties are a great distance from Ware. The data presented below, therefore, draws heavily from the Baystate Eastern Region 2016 CHNA, which is the only source that is focused specifically on this area. There is some data available for individual communities, which have used when appropriate.

The QHHC's service area lies within Baystate Health Eastern Region's service area. Every three years hospitals conduct a community health needs assessments (CHNA) as required by the 2010 Patient Protection and Affordable Care Act. Baystate Eastern Region's last CHNA was completed in 2016. The system is currently developing its 2019 CHNA but information from that document will not be available until later in 2019. However, community health leaders have confirmed that the major causes of morbidity and mortality identified for the service in the 2016 CHNA have not changed. Where possible, HCHC has updated the data from the 2016 CHNA to make the information more relevant.

Baystate Eastern Region 2016 CHNA identified high rates of chronic health conditions particularly for obesity, diabetes, cardiovascular disease, asthma and chronic obstructive pulmonary disease as significant causes of morbidity and mortality[7].

Diabetes

The Baystate Eastern Region CHNA ranked diabetes as a top health concern for residents in the service area, as determined through CHNA focus groups, and key informant interviews. According to the Centers for Disease Control (CDC), in 2013 two of the counties in the QHHC service area, Hampden and Worcester, had diabetes rates higher than the state average: 11% of Hampden County residents and 9.7% of Worcester County residents had diabetes compared with 7.7% of state residents. [8] Diabetes hospitalization rates are a measure of severe diabetes-related morbidities. Among QHHC service area communities in 2014, Ware had the highest hospitalization rate (age adjusted per 100,000) for diabetes, at 204.4, compared to the state average of 158.9, or nearly 29% higher. [9] Table 2 illustrates 2014 hospitalization rates among service area counties, the state and highlighted communities.

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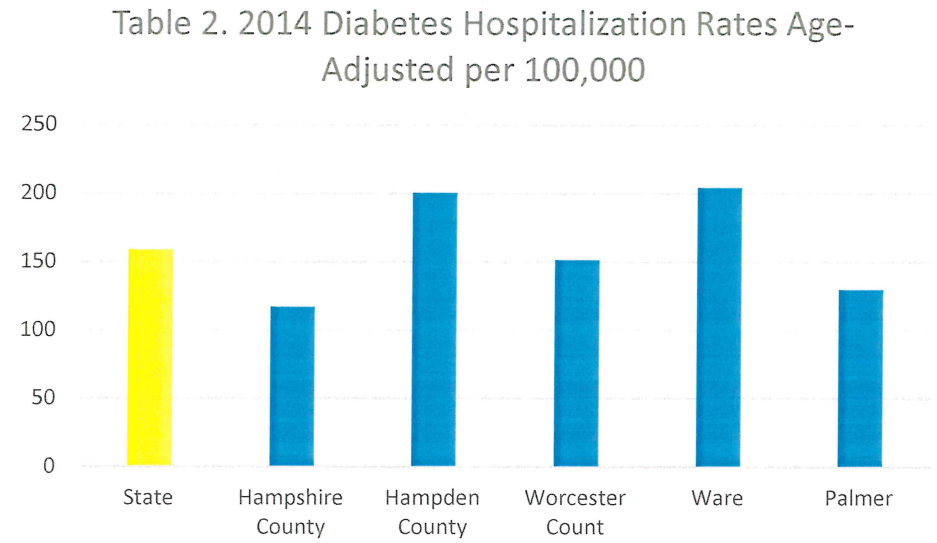
[7] Partners for a Healthier Community, Collaborative for Educational Services, Pioneer Valley Planning Commission, Baystate Eastern Region, *Community Health Needs Assessment, 2016*

[8] Centers for Disease Control, Behavioral Risk Factor Surveillance System, 2013

[9] Massachusetts DPH, PHIT, 2014



Source: MDPH, PHIT Data 2014

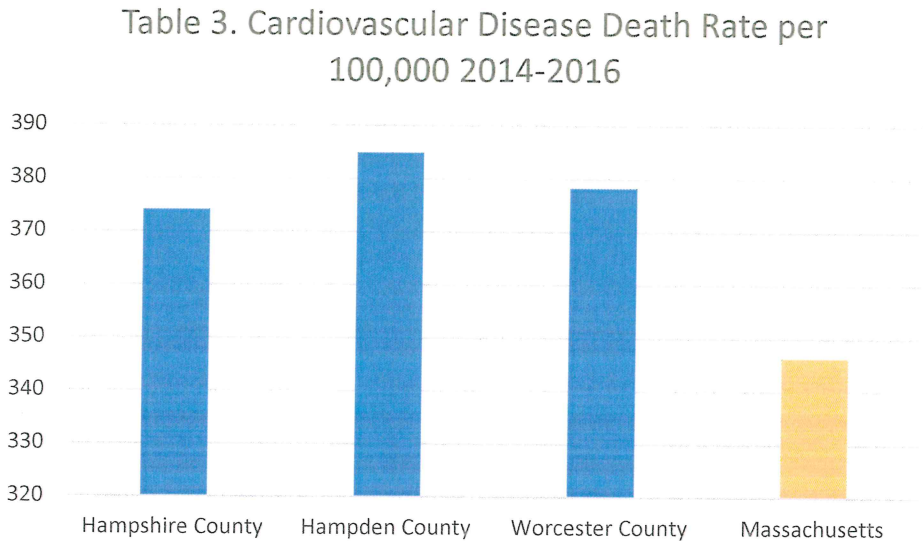
Obesity

Obesity is a major contributor to chronic illnesses such as diabetes and was identified in the CHNA as one of the three most urgent health concerns affecting service area residents. According to the County Health Rankings and Roadmap in 2019, of the three service area counties, Hampden County has the highest rate of obesity with almost 30% of adults obese followed by Worcester County with a 27% adult obesity rate. Hampden County's obesity rate is 50% higher than the state average rate of 20%.[10]

Cardiovascular Disease

The Baystate Eastern Region CHNA states that cardiovascular disease is among the top leading causes of death in all three counties, and identified it as a prioritized health need in 2016. According to the CDC, in 2016 the death rate from cardiovascular disease per 100,000 for adults aged 35+ was higher in all three service-area counties than the state (Table 3). Hampden County's death rate from cardiovascular disease at 385 per 100,000 was 11% higher than the state average of 346 per 100,000. Worcester County at 378 per 100,000 was 9% higher than the state average and Hampshire County at 374 per 100,000 was 8% higher.

[10] Robert Wood Johnson Foundation, *County Health Rankings and Roadmap, 2019*



Source: CDC, BRFSS Data

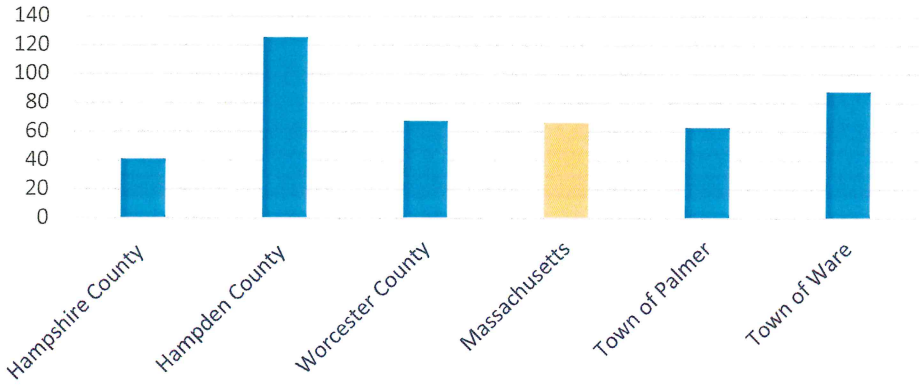
Hypertension

Hypertension increases the risk of cardiovascular disease. It is a particular concern for older adults. According to the Tufts Foundation Massachusetts Healthy Aging Data Report, in 2018 both Hampden County (81.5%) and Worcester County (77.4%) had higher rates of hypertension among residents 65 years of age and older than the state average of 76%. Within the service area towns, Palmer (81%), Ware (81%) and Warren (78%) had higher rates than the state.

Asthma

Many residents in the QHHC service area are impacted by asthma. Hampden County residents visited the ER for asthma at twice the statewide rate in 2015 with 125 visits per 10,000 per year compared with the state average of 66 visits per 10,000 per year. Worcester County also had a higher ER visit rate than the state (Table 4). Among the communities in the service area, the town of Ware had a 32% higher ED visit rate for asthma than statewide at 88 visits per 10,000 per year.

Table 4. 2015 Emergency Room Visits for Asthma
Age Adjusted per 10,000

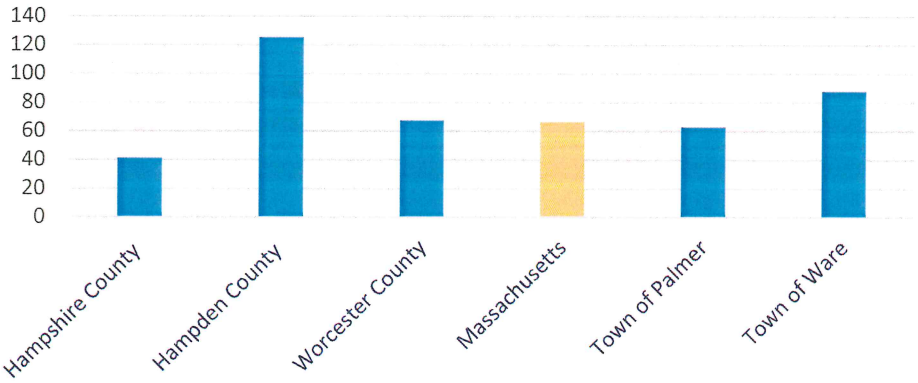


Source: MDPH, PHIT Data 2015

Chronic Obstructive Pulmonary Disease

According to the CDC, chronic obstructive pulmonary disease (COPD) was the third leading cause of death in the United States in 2011. Residents in the service area towns of Palmer and Ware are particularly impacted by the disease. In 2015 residents of the Town of Palmer visited the ER for COPD 140% (153 per 10,000) more often than the statewide average (63 per 10,000) and Ware residents 121% more often (141 per 10,000) than the state average (Table 5).

Table 5. 2015 Emergency Room Visits for COPD
Age Adjusted per 10,000



Source: MDPH, PHIT Data 2015

d. Health Disparities

A scant provider network, lack of adequate and affordable health coverage, and difficulty accessing high-quality care can lead to poor health conditions. New patients in Massachusetts, including those with insurance other than Medicaid (called MassHealth in the state), must wait

an average of 50 days for a new internal medicine appointment according to the Massachusetts Medical Society's 2013 *Physicians Workforce Study*, the most recent data available. Additionally, only 45% of internal medicine and 51% of family medicine providers are accepting new patients. The study also reports that only 66% of internal medicine and 70% of family medicine providers were accepting MassHealth (the state Medicaid insurance) in 2013. High wait times end up sending patients to emergency rooms for conditions that should be handled in a doctor's office. Gaps in the PCP workforce has increased the time practices spend recruiting physicians, leading to longer vacancy rates as well as staff retention issues. The workforce challenges are particularly pronounced for FQHCs, which struggle to compete with the salaries offered by large numbers of academic medical centers and other large practices.

In addition to difficulty accessing care, many residents remain uninsured. According to a study by the Blue Cross Blue Shield Foundation of Massachusetts and the University of Massachusetts Medical School, after initial gains in the statewide rate of insurance coverage in the two years after enactment of the 2006 Massachusetts health care reform law, the 2010 federal Affordable Care Act (ACA) has not yet translated into a significant decrease in the uninsured rate in Massachusetts. Currently over 200,000 individuals remain uninsured in the Commonwealth.[11] Key findings of the report point to the fact that individuals are uninsured for a variety of reasons, including the following:

- Inability to afford health insurance.
- Changes in circumstances that result in loss of employer-sponsored insurance (ESI), such as losing or changing jobs, or reducing work hours and therefore becoming ineligible for job-based insurance.
- Loss of eligibility for subsidized insurance.
- Missing a renewal date for subsidized insurance.
- Difficulties with the process of applying for health insurance and completing application materials.

