Hilltown Community Health Center

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

BOARD MEETING
September 12, 2019
WORTHINGTON HEALTH CENTER
5:30 PM

AGENDA

1. Call to Order

2. Approval of the August 8, 2019 Meeting Minutes (Vote Needed)

3. Finance Committee Report for August (Vote Needed)

4. Committee Reports (as needed) (Vote Needed)
    - Executive Committee
    - Quality Improvement
        1. July QI Meeting Minutes
        2. Quality Improvement Plan Policy
    - Fundraising
    - Credentialing/ Privileging-(Vote Needed)
        1. New Employee:
            - Gabrielle Sheridan, Medical Assistant
            - Karen Avery, Registered Nurse
    - Personnel
    - Facilities
    - Recruiting, Orientation, and Nominating (RON)
    - Strategic Planning
    - Corporate Compliance

5. Chief Executive Officer / Senior Manager Reports

6. Old Business
    - Immunization Against Influenza Policy (Vote Needed)

7. New Business
    - Policies (Vote Needed)
        - Administrative Policies:
            - Adverse and Near Miss Incident Policy
            - Conflict of Interest Policy
            - Continuity of Operations Plan
            - Electronic Information for Collection and Use Policy
            - Establishment of Business Associates Agreements
            - Firearms in the Workplace Policy
            - Fire Safety and Evacuation Plan
            - Gift Acceptance

        - Health Center Closure Policy
        - Hours of Operation
        - Legislative Mandates
        - Patient Complaint and Grievance Policy
        - Patient Satisfaction Survey
        - Policies Policy
        - Quality Improvement Program
        - Social Media
        - Telephone Coverage
    - Corporate Compliance Policies:
        - Corporate Compliance Program
        - Staff Corporate Compliance Committee Policy
- HRSA Site Visit Training

8. Executive Session

9. Adjourn

HCHC BOARD OF DIRECTORS MEETING
Date/Time: 08/08/2019 5:30pm
Huntington Health Center

MEMBERS: John Follet, President; Nancy Brenner, Vice President; Kathryn Jensen, Clerk; Deb Leonczyk, Treasurer; Matt Bannister; Lee Manchester; Alan Gaitenby; Kate Albright-Hanna
STAFF: Frank Mertes, CFO; Tabitha Griswold, Executive Assistant; Michael Purdy, Risk Manager
GUEST: Jenicca Gallagher
ABSENT: Seth Gemme; Maya Bachman; Eliza Lake, CEO; Wendy Long

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Minutes 07/11/2019	John Follet called the meeting to order at 5:31 pm. John Follet motioned to introduce Jenicca, potential new Board Member. Introductions to Deb were made. Correction to date and location July meeting minutes. The minutes from the meeting of July 11, 2019 were reviewed. Correction made to the date and location of the following meeting. **Matt Bannister moved to approve the July Board minutes as amended. Alan Gaitenby seconded the motion, which was approved by those present.**	July 11, 2019 Board minutes as amended were approved by all present
Finance Committee	• Deb Leonczyk reported on the June 2019 financial results. Deb reported that the finance team has had a challenging time in closing the month due to the eCW problem at the end of June. Net operating deficit is still better than the prior year. The cost of the eCW problem is estimated to be about $20K additional loss in revenue. However, HSN allowed for HCHC to submit bills on accounts previously written off, which helped offset the loss from eCW. Deb reported that senior management is seeking to reclaim that loss from the eCW problem. Overall, the trend is improving from last year, the results would have been on-	The Board voted unanimously to approve the finance committee report.

	budget if dental did not suffer from staffing shortage in June. o Lee Manchester requested clarification on the $115K for capital grant in which only $8K was spent in June. Frank explained that this is due to the grant money budgeted in as revenue that was not spent out during the month. **Alan Gaitenby moved to approve the finance report, Nancy Brenner seconded the motion.**	
CEO Report	• In Eliza Lake's absence Frank Mertes explained the e-consulting as questioned by John Follet. A discussion ensued regarding the e-consult program, and how the program is currently being piloted.	
Recruitment, Orientation & Nominating (RON) Committee	• Alan Gaitenby reported that Eliza Lake informed the committee of a possible new candidate, living in the valley. The committee will be following up with this candidate.	
Corporate Compliance Committee	• This committee did not meet.	
Credentialing/ Privileging Committee	• John Follet, on behalf of the Credentialing/Privileging Committee, presented the following new employees: o Jodi Brigman, Dental Hygienist o Amanda Kathleen Sheldon, Dental Hygienist o Alexandra Kowalczyk, Dental Assistant o Ellen Chechile, RN **Alan Gaitenby moved to approve the credentialing for the slate of new employees. Nancy Brenner seconded the motion.** • John Follet, on behalf of the Credentialing/Privileging Committee, presented the following employee for re-privileging: o Julia Goncalves, LICSW **Matt Bannister moved to approve the re-privileging for Julia Goncalves, LICSW. Nancy Brenner seconded the motion.**	The Board voted unanimously to approve the credentialing and privileging of the entire slate of employees. Bridget Rida, HR Manager to notify employee(s) of the granted credentials/privileges.

	• John Follet, on behalf of the Credentialing/Privileging Committee, presented the following employee for re-credentialing and re-privileging: o Yaileen Santiago, Medical Assistant **Nancy Brenner moved to accept the re-credentialing and re-privileging for Yaileen Santiago, Medical Assistant. Alan Gaitenby seconded the motion.**	
Facilities Committee	• Alan Gaitenby reported on completed projects that included: o parking lots cleared of winter sanding o septic tank blockage has been resolved (both sites) o vacuum pump repaired in Worthington o stairway treads replaced in Huntington o new lease agreement signed for 9 Russell Road o carpets cleaned at all sites o emergency exit fixed in Huntington. • Alan reported on facilities projects planned, which included o repair to the ceiling paint in Worthington o iron hand rail rust repair in Worthington o pressure treated wood to be replaced on ramps (both sites) o siding in Huntington to be replaced with same scalloping o updates to the dental rooms in Worthington	
Personnel Committee	• John Follet reported that the committee met to review the Employee Handbook and Human Resource policies as presented at this meeting. The minutes for the previous Personnel Committee meeting were handed out and reviewed by those present.	
Strategic Planning	• This committee has not met. Deb Leonczyk offered to the chair of the committee to join. This committee is slated to meet soon.	
Fundraising Committee