Other gaps in health care access for our target population include:

- Low Medicaid participation rate among physicians with private practices
- Long waiting lists for specialty services
- Lack of health education
- No established, continuous relationships with primary care providers

One of the most challenging shortcomings of health care delivery systems, particularly those serving low-income populations, is the fragmentation of care that is largely due to poor referral infrastructure and follow-through. This problem is greatest in rural areas where distance exacerbates system fragmentation. To address this issue, HCHC has worked diligently over the years to develop a multi-tiered referral system built upon formal and informal referral arrangements, and supported by electronic infrastructure, between providers and partner agencies both within the service area and without. Rural patients, our providers have found, tend to rely more heavily upon their PCPs to treat their chronic conditions for which more urban patients

[11] Blue Cross Blue Shield Foundation of Massachusetts and the University of Massachusetts, February 2016, *The Remaining Uninsured in Massachusetts: Experiences of Individuals Living Without Health Insurance Coverage.*

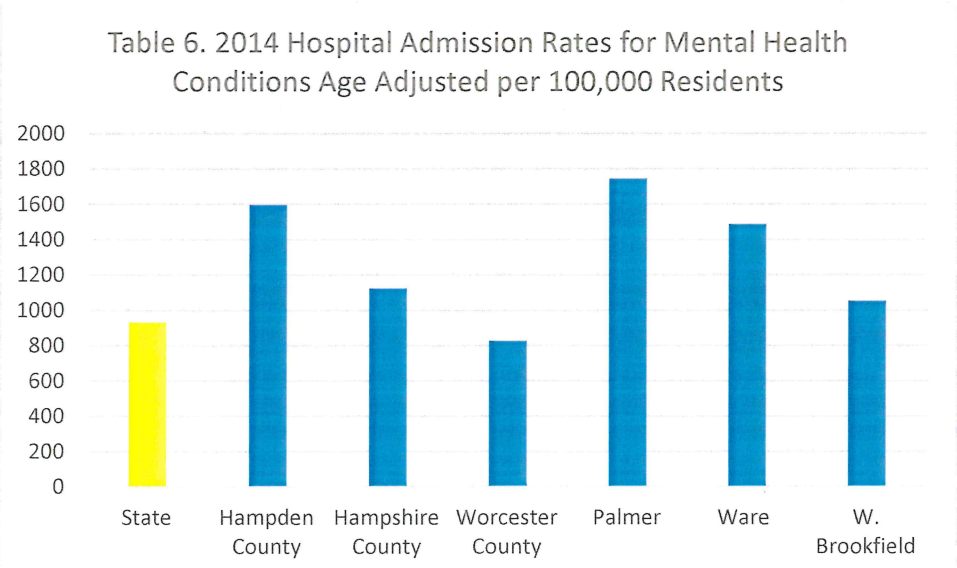
would turn to specialists, and also expect their PCPs to coordinate their care to a greater extent. HCHC's patient-centered system of care delivery is well-suited to meet this expectation.

e. Unique Health Care Needs

Across all key informant interviews and focus groups convened for the 2016 Baystate Wing CHNA, mental health conditions and substance use disorders overall and opioid use disorder specifically, were identified as top issues. There was overwhelming consensus among community members, health care providers, and administrators about the need for more treatment options, including access to long term treatment programs and increased integration between the treatment of mental health and substance use disorders, particularly in the primary care setting. Baystate Wing key informant interviewees noted the cyclical impacts of mental health, substance use, domestic violence, and the fragmentation of families as overlapping areas of significant concern for the region and service area.

Mental Health

Mental health is an important indicator of health, affecting physical health and contributing to health inequities. Within the QHHC service area counties, an estimated 13% of Hampden County residents, 12% of Hampshire County residents, and 11 % of Worcester County residents experienced poor mental health on 15 or more days a month compared to the state average of 11% in 2017[12]. Hospital admissions for mental health issues in 2014 according to MDPH were higher in both Hampden County (71%) at 1,598 per 100,000 and Hampshire County at 1,124 per 100,000 (20%) than the state average of 934 per 100,000 in 2014. The highest rates of hospitalization for mental health issues in the service area communities were in Palmer, Ware and West Brookfield. Palmer's hospitalization rate of 1,744 per 100,000 was 87% higher than the state average of 934 per 100,000. Ware's rate of 1,487 per 100,000 was 59% higher and W. Brookfield's rate of 1,053 was 13% higher than the state rate. Table 6 illustrates 2014 hospitalization rates among service area counties, the state and highlighted communities.



Source: MDPH, PHIT Data 2014

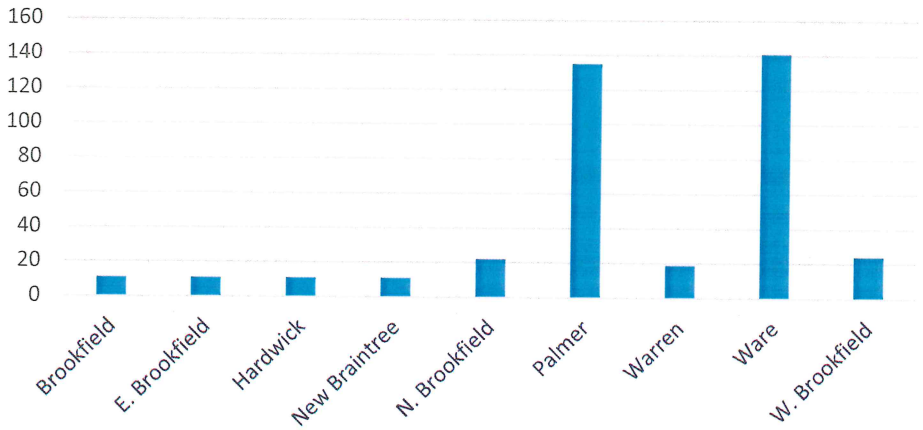
[12] Robert Wood Johnson Foundation, *County Health Rankings and Roadmap, 2019*

Substance Use

Opioid use disorder has rapidly emerged as a public health crisis in Massachusetts and across the country. Western Massachusetts is impacted as well. Key informant interviews for the 2016 CHNA frequently cited the opioid crisis as an emerging issue and a top health issue facing the community. According to the CDC, Massachusetts was among the top ten states with the highest rates of opioid-related overdose deaths. In 2016, there were 1,821 opioid-related overdose deaths in Massachusetts—a rate of 29.7 deaths per 100,000 persons—compared to the national rate of 13.3 deaths per 100,000 persons. Since 2012, deaths attributed to heroin overdose in Massachusetts have increased from 246 deaths to 630 deaths. The most dramatic increase was seen in the number of overdose deaths attributed to synthetic opioids rising dramatically from 67 deaths to 1,550 deaths from 2012 to 2016.

Across the service area, the impacts of SUD are highly concentrated in specific towns. Table 7 illustrates the number of opioid-related hospital discharges by town in 2014. For confidentiality reasons, where there are fewer than 11 hospital discharges, MDPH does not disclose the actual number. In 2014 this was true in Brookfield, E. Brookfield, Hardwick and New Braintree.

Table 7. Total Annual Opioid-Related Hospital Discharges in 2014



Source: MDPH Opioid Mortality Data 2014

Findings from key informant interviews and mental and substance use focus groups conducted for the 2016 CHNA identified the following needs:

- increased institutional support to promote harm reduction approaches, such as Narcan, to reduce morbidity and mortality that occur as a result of opioid overdose;
- more access to long-term medication-assisted treatment (MAT) programming;
- continued focus on therapeutic, not just pharmaceutical, treatment of substance use disorders;

B. Response

General Information Worksheet

As outlined in Form 1A: General Information Worksheet, in the first year of the Quaboag Hills Community Health Center's operations (calendar year 2020), we project that our providers will serve 934 new unduplicated patients with 2,000 visits. In the first year of operation the QHHC will have 1.42 providers. This estimate is based upon the following: during start-up, a full time medical provider typically has 1,408 visits a year. 1, 402 time 1.42 FTE equals 2,000 visits. 2,000 visits divided by an average of 2.14 visits per patient per year equals 934 medical patients. These numbers assume in the first year providers will be seeing a patient population that has not had a medical home for a while and therefore the productivity numbers are lower than the standard for HCHC's other providers. HCHC feels that the number of low income individuals currently un-served by a community health center (11,558 for the entire service area, 2,720 in Ware alone according to the UDS Mapper data) is sufficiently large that there will be no problem filling the available capacity with the proposed staffing plan for the QHHC.

1. Access to Services

a. Method of Provision of Services

Hilltown Community Health Centers, Inc. (HCHC) is a freestanding and unaffiliated organization, serving Hampshire and Hampden County Hilltowns since 1950 with a carefully designed model of rural health care. This model will be replicated to serve the communities in the QHHC service area.

There are two major factors in HCHC's current service area service area, also prevalent in the QHHC region that shape HCHC's approach to healthcare. First, there is a paucity of affordable, accessible services of all kinds in the service area. Those that do exist may be difficult for many residents to access. Without many of these services, it is difficult, if not impossible, to keep people healthy and the collective well-being of local communities suffer. Thus it is incumbent on HCHC to organize delivery of the whole range of health care and related services at its health center sites in a way that provides geographical accessibility. This involves offering diverse services directly as well as forming close working relationships with other providers in the service area to serve patients' individuals, family, and community needs.

The second factor, which is closely related, is the isolation and low health literacy of the low-income residents that HCHC targets. All too often providers see patients with undiagnosed problems, who have not sought treatment for chronic conditions for many years, and who are not well-educated about the role healthy habits and lifestyle play in their health and wellbeing. To address these barriers to good health, HCHC has chosen to develop and refine a model of integration that pervades its health care delivery and operations. Anyone can enter the HCHC integrated care system through any doorway and they will be connected to the services they need internal to HCHC, or through its many partners.

HCHC's model of care delivers a range of coordinated and comprehensive services designed to keep people healthy, from health education and social services, to promotion and screening for disease, to assessment, diagnosis, treatment and rehabilitation. The health care HCHC delivers:

- is easy to access and understand;
- is available when needed;
- helps people to stay healthy;

- provides appropriate care in the appropriate setting;
- responds to the needs of individuals and families when problems or acute needs are experienced;
- enables people to take control of and responsibility for their health;
- promotes effective communication with patients and encourages the role of the patient as a partner in health care;
- provides patient advocacy and coordination of health care services;
- contributes to reduction in health disparities; and
- improves the health of the local communities and all sectors of the local population.

HCHC's service delivery model is shaped by the expectations of patient clientele who, in turn, are a reflection of the composition, demographics and concerns of the community. To the extent that patient populations experience a level of disorganization or unpredictability in their lives, HCHC needs to offer continuity of care. The target population is particularly vulnerable to the adverse effects of fragmented, uncoordinated and discontinuous care. Thus HCHC structures service delivery to be comprehensive, integrated and continuous – the hallmarks of a medical home. HCHC provides the patient with a broad spectrum of care, both preventive and curative, over a period of time and to function as the central point for coordinating care around the patient's needs and preferences.

The HCHC's medical home team members – providers and support staff – coordinates and tracks and encompasses specialist care, other health care services, and non-clinical services as needed and desired by the patient, family members, and other caregivers. The care team (nurse, physician or nurse practitioner, medical assistant, receptionist, and Community Health Worker as appropriate) provides information about treatment options and plans, follow-up care, preventive care, counseling options and other services. Patient feedback is actively solicited and integrated into care planning. Patients can easily access a summary of their medical records on HCHC patient portal and can request prescription refills or appointments on-line.

Below is a summary of all of HCHC's current services. While initially only medical services will be provided at the QHHC, HCHC will immediately implement a system upon opening to ensure dental services at its Amherst site (the closest FQHC site to Ware) are available for those in need, including subsidizing public transportation to the site if necessary. HCHC will also ensure immediate access to behavioral health services through its Memorandum of Understanding (MOU) with the Behavioral Health Network (BHN). It is HCHC's intent to add dental services in Ware as soon as is feasible, and any other current services as needed and appropriate.

Services Provided:

- Medical Care: All HCHC locations provide primary preventative and acute care for people of all ages, routine physical exams, immunizations, behavioral health and nutritional counseling, gynecological exams, laboratory, podiatry services, etc. Providers have specialty focuses that include HIV, diabetes, and other chronic disease management, women's health, pediatrics, public health, and more.
- Oral/Dental Health: HCHC offers a full range of oral/dental health services in all of its clinical sites in order to best meet the needs of its patients. Specific services include: pediatric and adult dentistry, dental exams and cleanings, dental x-rays, fluoride treatments, fillings,

extractions, crowns, bridges, mouth guards, periodontal services, partial and full dentures, emergency dental care, and oral health education. HCHC's licensed dentists, licensed hygienists, and certified dental assistants keep up to date on the newest procedures and are fully trained to handle all oral hygiene issues with the utmost professionalism and care.

- Behavioral Health: HCHC's Behavioral Health Department is comprised of licensed psychotherapists who provide therapy and substance abuse services for children, adolescents, adults, and elders through individual, and family therapy sessions. The focus of the department is to help patients feel better quickly. Providers help patients identify and build upon their strengths and the support of their network of family and friends. Clinicians ensure access to any necessary psychiatric medication and support. At the QHHC site, behavioral health services will be provided through a formal written referral agreement with Behavioral Health Network. They will provide services at their outpatient clinic located next door to the QHHC on Main Street. Services available will include: crisis intervention services, outpatient mental health and substance use disorder treatment, care coordination and case management for specialty population including children and families, adults with MH/SUD, day care services for infant/toddlers and victims of domestic violence.

- Eye Care/Optometry: HCHC offers the full spectrum of optometry services and eye care. Patients can receive routine and acute eye care on site at the Huntington Health Center optical suite and, starting in Fall 2019, at the school-based health center. The office is equipped with state-of-the-art technology which allows HCHC to perform many procedures in-house and reduce the burden of additional referrals. The optometrists co-manage diabetes diagnoses and treatment, glaucoma treatment, and cataract and Lasik procedures with PCPs and outside specialists. Services include complete eye exams for all ages, diabetic eye exams, emergency eye care, and contact lens fittings. The Huntington Health Center also has a full service optical shop where patients can find a wide variety of affordable frames.
- School-Based Health Center (SBHC): HCHC operates a full-service health center at Gateway Regional High School in Huntington, which provides medical dental, and behavioral health services to the students of the Gateway Regional School District, grades pre-K through 12. In 2019, over 70% of the students in the entire school district are enrolled as patients at the SBHC. The only rural SBHC in Massachusetts, this clinic meets the needs of parents who, due to the lack of work opportunities within the service area and therefore the long commutes, are heavily impacted by the need to drive children to appointments. In operation for over 15 years, the SBHC offers immunizations, physical exams, emergency care, first aid, prescriptions, mental health counseling, nutrition counseling, treatment of illnesses, and mono, strep, STD, pregnancy and urine testing when appropriate. All care is coordinated with the school nurse, as appropriate.
- Portable Dental Outreach Program: HCHC operates a portable dental program that provides a full array of oral health services to children in local elementary schools bi-annually. Staffed by a dentist and a hygienist, the program provides students with dental exams, X-rays, dental cleanings, amalgam and composite fillings, fluoride varnishes, sealants, and emergency dental care.
- Health Outreach Program for Elders (HOPE): HOPE provides preventative and health maintenance care to seniors in their homes for free. HOPE provides elders in the Hilltowns in-home medical care, including: vital sign monitoring, blood draws, flu shots and

immunizations, medication management, assistance completing health care proxy forms, help arranging appointments with providers, and referrals for chore assistance. HOPE serves elders who have difficulty getting out of their home for medical services and are often very isolated. HOPE visits provide elders with the strong support that allows them to access other needed community and health programs to remain safely at home. HOPE nurses can also assist with helping to arrange appointments with physicians and specialists, including occasional home visits by PCPs.

- Nutrition: HCHC employs a nutritionist to provide dietary counseling for patients at its Huntington and Amherst health centers and the Gateway Regional School Based Health Center.
- Pharmacy: The health center participates in a 340B contract arrangement with five Walgreen Pharmacies in the surrounding communities, where uninsured or underinsured patients of the health center may obtain discounted medications.
- Laboratory Services: The Worthington Health Center has rented space to Baystate Reference Lab to offer full lab services onsite for patients and at the Huntington, and Musante Health Centers, for the public. HCHC will contract with Baystate Laboratories or another provider to offer Lab services at the QHHC site.

In addition to these services, HCHC rents space to a local health care organization in order to provide patients with access to physical therapy services.

b. Documentation of Services Provided through Contractual Agreements

As stipulated in its attached Form 5A, HCHC is responsible for paying for the following services on behalf of its patients: coverage for emergencies during and after hours, pharmaceutical services and translation services. In addition, HCHC has a contracted relationship with a nurse who does home visiting for elders, with a particular focus on podiatric management. These services support our providers' care for patients, and with the exception of the nurse, do not need to be documented in the patient record. If a patient calls after hours, the provider on call will document in the EHR, but the call service does not have access to the records. If a patient requires translation services, the need is noted by the care team, but the service does not have access to the services. And finally, patients may access pharmaceuticals through our contracted 340B program, but the care team and community health workers are the staff who would discuss with the patient their access of this service – the pharmacy is not involved and does not have access to the record.

c. Management of Services provided Through Formal Referral Arrangements

HCHC has formal written referral agreements with Berkshire Medical Center, Baystate Health System, and Tapestry Health, through which our patients can access those required and additional services that HCHC itself does not provide. These agreement lay out specific requirements for the management of patient care. The agreements outline that both parties will:

- Subject to the limitations of federal and state law and patient choice, refer patients to each other for services as appropriate.
- Provide each other with relevant patient information through either fax or other electronic means, including portions of the patient's medical record, as necessary to facilitate the referral with the patient's permission and as permissible under the Health Insurance Portability and Accountability Act (HIPAA).

- Follow up with the other party's staff as appropriate to effectively coordinate patient care and ensure that patients received desired services.
- Comply with the other party's requests for documentation of patient visits either by electronic copy, fax, or letter.
- Comply with requests for information regarding status of referrals.
- Maintain confidentiality and security of patient health information, both electronic and physical, to the extent required by law including, but not limited to HIPAA and its regulations. The parties agree that they will disclose and use any patient health information to which they have access by virtue of the MOU only for purposes of fulfilling their obligations under this agreement or as required by law.

All formal referrals are documented in the patient record by the medical assistants (MAs) at the time of the referral. Follow up on the referral is also tracked by the MAs in the electronic medical record as described in HCHC's Tracking Patient Referral policy. Referrals are reconciled by MAs every two weeks or during their pre-visit planning process, with the record/results of the referral visit scanned into the patient record and the Provider notified through the EHR.

d. How Enabling Services Will Increase Access to Care

HCHC has implemented the PRAPARE tool as part of its effort to ensure that patients' social determinants of health are being addressed either through HCHC programs or by referrals to community partners. Administered by CHWs during patients' annual comprehensive exam, the PRAPARE tool identifies issues beyond physical and mental health that can have a profound impact on an individual's health, including income, food security, etc. By co-locating the QHHC with the local CAA, Community Action Pioneer Valley, patients at the new site will be able to access energy assistance, youth employment, healthy families, home visiting, and community resources programs at the same location. Strong connections to Quaboag Hills Community Coalition members will enable referrals for housing, SUD recovery programs, domestic violence victim advocacy, and much more. In addition, the following programs currently offered by HCHC will be offered at the QHHC:

Outreach: Health Access Program: Through the efforts of HCHC's health insurance Navigators, uninsured or underinsured patients are provided with assistance in determining their eligibility for enrollment in the most appropriate insurance program, including MassHealth/Medicaid, Commonwealth Connector plans (Massachusetts's health insurance exchange), Medicare, and/or the state Health Safety Net program. Navigators help with the often time-consuming and confusing process of filling out appropriate paperwork to enroll in the program. This service is currently provided both on site at the Hilltown Community Center, John P. Musante Health Center in Amherst, and various community outreach sites, and will be available at the QHHC site. Navigators also help patients identify and sign up with a PCP that best meets their needs, if they do not have a medical home.

Case Management Services: HCHC provides, on an outreach basis, assistance to patients needed help obtaining food stamps, fuel assistance, enrolling in GED programs, finding housing and jobs. These services are provided by HCHC's Community Health Workers (CHWs). The CHWs assist patients with following treatment plan recommendations made by their PCP, and work individually with patients to develop and implement disease self-management plans to address chronic medical conditions. CHWs also assist patients in making and then keeping

appointments with a primary care physician; they are contacted by the front desk if a new patient misses their appointment and then works with the patient to address the barriers to keeping with their appointment. At times, this means CHWs facilitate transportation for the patient to attend a first appointment. CHWs conduct health education sessions in the community, including Diabetes Prevention Program and the Stanford Chronic Disease Self-Management Program groups. Finally, CHWs work with MAs and providers to identify patients that require assistance in accessing screenings such as mammograms and colonoscopies, conducting outreach and providing health education, as well as transportation and other supports. A CHW will be on staff at the QHHC site.

Health Literacy: HCHC's Navigators and CHWs work with patients to improve their health literacy in order to foster health promotion, health protection, disease prevention and screening. A greater level of knowledge about their own conditions and about healthy practices in general allows our target population greater access to care and navigation of health systems and supports the maintenance of their health. People develop confidence that they can cope with high-risk situations without relapsing to their previous unhealthy high-risk behavior.

Health literacy strategies are based on a developmental approach, addressing all stages of the life cycle (appropriate literature addressing the typical health concerns of elders, for example) Developmental perspectives help health educators guide the specific interventions used. HCHC patients are empowered by being able to read pamphlets, successfully make appointments and having access to health information and the capacity to use it.

Domestic Violence Victim Advocacy: HCHC's Hilltown Safety at Home program provides a domestic violence victim advocate for those who have experienced domestic and/or sexual abuse. The advocate works confidentially with people on the phone or in person. If it's safe for an advocate to come to a client's home, home visits are also available. The advocate can also help friends and family members who are trying to support a loved one in an abusive situation. HCHC has a MOU with the Ware River Domestic Violence Task Force to coordinate similar services in the Quaboag Hills region.

e. Ensuring Access to Required Services to Entire Underserved Population

Initially, the QHHC will provide onsite all of the required services currently in Column I of Form 5A, with the exception of preventive dental care. This service will be available at HCHC's Musante Health Center, which is the closest FQHC site to the Town of Ware. HCHC will provide patients in need of dental care with access to transportation to Amherst as needed. As is the case currently, all obstetrical care will be provider through a formal written referral agreement with Baystate Health. As soon as feasible, HCHC will develop an implementation plan to bring preventive dental services into Ware as well, as we have done at all of our other sites.

All services will be available to patients of all ages, and our health insurance Navigators will ensure that all patients have access to care through their enrollment in appropriate health insurance coverage or, as needed, enrollment in HCHC's sliding fee discount program.

2. Plans to Hire and Begin Services in 120 Days

As discussed below, the QHHC site will provide medical, lab, Navigator, and CHW services. Upon receipt of a Notice of Award, HCHC will immediately implement its recruitment plan,

which includes advertising on locally, regionally and nationally as well as use of a recruitment firm if necessary. Additionally, HCHC has recently adjusted its compensation plan to attract a larger pool of candidates and has already included the potential site in its current recruitment efforts.

See Attachment 12: Operational Plan, which details reasonable and time-framed activities that demonstrate that, within 120 days of award, all proposed sites noted on HCHC's Form 5B: Service Sites will have the necessary staff and providers in place to begin operating and delivering services as described on HCHC's Forms 5A: Services Provided and 5C: Other Activities/Locations. In addition, the plan demonstrates that the health center will be compliant with Health Center Program requirements within 120 days of award.

3. Proposed Delivery Site

a. Site Address and Location

The new Quaboag Hills Health Center (QHHC) will be located at 82 Main Street in downtown Ware, Massachusetts. This location is in the heart of Ware, the most centrally located community in the proposed service area. HCHC will be leasing this site: see documentation of intent to lease documentation in Landlord Consent Letter in Attachment 14.

b. Site Location Accessibility

The location, which is centrally located to the communities in the service area, will make health care geographically accessible as well as affordable for target population of the Quaboag Hills region who would otherwise have to travel long distances to find accessible primary care. The QHHC's service area may be small in numbers, but the site's proximity to underserved populations will make it a vital addition to the regional system of health care in Central-Western Massachusetts. Currently, patients have to drive at least half an hour to get to accessible primary care at an FQHC. The Pioneer Valley Transit Authority (PVTA) has a bus line that travels between the towns of Ware and Palmer, but it has limited stops and schedule and follows the main routes between the two towns. For people who are off the main routes and do not have cars, the Quaboag Connector is a non-profit on demand service that serves seven of the nine towns in the service area. It does not prioritize visits to medical providers, but HCHC would provide patients with vouchers to facilitate their using this new service.

HCHC will also reduce barriers related to socioeconomic groupings through close collaborations with other community providers, including the co-located Community Action Agency. In conducting our needs assessment for this proposal, HCHC learned that there is apprehension on the part of many low-income and other marginalized populations in the region about accessing clinical care. In particular, community partners mentioned hesitation to access services at the Mary Lane Outpatient Center – people are concerned about being judged for their lack of health literacy, about losing control of their care, and about the potential financial burden that accessing such care will create. Having a site downtown, next to the local behavioral health care clinic, and across the street from the job training site run by the local community college and the Community Development Corporation, will enable HCHC to establish trust with the target population. In addition, having Community Health Workers that will go out into the community

to introduce the QHHC through non-clinical services like health insurance navigation and disease self-management supports will create a rapport than will break down barriers to their accessing care at our site.

c. Distance and Duration of Patient Travel

Within the Quaboag Hills communities to be served by the QHHC, patients will have 10 miles or less to travel to the Ware site from any of the surrounding eight towns. Travel by car will take 14 minutes or less. Additionally, its downtown location is within walking distance of two low income housing developments known as Hillside and Highland Village Apartments that collectively have 191 units of rental housing. Until the QHHC provides preventive dental care, patients would be served at HCHC's Amherst location, which is a 30 minute drive. As mentioned previously, HCHC will work with patients to ensure that they have access to dental care, through bus vouchers or gas cards, as appropriate.

d. Facilitation of Scheduling Appointments and Accessing Services

HCHC's other health center sites are open five days a week, with evening hours available three nights a week. Saturday morning hours are also available for medical and behavioral health services at alternating health centers. All patients have access to 24-hour coverage for all emergencies. The QHHC will develop a Board-approved schedule that is responsive to the needs of patients, including those whose work schedule requires them to be seen before or after work. HCHC will solicit input from representatives of the target population in the Quaboag Hills region to ensure that the hours are responsive to patient needs. Specifically, HCHC will follow the procedure established in the *Hours of Operation and After Hours Coverage – Establishment and Patient Notification* policy:

1. Every year, or as often as deemed necessary, HCHC Senior Management, with the support of the Practice Manager, will determine if:

- the hours of operation ensure accessibility and meet the needs of the population to be served, and are appropriate and responsive to the community's needs.
- the after-hours coverage provides professional coverage for medical emergencies during hours when the center is closed.

They will take into consideration demand for services, accessibility, and organizational capacity. In order to do so, HCHC will look at a variety of factors, including but not limited to needs assessments, patient input, EHR data, etc., while ensuring that the proposal meets all federal requirements.

2. Senior Management will make a recommendation to the Board of Directors for any changes in the hours of operation and/or after hours coverage, and the Board will vote whether to approve the proposed changes.

At all health center sites urgent care requests are scheduled preferably on the same day as the initial call, and no later than 24 hours after a phone call.

In addition to having hours of operation that facilitate the scheduling of appointments and access to services, the QHHC will contain six exam rooms, double the number necessary to serve the initial number of expected patients, to allow for the smooth expansion of services as demand grows. The co-location of enabling services such as community health workers and insurance navigators within the QHHC is intended to assist patients overcome any potential barriers to care that they may encounter due to lack of health insurance or life circumstances that make it difficult for them to make or keep appointments. Finally, as mentioned previously, the QHHC's fixed-site location in downtown Ware, within walking distance of 191 units of low-income housing, on a local bus route and centrally located within the service area, was carefully chosen to facilitate access by service area patients to the highest degree possible.

4. Capacity for Responding to Patient Emergencies

a. Staff Certification in Basic Lifesaving Skills

At each service site, all clinical staff are certified in basic life support. This includes medical assistants, nurses, doctors, nurse practitioners, dental assistants, hygienists, dentists, mental health clinicians, optometrists, and the nutritionist. CPR is verified by presenting the Human Resources Director with a valid CPR card, and is monitored as part of the credentialing process.

b. After Hours Coverage

HCHC provides 24-hour coverage. After hours, health center phone lines are staffed by an answering service with access to telephonic interpreters who contacts the provider or dentist on-call to return patient phone calls as needed. Providers have full access to patient records through secure EHR portals, and document all interactions in the patient record. A Provider On Call policy lays out the process for ensuring that an MD or NP (with MD back-up) and a Dentist is available at all times that the clinic is closed. These providers are able to refer patients to any hospital ED or urgent care clinic, depending on the preference/location of the patient. In the case of referrals to a hospital ED, the provider will call ahead to inform the ED of the patient's intention to access care, and will document the referral in the patient's record. The nursing staff will, when the clinic opens again, follow up with the ED if treatment plans, etc, have not already been sent to HCHC.

c. Informing Patients of After Hours Coverage

HCHC has an *Hours of Operation and After Hours Coverage – Establishment and Patient Notification* policy that outlines the procedure for ensuring that patients are informed of the after-hours coverage. The relevant section of the policy's procedure is as follows:

> Patients will be notified of HCHC's hours of operation and after-hours coverage in the following manner:
>
> * A flyer in the New Patient Welcome Packet
> * Postings in all waiting rooms and bulletin boards
> * HCHC web site
> *HCHC main phone number recording

For after-hours issues or emergencies in any department, patients will be instructed to call the health center and the answering service will assist all patients with contacting the provider on-call.

All of these means of notification are sent/posted/available in English and Spanish – the website additionally allows for translation into multiple languages.

5. Continuity of Care for Hospitalized Patients

a. Arrangements between Health Center and Non-Health Center Providers

HCHC is a member of the Cooley Dickinson Physician Hospital Organization (PHO) and as members our providers have current admitting privileges at Cooley Dickinson Hospital and/or Baystate Health System. Since all local hospitals have transitioned to a hospitalist system of inpatient care, HCHC patients can be seen at any local hospital, and HCHC has access most hospitals' portals to access patient records. For those that do not provide such access, HCHC requests records as needed.

b. Procedures for Following Hospitalized Patients

A seamless continuum of care is accomplished under the direction of an RN Clinical Care Manager who has established collaborative links with area hospitals to track emergency room admissions and hospital discharges of HCHC patients. Linking, tracking and following up with patients and external providers, especially with hospital personnel involved with discharge planning, is one of the core components of an integrated, coordinated plan of care. Information sharing among health professionals and other support personnel is facilitated by the EHR and/or through hospital portals, through which they can track referrals, lab and diagnostic test results and written care plans for each patient with defined self-management goals. Care coordination is formalized to follow up on patients with Emergency Department visits at any our referral hospitals, and admissions to other facilities such as rehabilitation, nursing home or psychiatric facility. HCHC uses eClinicalWorks as its electronic health record; the system supports patient tracking and service utilization. HCHC's Medicaid ACO conducts care management post-discharge for Medicaid patients and the best practices from this model will be replicated for all QHHC patients.

c. Health Center Follow-Up for Patients After a Hospital Visit

HCHC has a *Coordinating Care Transitions Policy* that formally documents process for coordinating the transition of care for patients recently discharged from the hospital, emergency room or other clinical care facility. It states:

1. Providers, RN (care manager), nursing, medical assistants, reception staff will identify patients with a hospital admission and or Emergency Department (ED) visit.
2. RN (care manager), nursing, medical assistants/reception will share clinical information securely with admitting hospital or ED and will continue two-way communication during the patient's hospitalization.
3. RN (care manager), nursing, medical assistants/reception will request patient discharge summaries before follow-up appointment date.

4. A member of the patient's clinical care team will contact and arrange follow-up appointments within 48 hours of discharge from ED or hospital.
5. HCHC will obtain proper consent for release of information and securely exchange information with community partners.

6. Sliding Fee Discount Program

HCHC maintains a policy, the Sliding Fee Discount Program (SFDP) policy, approved by the Board of Directors and the Commonwealth of Massachusetts that documents the process for providing free or discounted care to those who have no means or limited means to pay for their medical, optometry, behavioral health and/or dental services. This policy was last revised in April 2019. The SFDP policy covers the following:

a. Definition of Income and Family Size

Item 7 of the HCHC SFDP policy provides the following definitions of, and requirements for verifying income and family size:

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.

b. Procedures for Assessing Eligibility Based Only on Income and Family Size

Item 7c of the HCHC SFDP policy defines the procedures for assessing eligibility for all patients based only on income and family size as follows:

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.

c. Applicability to all Required and Additional Services

Item 3 under the SFDP policy describes the applicability of the SFDP to all required and additional services as follow:

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.*

d. Procedures for Nominal Charges

Item 9 of the SFDP policy describes the nominal fee policy:

Nominal Fee: *Patients receiving a full discount **will not** be assessed a nominal charge per visit*

e. Determination of Number and Income Ranges of Sliding Fee Discount Pay Classes

Item 9 of the SFDP policy describes the nominal fee policy; see Attachment 8: Sliding Discount Fee Discount Schedule. The chart below outlines HCHC's 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% Slide 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%

f. Informing Patients of Sliding Fee Discounts

Item 1 of the SFDP policy describes the manner of notifying patients of the SFDP as follows:

> ***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.*

All forms of notification are available/posted in Spanish and English, and the website has a built-in translator for access in other languages. In addition, HCHC has receptionists and an insurance navigator who are bi-lingual in Spanish and English, who are trained on the application of HCHC's sliding fee discount policies and procedures.

g. Evaluation of the Sliding Fee Discount Program

Item 14 under the SFDP policy describes the procedure for evaluating the SFDP as follows:

> *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 car. 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.*

C. COLLABORATION

1. Collaboration with Other Primary Care Providers in the Service Area

Baystate Health System operates the local hospital and outpatient care center for the Quaboag Hills region, which is called Baystate Eastern Region. HCHC has collaborated with Baystate in many contexts, including the development of the 2016 and 2019 Community Health Needs Assessments and two of its local Community Benefits Advisory Councils, but was unable to secure a letter of support for this application despite repeated requests. While we did not receive any formal response, our understanding is that Baystate is providing another FQHC, which is part of the Baystate ACO and which is submitting a NAP proposal for the Quaboag Hills region, with space for their proposed site in the outpatient center in Ware. In person, they have expressed support for an FQHC developing a site in the region, and we are confident that should HCHC be successful in its NAP application, we would have a collegial and collaborative relationship with Baystate Eastern Region. HCHC has agreement on language for a formal written referral agreement with Baystate Health Systems that is fully compliant with HRSA requirements as outlined in the HRSA compliance manual. This agreement will support current and future HCHC services. It is expected that the agreement will be fully executed by the end of April, 2019.

Collaborations and reciprocal service agreements between the health center and a variety of other community agencies and health care organizations provide patients with ready access to both specialized services and community support. It strengthens continuity of care for patients. HCHC's range of services (medical, dental, behavioral health) and its ability to refer patients to supportive services run either by HCHC or by collaborating agencies can assist in the reduction of non-urgent use of ERs.

2. Collaborative Documentation with Other Service Area Providers/Programs

HCHC embraces collaboration as the foundation to the successful development and implementation of services and actively seeks community involvement in its programs. Over the years, HCHC has established close working relationships with its fellow FQHCs, town selectboards and public health departments; local public schools; numerous community-based organizations; and elected officials in the service area.

HCHC collaborates extensively with other existing Section 330 grantees and critical access hospitals. The FQHCs work closely to ensure that we are appropriately meeting the needs of the vulnerable populations of western Massachusetts. This includes supporting each other's grant applications, sharing best practices, developing collaborative projects when appropriate, and referring patients for care when necessary.

In addition to these activities, in 2017 HCHC joined a Medicaid Accountable Care Organization (ACO) through the state Office of Medicaid's 1115 Waiver demonstration project. The ACO, called Community Care Cooperative (C3), is comprised solely of 17 Massachusetts FQHCs, and is possibly the only ACO in the nation that does not include a hospital or a health plan. The state's acceptance of C3's proposal was recognition of the high-quality and cost-effective care that FQHCs provide. Three of HCHC's nearest FQHC partners to the proposed QHHC site are also part of C3: Community Health Center of Franklin County, Family Health Center of Worcester and Holyoke Health Center. Being part of this ACO made up of other FQHCs allows the members to share a common mission and values and are able to cooperatively

share best practices. This includes the ability to serve each other's patients without referrals, as all the members strive to contain the total cost of care together.

As mentioned above, Caring Health Center of Springfield, MA, is also submitting an application for NAP funding. We have spoken with them about our competition for this funding, and have both presented to the same community events, and have jointly asserted to the community that we fully support each other's efforts to bring a health center to the Quaboag Hills region. We have not, however, requested letters of support from each other.

In developing its proposal to open the QHHC, HCHC spoke to: town officials and health care advocates in the region including the Town of Ware Board of Selectmen, the Director of Public Health for the Quabbin Health District (which includes Ware), the superintendent of schools in Ware, and members of the Quaboag Hills Community Coalition, a group of agencies and organizations working together to increase access to services for the residents of the region.

HCHC has a Memorandum of Agreement with: Community Action Pioneer Valley to provide supportive social services to be co-located on-site at the QHHC; Behavioral Health Network, the local behavioral health (BH) provider system for BH services; and the Ware Valley Domestic Violence Task Force to provide victim support and advocacy services for persons experiencing domestic violence. See Attachment 9A for copies of these agreements.

HCHC has received letters of support from the following agencies documenting willingness to collaborate:

Other Adjacent FQHC's

- Community Health Center of Franklin County
- Holyoke Community Health Center
- Family Health Center of Worcester

State-wide Primary Care Association

- Massachusetts League of Community Health Centers

Town Agencies

- Ware Board of Selectmen
- Ware Regional School District
- Quabbin Health District

Community Groups

- Hampshire HOPE – local opioid education and recovery task force
- Quaboag Hills Community Coalition
- Ware River Valley Domestic Violence Task Force
- Quaboag Valley Community Development Corporation
- Meredith Management Company – local low-income housing management company

D. EVALUATIVE MEASURES

1. Quality Improvement and Quality Assurance (QI/QA) Program Specifics

The scope of HCHC's quality improvement program is organization-wide and includes activities that monitor and evaluate all phases of the health care delivery system through objective, criteria-based audits, outcome audits, tracking tools, and reporting systems. HCHC's quality improvement program is detailed in its Quality Improvement Program Policy, revised in September 2018 and overseen and implemented by the HCHC Quality Improvement/Risk Management (QI/RM) Committee. The goals of HCHC's QI program, as specified in the policy, are:

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

Quality improvement reviews, surveys and other tools are used on a regular basis to assess and improve the quality of health care services and service delivery. Feedback about patient experience is actively and regularly solicited.

Assessments of the appropriateness of service utilization, quality of services delivered, and/or the health status outcomes of health center patients are done on a regular basis. The QI/RM Committee is made up of two or more Board members (one of whom is the chair), all Department Heads (Medical, Dental, Behavioral Health, Optometry, and Community), the Practice Manager, the Director of Clinical Operations, the Chief Clinical and Community Services Officer, and the CEO. The Committee reviews all results, and the Chair then reports at least six times a year to the full Board. The clinical departments conduct monthly meetings to conduct peer review monitoring, and discuss quality dashboards such as HEDIS, P4P, UDS, and other quality indicators required by grants. Reports are forwarded to the QI Committee. The non-clinical departments regularly report on their departmental dashboards and quality improvement activities as well.

HCHC uses the PDSA (Plan, Do, Study, Act) method of process improvement deploying process improvement teams as well as utilizing rapid cycle PDSAs. With the implementation of our EMR (eClinicalWorks) and in collaboration with other CHCs using the same product, updated guidelines and standards of care are incorporated into various embedded "decision support modules" that will prompt providers who may be deviating from practice guidelines. There is the further opportunity to embed reminders regarding specialty referral guidelines (medical, pediatric, women's health and surgical specialties), so as to minimize the misuse of our limited specialty

referral networks and assure consistency with precertification guidelines of our various managed care insurance plans.

a. Adherence to Current Clinical Guidelines and Standards of Care

Clinical standards of care are developed by the Medical Director, Dental Director and Behavioral Health Director, reviewed by the CEO and then approved by the Board of Directors. HCHC bases written clinical policies and protocols on and maintains compliance with clinical standards of care as established by American Academy of Pediatrics, American Diabetes Association the JCAHO, AMA, ADA, American Board of Family Practice and internal BOD approved policies. HCHC maintains clinical excellence through the monitoring of:

- Provider staff performance (through continuing medical education activities, ER utilization, and referral audits)
- Support staff performance (through electronic chart audits, patient satisfaction responses)
- Medical Record Quality (through electronic chart audits)
- Patient health status (through childhood immunization data, abnormal pap results, mammography results, asthma inpatient admissions, etc)
- Patient satisfaction (through patient satisfaction surveys)
- Patient compliance (through ER utilization, patient no-show statistics, prenatal no-show statistics)
- Access to care (through patient satisfaction survey , which can be completed online through the patient portal)
- Appropriateness of care (through Medicaid and other insurer audits)
- Cost of service (through financial reports and analysis)

b. Identification and Analysis of Patient Safety, including Adverse Events.

HCHC's Incident Reporting Policy lays out the internal and external reporting process for all incidents including patient complaints, work related injuries, patient injuries and clinical errors. Specifically, the policy states:

- Each provider, employee, or volunteer shall be responsible to report all adverse events, incidents, and near misses at the time they are discovered to his or her immediate supervisor and/or the risk manager. They must use the Incident Reporting Form, and must follow the procedure outlined in a flow chart that clearly states the process and responsibilities of staff involved.
- Immediate evaluation and stabilization of the patient or other individual involved in the event should be carried out. After any needed intervention has been provided to the patient or other involved individual, the HCHC Incident Report should be completed. Persons knowledgeable about the event should complete the Incident Report objectively, accurately, and without conclusions, criticisms, or placement of blame. All Incident Reports will be forwarded as soon as possible, but at most within 24 hours, to the Risk Manager, currently the CCCSO, for review. All incidents reports will be summarized to the QI/RM Committee, which will develop and monitor any needed corrective actions, and will be signed off on by the Committee Chair and the CEO. All incidents are recorded in the Incident Tracking spreadsheet held by the Executive Assistant, which is regularly reviewed by the Risk Manager, CEO, and QI/RM Committee to discern patterns and the need for a PDSA response.
- Serious injuries and deaths resulting from an adverse event should also be reported immediately by telephone to the risk manager. Per HCHC policy, the CEO and Medical

Director should be notified of any events in Category F (i.e., requiring hospitalization) or higher within 24 hours.

- Serious reportable events (SRE's) must be reported, by the Department Head or Risk Manager, to the patient/family, third party payer, and DPH's Bureau of Health Care Safety and Quality (BHCSQ) within seven days of the incident. An SRE is an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations. The Risk Manager will also conduct a follow-up report within 30 days of the initial report and distribute to all 3 parties. This report will include documentation of the root cause analysis findings and determination of preventability as required by Massachusetts regulation.
- The HR Coordinator will complete the Employee Injury portion of Incident Reporting Form, and will notify insurers (e.g., liability, property, Workers' Compensation) in accordance with established notification procedures.

c. Patient Satisfaction and Grievances Processes

Patient satisfaction surveys are conducted online twice a year utilizing the Standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Centered Medical Home (PCMH) survey tool for all medical patients. All other patients are surveyed by paper. Patients who leave the practice are sent a survey to determine the reason they left and to identify ways the agency can improve its services. Satisfaction surveys are done yearly at the School-Based Health Center and for the HOPE program, the Family Education and Support Program, and the Family Center program. Satisfaction surveys are also available at the Patient Portal and website, and may be completed on line.

Patients are able to file a grievance at any time, and are made aware of this at the time of registration. The Chief Executive Officer (CEO) serves as the Health Center's Privacy Officer and the QI/RM Committee reviews all patient complaints/compliments and identifies strategies for resolution and system improvements. The complaint procedure is established to meet the requirements of the Americans with Disabilities Act. Individuals with disabilities or their authorized representatives who believe that they have been discriminated against on the basis of disability in the provision of services, activities, programs, or benefits are encouraged to bring their complaints to the attention of the CEO. Complaints are submitted in writing and include a description of the alleged discriminatory incident or action, the place and date of its occurrence, and the name of any employee or representative involved. Grievances are investigated by the Practice Manager and relevant Department Head and addressed directly with the patient.

d. Completion of Quarterly QI/RM assessments

The clinical departments conduct monthly meetings which include peer review monitoring. Quality dashboards (such as HEDIS, P4P, UDS, and other appropriate quality indicators) required by grants are reviewed and assessed using process improvement methodology. Reports are forwarded to the QI/RM Committee, which discusses them, generates possible corrective action, and then the Chair reports to the Board of Directors. The non-clinical departments also report regularly on their departmental dashboards and quality improvement activities.

e. Production and Sharing of QI/RM reports

The board representative on the QI/RM Committee reports to the Board at least six times a year, sharing minutes and reports from the QI/RM committee meeting after acceptance of those minutes and reports by the QI committee. The Board provides input and feedback to the QI/RM Committee directly and through the involvement of two Board members on the Committee itself.

2. Responsibilites of QI/QA Program Manager

HCHC has a Director of Medical Quality Improvement who works with the Quality Improvement/Risk Management Committee, Medical Director and Senior Management to assure that HCHC provides the highest possible quality of care and is engaged in the process of continuous quality improvement. This position is assisted by the Director of Clinical Operations position whose assists in the oversight, monitoring and assessment of the QI/QA program through the creation and analysis of systems and data, identifying and resolving clinical operations problems that impede patient care, efficiency, coverage, and/or cost-effectiveness for the medical, behavior health and eye care departments; and developing and implementing desired outcomes.
Both positions are members of and report to HCHC's QI Committee.

a. Implementation and Frequency of Updating QI/QA Operating Procedures

The QI/RM Committee is a Board level committee and is chaired by a member of the Board of Directors. The QI committee chair, independently or in conjunction with the QI Committee, reports semi-annually to the Board of Directors (1) the results of patient satisfaction surveys (2) departmental clinical goals as reported to the Bureau of Primary Health Care and progress made towards these goals (3) trend analyses of quality indicators and a plan to improve those indicators. Annually, the QI committee chair, with the committee, will evaluate the quality improvement program to determine whether the program has been effective in meeting its goals and objectives and to make revisions to the program as deemed necessary and appropriate to be aligned with the health center's strategic plan.

b. Monitoring of Associated QI/QA Outcomes

The QI/RM Committee chair reports to the Board the minutes from any six meetings evidencing oversight of QI/QA activities that took place during the course of the year. Reviews are conducted utilizing the following data collection and information resources:

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

3. QI/QA Assessments by Health Center Medical Providers

a. Adherence to Current Evidenced-based Guidelines and Standards of Care

Clinical standards of care are developed by the Medical Director, Dental Director and Behavioral Health Director, reviewed by the CEO and then approved by the Board of Directors. HCHC bases written clinical policies and protocols on and maintains compliance with clinical standards of care as established by American Academy of Pediatrics, American Diabetes Association the JCAHO, AMA, ADA, American Board of Family Practice and internal BOD approved policies. HCHC maintains clinical excellence through the monitoring of:

- Provider staff performance (through continuing medical education activities, ER utilization, and referral audits)
- Support staff performance (through electronic chart audits, patient satisfaction responses)
- Medical Record Quality (through electronic chart audits)
- Patient health status (through childhood immunization data, abnormal pap results, mammography results, asthma inpatient admissions, etc.)
- Patient satisfaction (through patient satisfaction surveys)
- Patient compliance (through ER utilization, patient no-show statistics, prenatal no-show statistics)
- Access to care (through patient satisfaction survey , which can be completed online.
- Appropriateness of care (through Medicaid and other insurer audits)
- Cost of service (through financial reports and analysis)

b. Processes for Addressing Patient Safety and Adverse Effects and Patient Satisfaction

As stated above, patient safety and adverse events are identified, analyzed and addressed through an internal reporting process for all incidents including patient complaints, work related injuries, patient injuries and clinical errors. Each employee is oriented to the incident reporting system during new employee orientation. Written and verbal reports are made to the employee's immediate supervisor. Each incident report is reviewed and followed-up by the department director and then reported to the CEO. Each incident report includes a written description of the issue being reported, resolution to the issue, and findings for performance improvement. Incident Report summaries are reviewed by the staff QC monthly and the Board QI/RM Committee quarterly.

Patient satisfaction surveys are conducted for medical patients twice a year at the two main locations utilizing the Standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool. A link to satisfaction surveys for medical patients are also available at the Patient Portal and website, and may be completed online. A random sample of patients of the dental, behavioral health, and eye care departments are also surveyed twice a year with an instrument developed by the QI/RM Committee and the Board of Directors. Patients who leave the practice are sent a survey to determine the reason they left and to identify ways the agency can improve its services. Satisfaction surveys are done yearly at the School-Based Health Center and for the HOPE program and the Community Programs. Satisfaction surveys are also available on HCHC's website and may be completed online. Results from the surveys are reviewed by the QI/RM Committee. The Committee assess the results and where necessary, make recommendations for change, development of a PDSA team response, or other measures to address the concern.

In addition to these measures, HCHC has a robust Risk Management Program, which utilizes the following four-step model for Risk Management:

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

This model encompasses a wide range of risk areas, including staff trainings, infection control, HIPAA privacy and security, and emergency planning and response. These efforts enable HCHC to minimize the risks to patients and staff.

4. Description of Health Record System (EHR)

a. Optimizing Health Information Technology

The QHHC site will use the same EHR as is currently in place for all of HCHC's existing sites. HCHC uses eClinicalWorks, LLC (eCW) for our electronic medical records for all medical, behavioral health, optometry, and community health worker services. eCW is a Meaningful Use certified electronic medical record application. HCHC utilizes both the Practice Management and Medical Record functionality of the application. The patient chart is documented full cycle from registration, scheduling, visit documentation through billing. HCHC uses the EHR to ensure continuity of care, comprehensive care coordination, and population health management. Care teams use the EHR to conduct pre-visit planning, referral tracking and transition planning, and all the other patient-centered activities required to ensure the highest quality of care. In addition, HCHC uses the PRAPARE tool to ensure that our Community Programs, including Community Health Workers, are addressing the social determinants of health that will impact patient outcomes.

b. Protection of Patient Health Information (PHI)

HCHC has implemented extensive Privacy and Security policies, as required and in order to be compliant with by Title 45 CFR 164.500 – 534(e) and 45 CFR 164.308(a)(1)(i). HCHC utilizes both role-based security access as well as individual patient secure access control (P.S.A.C.) to secure patient information. Staff access to patient information is granted/restricted based upon their role in the practice. Clinical staff are granted access to appropriate sections in the patient chart with increasing levels of access and functionality. Mid-level clinical staff have access to the patient chart commensurate with support role. Providers have the greatest level access. Front office staff are similarly restricted with front office administrators having the greatest level of front office access. This is also the case for billing staff and managers. In addition to role based security, individual patient's charts can be restricted to specific staff using the P.S.A.C. functionality. The patient chart is designated as a secure access chart and staff who are permitted access are assigned to the chart.

c. Facilitation of Collection and Utilization of Data for Program performance Monitoring

HCHC uses the data collected in its EHR, and the analysis of such data by its staff and third party aggregator, to monitor its performance. As participants in several quality initiatives including MU, UDS, HRSA, PCMH, and individual DPH/CDC sponsored grants we routinely

report on a variety of quality measures. Some of these measures include colon, breast and cervical cancer screenings, as well as, chronic disease specific measures such as A1C, IVD aspirin therapy and appropriate medications for asthma.

eCW is preloaded with a Meaningful Use Quality Dashboard which reports on all providers for all measures across the practice using eCW pre-loaded, structured data.

Further, we have a third party aggregator, the Azara DRVS suite of reports, which we utilize to report quality measures for UDS, HRSA, PCMH and other quality initiatives.

HCHC uses eCW to capture health information to monitor individual patient conditions as well as track and trend patient populations with specific conditions such as diabetes and hypertension to identify opportunities for intervention

eCW has a separate reporting application, eBO (Enterprise Business Optimization), in which we have created custom reports to report on a variety of specialized projects including our pre-diabetes/undiagnosed hypertension initiatives sponsored by the CDC. We have created customized structured data items within our EMR and the companion reports to report on these individual initiatives.

Provider and site compliance scores are published at a regular frequency, displayed in standardized report card format. Action plans are required for metric performance below expected targets. Where sites continue to show no improvement in scores, Quality Improvement/Risk Management Committee members conduct a gap analyses, review specific provider performance and meet with site leadership. Parameters for improvement are agreed upon and monitored more frequently.

5. Clinical and Financial Performance Measures Forms

See attached Clinical and Financial Performance Forms

6. Efforts to Focus on HRSA Clinical Priorities

a. Diabetes

In 2018, 28.45% of HCHC patients with diabetes, had an HbA1c greater than 9, or had no test conducted in the previous year. This percentage has been steadily falling over the last five years, but to further address the issue, in October 2018, HCHC received Diabetes Performance Improvement Technical Assistance from HRSA, and developed a Diabetes Action Plan in consultation with the clinical consultant and Project Officer. While the numbers of patients who meet the criteria below is small, due to most patients with diabetes are in current active management with their PCP or endocrinologist, the final Action Plan calls for the following actions:

- 15% of patients with an HbA1c greater than 8 will be contacted to schedule an appointment with their primary care provider. Contact will include two calls and a follow-up letter, if non-responsive.
- 40% of patients with an HbA1c greater than 8 will be contacted to schedule an appointment with a community health worker. Contact will include two calls and a follow-up letter, if non-responsive.

- 40% of patients with an HbA1c greater than 8 will be contacted to schedule an appointment with a nutritionist. Contact will include two calls and a follow-up letter, if non-responsive

All current clinical activities will be replicated at the QHHC site, including the use of a nutritionist and Community Health Workers to help patients access adequate food and nutrition, exercise, peer support, etc. The CHWs will be trained in the Diabetes Prevention Program and hold year-long sessions in the community at locations accessible by patients.

b. Depression Screening and Follow-Up

HCHC has made a concerted effort over the last two years to improve the percentage of patients age 12 and older who are both screened at a medical visit and, if the warranted, referred to follow-up care. The Medical and Behavioral Health (BH) departments have improved their communication and workflows, and have adjusted the BH schedule so that, for the last year, there have been same day visits available for any patient referred by a PCP. Adjustments were also made in the EHR to ensure that the process was appropriately and accurately documented. This new system has increased the number of patients who have been screened and have a plan for follow-up care from 28.90% in 2017 to 36.51% in 2018. With the additional funding available through the SUD-BH grant and the 2019 HRSA IBH grant (if funded), HCHC anticipates that it will continue to expand its capacity to serve patients with BH services, and will work to increase this percentage to at least 40%.

c. Child Weight Assessment and Counseling

HCHC struggled for many years with the documentation of providers' activity related to child weight assessment and counseling – the activity was occurring, but was not being appropriately documented in the patient's record. After concerted effort, this has changed: in 2018, the percentage of patients for whom this activity was recorded rose to 22.43%, from 0.66% in 2016, and from 0% in 2015. HCHC's Medical Department continues to train its providers on the appropriate documentation, and has created stronger relationships between the Community Health Workers, Nutritionist, and PCPs to ensure that the primary care team is working closely to meet all clinical and social determinants of health for this population. Specifically, HCHC's school-based health center has on-site these same team members, and can work closely with the children, the school nurse, and the adjustment counselors to address concerns about the students' BMI.

d. Body Mass Index

As with the child weight assessment and follow-up, HCHC has confidence in its providers practice and adherence to the measure, but has been working to increase its accurate coding and documentation. The issue is not the recording of the BMI data, or even the development of a follow-up plan, but the accurate documentation of the plan. There has been improvements over the last few years – in 2015 the measure was at 32.09% and in 2018 it increased to 36.51%, and we anticipate increasing the number to 40%. In terms of actions to address patients with a BMI outside of normal parameters, the primary care team works very closely with the Community Health Workers and nutritionist to ensure that they are working together on individual patients' plan for weight loss. This includes HCHC-led walking groups, and support for local food

security coalitions and initiatives. In Ware, HCHC already has relationships with local community partners that are working on these issues, and will have a Community Health Worker onsite to support patients in their efforts.

e. Combating the Opioid Crisis

HCHC has expanded and improved its provision of behavioral health services to treat patients who have or may develop substance use disorder; developed new nursing workflows to monitor those patients who are currently prescribed opioids; enrolled providers in an Opioid ECHO program; and developing an MAT program pilot at its Amherst site. For the QHHC, HCHC has an MOU with the largest local behavioral health system, whose outpatient clinic is directly next door, to provide substance use disorder services, as well as developing relationships with the very strong local recovery community. All QHHC providers will also be waivered to provide MAT.

E. RESOURCES AND CAPABILITES

1. Organizational Structure (including any sub-recipients)

Hilltown Community Health Centers, Inc. (HCHC) is a stand-alone incorporated entity with 501(c) (3) status. It is governed by a community board and is overseen by a Chief Executive Officer (CEO) assisted by a senior management team consisting of the Chief Financial and Administrative Officer (CFAO) and the Chief Clinical and Community Services Officer (CCCSO). These Senior Managers in turn have direct line authority over all other Department managers including the Medical Director, Director of Clinical Operations, Dental Director, Behavioral Health Director, Nursing Director, Director of Community Programs (which includes Outreach and Case Management), Practice Manager, School Based Health Director, and Director of Optometry. The CEO is accountable for the overall planning, organization, fiscal integrity and direction of HCHC; responsible for its overall performance; and exercises all authority delegated by the Board of Directors and by law.

The Board of Directors hires and evaluates the CEO who in turn hires and supervises the CFAO and CCCSO and other administrative staff. Each Department Director is responsible for supervising his/her departmental staff. The Practice Manager oversees the front desk/office staff, as well as the Referrals Department and School-Based Health Center operations.

The organizational structure has been developed and revised over the years to keep up with the growth of the organization and changes to the health care field. Each major department (medical, dental, behavioral health, financial, community programs) has a director. Each department holds its own regular meetings to address departmental issues and to inform staff of larger agency events. The structure promotes integration of services through regularly scheduled department director meetings, and other regularly scheduled inter-departmental meetings. There are also regularly bi-annual all-staff meetings from the CEO updating all staff on larger, agency-wide issues.

See Attachment 3 for the HCHC Organization Chart.

2. Staffing Plan

a) Appropriateness of Staffing Levels

The QHHC's staffing will enable HCHC to provide all required and additional services within its approved scope, with the exception of preventive dental services, which will be provided at its Amherst site. Our target populations have high rates of chronic conditions, low health literacy,

and entrenched traditions of risk-taking or unhealthy behavior. To address these issues in a coherent fashion, primary care at HCHC's current sites, and also at the proposed QHHC site, is provided by a Primary Care Team who are specialists in the primary medical care of men, women and children across the life spectrum. A Primary Care Team is composed of a primary care provider, a receptionist, a medical assistant, a nurse, and a Community Health Worker. The Team coordinates all routine medical care: exams; lab tests; medical imaging, diagnosis, and treatment and makes referrals for oral health services; mental health and substance abuse screening; and other appropriate services. The Team refers patients to both in-house and external health education programs, depending on their need and health issues. The Team also connects the patient/family to HCHC's comprehensive case management services, which is especially necessary for chronic disease management and for families and individuals with complex and multiple challenges with social determinants of health.

Experienced, well-qualified staff members fill these positions. HCHC's clinical staffing pattern is appropriate for the volume and mix of services to be provided and is consistent with current operations. The clinical staff pattern allows HCHC to provide high quality care and ensures continuity of care for its patients. All clinical staff are direct employees of HCHC.

Medical Department staffing is consistent with HCHC's use of the medical home model for patient care, ensuring that there are enough staff members to form medical teams who are familiar with the patient and able to help coordinate and manage their care, advocate for other services the patient may need and integrate their care with that of the other departments.

Similarly, the Dental Department, Eye Care, and Behavioral Health Department staffing is adequate to serving the patients, providing the variety of services the population needs. For instance, the Dental Department is strong enough for the agency to be able to provide children with services at their schools through our portable dental clinic.

Staffing at the QHHC will initially be comprised of medical providers and support staff;

QHHC Direct Services Personnel	FTE
ADMINISTRATIVE STAFF	**.12**
CEO	.04
COO	.04
CMO	.04
MEDICAL STAFF	**4.77**
Family Practitioners	.71
Nurse Practitioner/Physicians Asst.	.71
Nurses (RNs)	1.18
Medical Assistants (MA)	2.13
Director of Clinical Operations	.04
ENABLING STAFF	**1.42**
Community Health Workers	.71
Insurance Navigator	.71
SUPPORT STAFF	**2.01**
Practice Manager	.04
Front Desk	1.42
Site Manager	.34
Facilities Manager	.04
EHR Specialist	.04
Billing	.09

IT	.04
TOTAL	**8.32**

See Form 2 for a full staffing roster for all of HCHC sites which includes the staffing for the QHHC as listed above.

b) Consideration of Target Area Characteristics in Determining Staffing

As outlined in the Need section of this application, our target populations have high rates of chronic conditions, low health literacy, and entrenched traditions of risk-taking or unhealthy behavior. The population is very similar to the rural population that HCHC currently serves in its Hilltown locations, and our staff have a lot of familiarity with the barriers that must be addressed and successful strategies for treatment.

The staffing that HCHC is proposing, as well as the MOUs that we have developed with other community providers, will enable the QHHC to meet the needs of its patients for primary and preventive medical care and other required and additional services in HCHC's scope. This includes the very important role of the Community Health Worker, who has a dramatic impact on the providers' ability to engage and collaborate with the patients in their care.

In order to ensure access to preventive dental services, HCHC will serve patients at its Amherst site, which is the closest FQHC site to the proposed location. If patients face barriers to this service due to transportation or other access issues, the Community Health Worker will develop a plan to ensure access, including bus vouchers, gas cards, etc.

c) Procedures for Credentialing Staff

HCHC has a Board approved Credentialing and Privileging Policy. Section IV of the program outlines the procedures for initial and recurring review and documentation of credentials and privileges for all clinical staff members, by provider category, as follows from the Policy:

Verification of Credentialing and Privileging Activity			
	Licensed or Certified Practitioner		**Non-licensed/Certified/Registered Clinical Staff***
Examples of Staff	*Physicians, dentists, nurse practitioners, physician assistants, LICSW, LMHC, optometrists*	*RN, LPN, certified medical assistant, registered dietitians/nutritionist, LCSW, dental hygienists, dental assistants*	*Medical assistants, community health workers*
Initial Credentialing Activities	**Verification Method**		
Licensure, registration, certification	Primary source	Primary source	Not applicable
Education and training/ graduation verification	Primary source	Secondary source[2]	Secondary source*

National Practitioner Data Bank (NPDB) query	Copy of NPDB report or documentation that the health center is signed up for NPDB continuous query	Copy of NPDB report or documentation that the health center is signed up for NPDB continuous query (Not applicable for some OLCHPs)	Not applicable
Government-issued picture identification	Secondary source	Secondary source	Secondary source*
Immunizations as required	Secondary source	Secondary source	Secondary source
Life support training	Secondary source	Secondary source	Secondary source*
Drug Enforcement Administration registration[4]	Secondary source	Not applicable	Not applicable
Malpractice insurance coverage	Secondary source	Secondary source	Not applicable
Massachusetts Controlled Substance Registration (MCSR)	Secondary source, if applicable	Not applicable	Not applicable
Work History	Secondary Source- at least 5 years of professional work history	Secondary source, if applicable	Secondary source, if applicable
Certification	Secondary source, if applicable	Secondary source, if applicable	Secondary source, if applicable

3. Management Plan

a. Management Team's Support and Oversight of proposed Project

HCHC management team is comprised of a Chief Executive Officer (CEO), a Chief Financial and Administrative Officer (CFAO) a Chief Clinical and Community Services Officer (CCCSO) and a Medical Director. The CEO directly supervises the CFAO and the CCCSO. The CFAO has responsibility for all financial, operational, and information technology aspects of the health center and directly supervises the practice manager, the IT staff, the billing and finance managers, the human resources director and the facilities manager. The CCCSO has responsibility for all clinical and community service aspects of the health center and directly supervises the Medical Director as well as the Director of Clinical Operations, the dental, optometry, and behavioral health directors, and the director of community programs. This management team will have supervision over all QHHC operational and clinical functions.

b. Training, Experience, Skills and Qualifications

HCHC's management structure has been updated in the last year specifically to be able to more efficiently manage the complex requirements of managing a growing health organization.

The Chief Executive Officer is responsible for developing and facilitating an organization that is dynamic, adaptable, sustainable, and efficient in meeting the health needs of the service area. The CEO's duties include: overseeing all clinical services including medical, dental,

optometry, behavioral health, health education, community outreach, financial and administrative operations of the organization within the management structure; providing sound fiscal oversight; functioning as the liaison between the Board of Directors and the staff; providing guidance around strategic planning and corporate compliance; and acting as the liaison to federal, state, and community organizations. The CEO is required to have a minimum of three to five years of progressive management experience, including three years of experience as a senior manager of a non-profit or government entity. The CEO possesses considerable knowledge of organization administration and fiscal management, and is familiar with all federal and state regulations applicable to a health center.

The Chief Financial and Administrative Officer oversees the financial operation of the organization. This includes supervision of the Financial and Billing departments, preparation and monitoring of the organization's annual operating budget, cash management and representing the fiscal interests of the organization in external business relationships. The CFAO also oversees all Practice Manager, IT, Facilities, and HR departments. Finally, the CFAO is responsible for shepherding, as a member of the Senior Management team, organizational strategic planning and site expansion implementation. The CFAO is required to have a Master's Degree in Accounting or Business Administration, with a minimum of five years' experience in non-profit finance, and a CPA experience is highly desirable.

The Chief Clinical and Community Services Officer's (CCCSO) is responsible for ensuring quality integrated care is delivered to the patients of HCHC through coordination of care, consistent policies and procedures, data collection and analysis, and collaboration. The current CCCSO is an Eye Care provider, but the position can be held by a Medical, Dental, or Eye Care provider, licensed and in good standing with the state of Massachusetts, with a minimum of five years of post-certification practice experience, a minimum of 3 years appropriate management experience and/or training and be committed to community health and have a working knowledge of clinical and community services and needs.

The Medical Director is responsible for working with Senior Management, the Quality Improvement Committee (including the Director of Medical Quality Improvement), and the medical staff to assure that HCHC provides the highest possible quality of medical care and is engaged in a process of continuous quality improvement. The position supports HCHC's efforts in population medicine to improve health indicators for patients seen at HCHC's clinics, and in the broader community.

See Attachment 4 for Position Descriptions.

c. Individuals in Key Management Positions

Chief Executive Officer Eliza Lake, MSW, has implemented numerous state- and federally-funded projects over the last 24 years for the Commonwealth of Massachusetts and other non-profit providers. She has developed, managed and evaluated projects in the areas of long-term services and supports and its financing, Medicaid policy, strategic planning, needs/gap analyses, and regulatory compliance. Since she's became HCHC's CEO in 2014, she shepherded the opening in 2018 of the organization's first new site in 30 years. She is a former Board member of an FQHC.

Chief Clinical and Community Services Officer Michael Purdy, OD, is an optometrist who has worked at FQHCs in Boston, Alabama, Arizona, and Mississippi, and is deeply knowledgeable about community health provision to underserved populations. Dr. Purdy is

responsible for oversight of all clinical departments heads (medical, oral health, optometry, and behavioral health), as well as HCHC's extensive community/outreach programs.

Chief Financial and Administrative Officer Frank Mertes, MBA, CPA came to HCHC after many years as the chief financial officer at another local FQHC and oversees all financial, billing, IT and grant management operations. At both FQHCs he oversaw the opening of numerous new sites, including oversight of all construction/renovation activities and financing.

Medical Director, Jonathan Liebman, ANP, MPH, has been working in FQHCs for over 20 years. Prior to working at HCHC he worked at Holyoke Health Center, one of HCHC's fellow FQHCs in the C3 Accountable Care Organization (ACO).

d. Employment Arrangement of CEO

HCHC's CEO is a full-time direct employee of Hilltown Community Health Centers, Inc. She is employed under a one-year, automatically renewing contract.

e. CEO Oversight of Other Key Management Staff and Reporting to Governing Board

In addition to directly supervising the CFAO and CCCSO, the CEO directly supervises the Development Director and Executive Assistant. She attends all Board of Director meetings in order to:

a. Provide accurate, relevant information for board decision-making, including a monthly CEO Report that provides the Board with information on key financial and strategic priorities;
b. Make recommendations to the BOD regarding new policies or revisions to existing policies, and to oversee their implementation;
c. With the BOD, review and determine HCHC's goals, direction and quality improvement plans in keeping with its stated mission and strategic plan;
d. Assist the BOD in carrying out the mission;
e. Recommend and arrange BOD education opportunities; and
f. Perform other duties as the BOD may request.

She is a also member of the QI/RM, Credentialing, Finance Committee, Strategic Planning, Fundraising, and other Board committees as appropriate. The CEO meets at least weekly with the CFAO and CCCSO, as well as regularly attending Department Head and Provider meetings. On a bi-annual basis, she and Senior Management review the Strategic Plan to update the organizational strategic Action Plan.

f. Recruitment Plan for Filling Key Management Positions

HCHC recruits new management staff through extensive online and print media advertising, as well as outreach to community partners in the region. For the CEO position, the organization would hire an outside firm to conduct a comprehensive search. Whenever possible, HCHC tries to recruit for management from internal staff who have proven that they are qualified, committed to the mission, and patient-centered. The recruitment plan includes a focus on continuing retention efforts, including fostering productive communication, appropriate involvement in decision-making, competitive employee benefits, training opportunities, and financial incentives. HCHC offers competitive salaries, a positive work environment, generous health, dental and life

insurance, short-term and long-term disability insurance, and 403(b) retirement with employer match.

4. Oversight of Contracted/Subawarded Services and Sites

Consistent with Form 5A, Services provided, HCHC contracts for services with: Walgreen Co. Pharmacy for 340B pharmacy services, Crocker Communications for after-hours messaging and communications, and Pacific Interpreters for telephonic interpretation services. No direct clinical services are included in contracts for required services, with the exception of one nurse who provides home visits to homebound elders.

a. Structure of the Agreement

Each agreement details the services to be provided by the contractor as well as privacy requirements related to patient health information (PHI). All four agreements allow for the termination of the agreement by either party after written notification and a specified waiting time.

b. Contractors/Sub-recipients Compliance

The Walgreen Pharmacy agreement contains a provision regarding regulatory compliance with all regulatory requirements of the 340B Drug Program and all relevant federal regulatory requirements. HCHC's *Corporate Compliance Plan, Annex 8: 340B Pharmacy Program*, has strict requirements for both HCHC and the pharmacies about record keeping, reporting, and internal audits, ensuring full compliance.

c. Monitoring Contractors/Sub-recipients

The Walgreen Pharmacy agreement has extensive provisions regarding records for auditing and monitoring purposes. As noted above, HCHC's *Corporate Compliance Plan, Annex 8: 340B Pharmacy Program*, has strict requirements for both HCHC and the pharmacies about record keeping, reporting, and internal audits, ensuring full compliance.

d. Contractor/sub-recipient Requirements to Provide Necessary Data

The Walgreen Pharmacy and Crocker agreements as well as HCHC's documented 340B Compliance documentation have provisions stating that the contractor will provide relevant data to HCHC for reporting purposes. For the purposes of demographic data reports, HCHC's EHR captures information regarding patients' need for translation. Pacific Interpreters' will invoice HCHC for any and all translation services that are used, and this is also captured in the patients' records.

5. Conflict of Interest Policies and Procedures

HCHC's Standards of Conduct (*Annex 1* of the *Corporate Compliance Plan, Section B*) contains general prohibitions, affirmative disclosure requirements, determination of a conflict process, procedures for addressing a conflict of interest, how to address violations of the standards related to conflicts of interest, and how these processes will be recorded. All staff are trained on the standards of conduct, and must confirm annually that they have received and understand the contents. In addition, the Board of Directors reviewed and approved on September 27, 2018

HCHC's Conflict of Interest Policy, in order to have a formal and detailed documented process for disclosing all real or apparent conflicts of interest that are discovered or that have been brought to attention in connection with HCHC's activities.

Conflict of Interest Policy:

1. Employees of HCHC, its board of directors and agents are prohibited from participating in the selection, award and/or administration of any contract supported by federal funds that furnishes goods or services to HCHC.
2. No board member, HCHC employee or agent of HCHC may solicit or accept gratuities or favors of a monetary value from any person or organization having a contractual relationship with HCHC. This includes businesses soliciting business from HCHC.
3. No board of director member or an immediate family member shall be an employee of HCHC.
4. All board members and senior management shall disclose real or apparent conflicts of interest.
   All officers, Board members, and senior management employees (Chief Executive Officer, Chief Financial Officer, Chief Clinical and Community Services Officer, Department Managers) of this organization shall disclose all real or apparent conflicts of interest that they discover or that have been brought to their attention in connection with this organization's activities.

   "Disclose" shall mean providing properly, to the appropriate person, a written description of the facts comprising the real or apparent conflict of interest. An annual disclosure statement shall be circulated to officers, Board members, and certain identified employees to assist them in considering such disclosures, but disclosure is appropriate and required whenever conflicts of interest may occur.

   The written notices of disclosures shall be filed with the Chief Executive Officer or other person designated by the Chief Executive Officer to receive such notifications.

5. The Chief Executive Officer shall ensure that all officers, agents, employees, and independent contractors of the organization are made aware of the organization's policy with respect to conflicts of interest. Violations of this policy will be handled in accordance with procedures established in the Corporate Compliance Plan, Sect III, Para A & B, and the Board of Directors' By-Laws.

6. Financial Accounting and Control Systems

a. Reflect General Accepted Accounting Principles (GAAP)

Hilltown Community Health Centers, Inc. (HCHC) is required to maintain accounting and internal control systems appropriate to the size and complexity of the organization reflecting Generally Accepted Accounting Principles (GAAP) and separate functions appropriate to organizational size to safeguard assets and maintain financial stability. As such, HCHC management has adopted a policy to have a formal documented process to meet these requirements and establish guidelines for developing financial and accounting procedures necessary to safeguard the financial resources of HCHC.

b. Maintain effective control of all assets

HCHC maintains effective internal control over the Federal and state award that provides reasonable assurance that HCHC is managing the Federal and state award in compliance with Federal and state statutes, regulations, and the terms and conditions of the Federal award. These internal controls are compliant with guidance in "Standards for Internal Control in the Federal Government," issued by the Comptroller General of the United States or the "Internal Control Integrated Framework," issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

c. Safeguard all assets

HCHC maintains effective control over, and accountability for, all funds, property, and other assets to assure that they are used solely for authorized purposes.

d. Ability to track financial performance

The chart of accounts is designed to provide management with an analysis of financial position and a statement of operating revenues and expenses on an accrual basis. The chart of accounts is established using the total grant concept. As such, each individual funding source is segregated in the general ledger to allow management to easily distinguish revenues and expenses by funding source. This allows for easier preparation of monthly reimbursement vouchers for contracts as well as regulatory reporting (FSR, UFR, UDS, etc.)

e. Accountability of health center award and other federal grants

HCHC's financial management systems, including records documenting compliance with Federal and state statutes, regulations, and the terms and conditions of the Federal and state awards, must be sufficient to permit the preparation of reports required by general and program-specific terms and conditions; and the tracing of funds to a level of expenditures adequate to establish that such funds have been used according to the Federal and state statutes, regulations, and the terms and conditions of the Federal award.

f. Ability to collect and report organizations financial performance data

The electronic financial system (Financial Edge) along with the chart of accounts is designed to provide management with an analysis of financial position and a statement of operating revenues and expenses on a time accrual basis. The chart of accounts is established using the total grant concept. As such, each individual funding source is segregated in the general ledger to allow management to easily distinguish revenues and expenses by funding source. This allows for easier preparation of monthly reimbursement vouchers for contracts as well as regulatory reporting (FSR, UFR, UDS, etc.).

g. Accounting of all federal awards

Systems and reports have been established to help the health center comply with all regulatory reporting. Many reports are required of the health center and all reports require different formats to report the information. The accounting system has been developed to allow for the different reporting formats and must include:

- Identification, in its accounts, of all Federal awards received and expended and the Federal programs under which they were received. Federal program and Federal award identification must include, as applicable, the CFDA title and number, Federal award identification number and year, name of the HHS awarding agency, and name of the pass-through entity, if any.
- Accurate, current, and complete disclosure of the financial results of each Federal award or program in accordance with the reporting requirements set forth in §§75.341 and 75.342. If an HHS awarding agency requires reporting on an accrual basis from a recipient that maintains its records on other than an accrual basis, the recipient must not be required to establish an accrual accounting system. This recipient may develop accrual data for its reports on the basis of an analysis of the documentation on hand. Similarly, a pass-through entity must not require a subrecipient to establish an accrual accounting system and must allow the subrecipient to develop accrual data for its reports on the basis of an analysis of the documentation on hand.
- Records that identify adequately the source and application of funds for federally-funded activities. These records must contain information pertaining to Federal awards, authorizations, obligations, unobligated balances, assets, expenditures, income and interest and be supported by source documentation.
- Effective control over, and accountability for, all funds, property, and other assets. The non-Federal entity must adequately safeguard all assets and assure that they are used solely for authorized purposes.
- Comparison of expenditures with budget amounts for each Federal award.
- Written procedures to implement the requirements of §75.305.
- Written procedures for determining the allow ability of costs in accordance with subpart E of this part and the terms and conditions of the Federal award.

h. Disclosure of financial awards of each federal award in compliance with reporting requirements

Disclosure is maintained in our annual audit report and can also be found in major reports which are required and may include:

1. Annual, Federal Uniform Data System (UDS) Report
2. Annual audit in accordance with Title 2 U.S. Code of Federal Regulations (CFR) Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards
3. 45 (CFR) Part 75
4. Annual grant year Federal Financial Status Report (FSR)
5. State annual Uniform Financial Report (UFR)
6. IRS Tax Form 990
7. State tax Form PC
8. Federal cash draw down quarterly report PSC-272
9. Medicare annual cost report

10. Medicaid annual cost report

The system also allows for grant reporting, salary surveys and other numerous reports which may be required from time to time. These include the annual Federal 330 grant budget renewal.

i. Implementation of Federal Payment System (PMS)

HCHC utilizes the PMS system and reports draws quarterly and has established internal controls that have to assure safeguards. The PMS draws and reporting are also reviewed by Independent Auditors Draw downs on Federal awards must minimize the time elapsing between the transfer of funds from the United States Treasury or the pass-through entity and the disbursement by HCHC.

j. Assuring award costs are allowable under Federal Award and Cost Principals

A budget for all awards is maintained and reviewed. Staff are trained to identify the cost on allowable and unallowable costs associated with Federal awards.

7. Billing and Collection Systems

a. Requesting applicable payments from payments while ensuring no patient is denied service based upon inability to pay

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, which include a sliding fee scale.

b. Educating patients on insurance

HCHC has specific staff assisting patients in applying for public insurances and assistance. HCHC also trains all front desk staff to assist patients and direct them to the appropriate staff for help.

c. Billing Medicare, Medicaid and Children's Health Insurance Program (CHIP)

HCHC bills all appropriate public insurers.

d. Incorporating additional elements such as payment plans, grace periods, and prompt payment incentives, if applicable.

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

e. Policies and operating procedures that address the waiving or reducing of amounts owed by patients due to a patient's specific circumstances related to inability to pay.

HCHC 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 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.

f. Collecting reimbursements for costs in providing health care services, consistent with the terms of such contracts and arrangements.

HCHC applies the Board and Massachusetts Commonwealth collection policy to all patients.

g. Policies regarding informing patients of out of pocket costs prior to the time of service if you provide supplies or equipment that are related to, but not included in, a service as part of prevailing standards of care (e.g., eyeglasses, prescription drugs, dentures) and you charge patients for these items.

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.

h. Policies that distinguishes between refusal to pay and inability to pay if a health center elects to limit or deny services based on a patient's refusal to pay.

HCHC's policies clearly outline patient responsibilities and have clear guidelines on who is eligible for the sliding fee scale and which services are covered.

8. Telehealth

In 2018, HCHC received funding through HRSA's SUD-MH Expanded Access grant program. Funds from that grant are being used to purchase videoconferencing and telehealth equipment to facilitate telehealth BH sessions when a provider is not available on-site, to allow HCHC BH and medical providers to communicate across sites to better coordinate patient care and to facilitate on-line SUD training for BH and medical staff.

9. National Quality Recognition/s

In 2018 HCHC received NCQA PCMH Level 2 recognition for both its Worthington and Huntington sites. Its Amherst site was not open at the time of certification.

F. GOVERNANCE

1. Board Composition Requirements

The HCHC Board approved updated corporate by-laws on April 14, 2016. HCHC's independent governing board has the following authorities: (See Attachment 2 Corporate By-Laws and Attachment 9 Articles of Incorporation). Below are the specific language and by-law section for board composition requirements.

a. Board has a Minimum of Nine but no More than 15 Members, as Appropriate for the Complexity of the Organization:

HCHC has nine Board members. **Bylaws Article III.3.1**

b. At least 51 percent of Board Members are Individuals who are/will be Patients of the Health Center:

The HCHC Board of Directors is the "consumer-majority" board whose members use HCHC's services and represent the overall patient population, particularly with respect to race/ethnicity and socio-economic status. The Board serves as a critical link between the community and the health center. Seventy-eight percent of the Board are HCHC patients. **Bylaws Article III.3.1**

c. As a Group, the Patient Board Members reasonably represent the Individuals served by the Organization in terms of Race, Ethnicity, and Gender:

The HCHC Board members mirror exactly the composition of HCHC's patient population by race, ethnicity, and gender. **Bylaws Article III.3.1**

d. Non-patient Board Members are representative of the Community in which the Health Center's Service Area is located

All non-patient board members live in the service area, many have lived in the area for extensive periods of time and are engaged in other community activities that reflect the needs/concerns of the service area community.

e. Non-patient Members selection based on Relevant Expertise and Skills

The citizen members of the Board of Directors brings a wide range of skills to their service as Board members. The members include a psychotherapist, MD psychiatrist, grants writer, social worker, paralegal, educational program manager, emergency room MD, dental hygienist, law professor, teacher, marketing manager, and local school district representative. All of these varied skills and experiences bring informed leadership to the organization from people who not only have professional insight into the workings of a non-profit organization but also have close ties to the community in ways that inform their decision making about the best way for the Health Center to meet community needs. (see Form 6-A and Attachment 2)

f. No more than half of the Non-patient Board Members derive more than 10 percent of their Annual Income from the Health Care Industry.

Only three board members, or 25%, derive their income from the health industry. **Bylaws Article III.3.1**

g. No Board Member is an Employee of the Health Center or an Immediate Family Member of an Employee. (The ED/CEO may serve only as a Non-voting Ex Officio Board Member.)

None are family members or related parties. **Bylaws Article IX.9.1**

2. **Governing Authority Requirements**

a. Meets at least once a Month:
The HCHC Board meets once a calendar month. **Bylaws Article III.3.4**

b. Approves the selection/dismissal of the Organization's Executive Director/CEO
The Board of Directors shall select a Chief Executive Officer and shall determine the terms of his or her employment. **Bylaws Article III. 3.3**

c. Approves Applications and the Health Center's Applications and Annual Budget:
The Board of Directors shall have and may exercise all powers consistent with the Articles of Incorporation, as may be amended from time to time and relevant law. Duties of the Board are to:

- Approve the center's section 330 grant application
- Approve the center's annual budget

Bylaws Article III.3.2

d. Approves Proposed Sites, Hours of Operation and Services:
The Board votes approves of the hours during which services will be provided. **Bylaws Article III.3.2**

e. Evaluates the Performance of the Health Center:
The Board's Strategic Planning Committee develops, in collaboration with Senior Management and with input from the staff and community, a tri-annual Strategic plan, and then monitors the progress through reports on its Action Plan from Senior Management twice a year. The requirement for strategic planning is contained in **Bylaws Article III.3.2**

f. Establishes General Policies for the Organization:
The HCHC Board of Directors sets policies for the following areas of operations **(Bylaws Article III.3.2):**

- clinical infrastructure;
- contractual relationships;
- clinical protocols;
- medical quality and privacy compliance;
- patient satisfaction expectations;
- adverse outcomes;
- program services;
- credentialing and privileging;
- cultural competency;
- staff training;
- risk management;
- emergency preparedness; and
- corporate compliance issues

g. Assures that the Health Center operates in compliance with applicable Federal, State and local Laws and Regulations.

The Board ensures that the health center is operating in accordance with applicable federal, state and local laws and regulations, as well as its own established policies and procedures **(Bylaws Article 3.2)**. There are quarterly reports to the Board by the Corporate Compliance Committee, as well as monthly reports from the CEO on on-going and new regulatory compliance efforts.

3. Governing Board Authority and Oversight

a. Ensures that no Individual, Entity or Committee has Approval/Veto Power over the Board:

Article II, Section 2.1 of HCHC's bylaws sates that any action or vote required or permitted by Massachusetts General Laws. Chapter 180, as amended, to be taken by members shall be taken by action or vote of the same percentage of directors of the Corporation in accordance with Section 3 or said Chapter as amended.

b. Protection of Board's required Authorities and Functions in Collaborations or Agreements.

HCHC's Memorandum of Agreements (MOU) with other organizations state that "each party shall be responsible for its own acts and omissions, and shall not be responsible for the acts and omissions of the other party."

G. SUPPORT REQUESTED

1. Detailed Budget Presentation

See forms-SF 242A; Budget Narrative; Form 2: Staffing Profile and Form 3: Income Analysis.

2. Mitigation Plan for Adverse Financial Impacts

See Form 3 Income Analysis.

The financial health of HCHC rests on creating and sustaining multiple revenue streams, balanced across patient services, public grants and contracts, and private contributions from individuals, foundations and corporations. HCHC continues to experience ongoing financial stability as a result of these multiple revenue streams.

Payer	% Users
Commercial Ins	35%
Medicaid	36%
Medicare	13%
Self-pay	16%

Data Source: UDS 2018

Over 100 forms of insurance are accepted at HCHC. We employ tracking systems in order to ensure that we are administering, accounting for and billing for those services that are reimbursable in the most appropriate and efficient way possible and that we are always in compliance with

regulations set forth by the grant, HRSA/BPHC, MassHealth, the Health Safety Net Trust Fund, insurance companies, and Federal auditing standards.

At the same time, the success and viability of Hilltown service delivery system is dependent on the continued support of the Section 330 grant dollars, which provide about 17% of the program's total, a small but vital proportion of operating funds. While HCHC maintains a strategic objective to grow the number of patients covered by insurance, the population's uninsured health care needs continue to be significant.

Workforce challenges will be addressed by following the recruitment strategies, including the new, more attractive pay levels discussed in the operational plan.

3. Total and Federal Costs Break Down

The total cost per patient for the QHHC is $1,159.32. The total federal cost per patient is $695.53. Both the total cost and federal costs are high as they include the first year $1,082,804 renovation costs. In the second budget year, these cost reduce substantially and more closely approximate costs at our other sites.

Hilltown Community Health Centers, Inc.
Grant Number : H80CS00601
QUABOAG CHC NAP BUDGET NARRATIVE

Budget Justification	Year 1		Year 1 Total	Year 2 Total
	Federal Grant Request	Non-Federal Resources		
REVENUE: Con*sistent with information presented in Sections A and C of the SF-424A*				
NAP FUNDING REQUEST	$ 650,000	$ -	$ 650,000	$ 650,000
APPLICANT ORGANIZATION	-	-	-	-
STATE FUNDS	-	-	-	-
LOCAL FUNDS	-	-	-	-
OTHER SUPPORT	-	-	-	-
PROGRAM INCOME	-	311,720	311,720	787,243
TOTAL REVENUE	**$ 650,000**	**$ 311,720**	**$ 961,720**	**$ 1,437,243**
EXPENSES: *Object class totals are consistent with those presented in Section B of the SF-424A*				
PERSONNEL: See budget details for each staff position as seen in Personnel Justification below.				
ADMINISTRATION	$ 11,696	$ 1,300	$ 12,996	$ 18,937
MEDICAL STAFF	324,360	36,780	361,140	645,325
ENABLING STAFF	44,955	4,996	49,951	70,200
OTHER STAFF	61,739	6,858	68,597	128,572
TOTAL PERSONNEL	**$ 442,750**	**$ 49,934**	**$ 492,684**	**$ 863,034**
FRINGE BENEFITS				
FICA @ 7.52%	$ -	$ 37,551	$ 37,551	$ 64,900
Medical @ 6.0%	-	29,961	29,961	51,782
Retirement @ .35%	-	1,748	1,748	3,021
Dental @ .65%	-	3,246	3,246	5,610
Unemployment & Workers Compensation @ .54%	-	2,696	2,696	4,660
Disability @ .51%	-	2,546	2,546	4,401
TOTAL FRINGE @ 15.57%	**$ -**	**$ 77,748.00**	**$ 77,748.00**	**$ 134,374.00**
TRAVEL				
Employee Travel reimbursement. ($.44 cents per mile)	$ -	$ 4,396	$ 4,396	$ -
TOTAL TRAVEL	**$ -**	**$ 4,396.00**	**$ 4,396.00**	**$ -**
EQUIPMENT - Total cost associated with one-time equipment purchases. Line-item cost information for equipment is included in the Equipment List form. Maximum federal request of $150,000 for Equipment and/or minor AR costs in year 1 only. All equipment needed to run/support Quaboag CHC is year 2 - see equipment and minor AR budget.				
TOTAL EQUIPMENT	**$ -**	**$ -**	**$ -**	**$ -**
SUPPLIES				
Medical Program Supplies - Loratadine, aspirin, ibuprofen, pregnancy test kits, eye wash, wrist splits, saline, hemcue control kits, masks, etc.	$ -	$ 3,400	$ 3,400	$ 5,100
Medical Program Supplies - Distilled water, syringes, speculum bandages, forceps, scissors, table paper, nebulizer, oxygen, underpads, gauze , etc.	-	3,200	3,200	4,800
Medical Program Supplies -IUD's, sterilizer packages, testing supplies etc.	-	6,600	6,600	9,900
Vaccine Costs On-Site Supplies (Flu 400 x $14.94 = $5,976; Boostrix 30 x $43.69 = $1,310; Engerix 30 x $43.55= $1,306; MMR 40 x $94.51 = $3,780; Gardasil 20 x $212.79 = $4,256; Varivax 30 x $122.02 = $3,661; Pheumovax 40 x x$100.09 = $4,007)	7,250	17,046	24,296	26,000
Office Supplies (paper, pens, tape, etc.)	-	5,000	5,000	7,500
TOTAL SUPPLIES	**$ 7,250**	**$ 35,246**	**$ 42,496**	**$ 53,300**

Hilltown Community Health Centers, Inc.
Grant Number : H80CS00601
QUABOAG CHC NAP BUDGET NARRATIVE

CONTRACTUAL – *Include sufficient detail to justify costs.*				
Facility Lease (12 sq. ft. for 6,000 sq. ft.)	$ 50,000	$ 22,000	$ 72,000	$ 72,000
Contracted VOIP Phone and Internet ($3,125 /Mo 8 months)	-	25,000	$ 25,000	37,500
Shredding Service ($35 / mo. x 8 months)	-	280	$ 280	420
Medical Waste pick-up/disposal ($90 / mo. x 8 months)	-	720	$ 720	1,080
Trash pick-up/disposal ($150 / mo. x 8 months)	-	1,200	$ 1,200	1,800
Security Alarm ($100 per month)	-	800	$ 800	1,200
Equipment Leases - 3 Copiers ($90 / mo. x 8 months)	-	3,240	$ 3,240	3,240
TOTAL CONTRACTUAL	**$ 50,000**	**$ 53,240**	**$ 103,240**	**$ 117,240**
CONSTRUCTION - Total cost associated with one-time minor A/R project. Line-item cost information for minor A/R is included in the A/R Project Budget Justification. Maximum federal request of $150,000 for Equipment and/or minor AR costs in year 1 only.				
Minor A/R costs for administrative and legal expenses at Quaboag CHC	$ -	$ 18,797	$ 18,797	$ -
Minor A/R costs for architectural and engineering fees at Quaboag CHC		80,177	80,177	-
Minor A/R costs for project inspection fees at Quaboag CHC		8,500	8,500	-
Minor A/R costs for site work at Quaboag CHC		3,500	3,500	-
Minor A/R costs for demolition and removal at Quaboag CHC		5,000	5,000	-
Minor A/R costs for construction at Quaboag CHC	150,000	776,316	926,316	-
Minor A/R costs for contingencies at Quaboag CHC		40,514	40,514	-
TOTAL CONSTRUCTION (See Minor A/R Budget Justification)	**$ 150,000**	**$ 932,804**	**$ 1,082,804**	**$ -**
OTHER – *Include sufficient detail to justify each item.* Note : Federal funding CANNOT support grant-writing, fundraising, or lobbying costs, no such costs are included.				
Computer Hardware & Software Maintenance, Licenses and Fees (Website $200; Microsoft Office $200/month x 8 months =$1,600)	-	1,800	1,800	2,600
Small equipment	-	-	-	5,000
PHO Hospital Dues ($375 / provider = $750)	-	750	750	1,125
Provider Clinical Support (CME's) ($2,000 per provider)	-	4,000	4,000	6,000
Licenses and fees (DEA $781 x 3 = $2,343; Ma Controlled Substance $900; DPH Inspection $150)	-	3,393	3,393	4,478
EMR Licenses ($1,500 per provider x 2)	-	3,000	3,000	4,500
Advertising (planned radio, print and on-line media)	-	7,500	7,500	10,000
Recruitment (staff recruitment)	-	7,500	7,500	6,000
Postage (2,000 mailings @ .50 ea.)	-	1,000	1,000	1,500
Printing (Business Cards, Letterhead, envelopes, patient forms)	-	5,000	5,000	4,000
Audit & Legal Services (Audit $3,000, Legal $2,500)	-	5,500	5,500	550
Subscriptions, Dues & Memberships (Up-to Date $475 x 2 = $950; MA League $2,000; NACHC $1,000; AAFP $500; AAFNP $250)	-	4,700	4,700	5,425
General liability Insurance	-	2,000	2,000	2,750
Interest expense on renovation loan ($932,804 loan at 5% = $44,965)	-	44,965	44,965	41,191
Utilities (Oil $$12,464; Electric $7,500: Water $950)	-	20,914	20,914	25,092
TOTAL OTHER	**$ -**	**$ 112,022**	**$ 112,022**	**$ 120,211**
TOTAL DIRECT CHARES (Sum of all TOTAL Expenses rows above)	**$ 650,000**	**$ 1,265,390**	**$ 1,915,390**	**$ 1,288,159**
INDIRECT CHARGES – *Include approved indirect cost rate.*				
X.XX% indirect rate (includes utilities and accounting services)	$ -	$ -	$ -	$ -
TOTALS (Total of TOTAL DIRECT CHARGES and INDIRECT CHARGES above)	**$ 650,000**	**$ 1,265,390**	**$ 1,915,390**	**$ 1,288,159**

Hilltown Community Health Centers, Inc.
Grant Number : H80CS00601
QUABOAG CHC NAP BUDGET NARRATIVE

Additional Budget Narrative: QUABOAG CHC NAP
Personnel Object Class Category Justification

Federally-Supported Personnel Justification Table

Name	Position Title	% of FTE	Base Salary	Adjusted	Federal Amount Requested
E. Lake	CEO	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
F. Mertes	CFO & Chief Admin Officer	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
J. Liebman	CMO	3.4%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Physician	64.0%	$ [redacted]	$ 189,600.00	$ [redacted]
To Be Determined	Nurse Practitioner	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Nurse	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Nurse	42.7%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Medical Assistant	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Medical Assistant	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Medical Assistant	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
D. Flatt	Director of Clinical Services	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Navigator	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Community Worker	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Receptionist	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Receptionist	64.0%	$ [redacted]	no adjustment needed	$ [redacted]
To Be Determined	Site Manager	30.3%	$ [redacted]	no adjustment needed	$ [redacted]
C. McGrath	Practice Manager	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
R. Jordan	Facility /Maintenance	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
B. Blanchard	HER Specialist	3.2%	$ [redacted]	no adjustment needed	$ [redacted]
K. Nelson	Medical Biller	8.3%	$ [redacted]	no adjustment needed	$ [redacted]
D. Worpek	IT Specialist	3.2%	$ [redacted]	[redacted] adjustment needed	$ [redacted]
TOTAL					**$ 442,750**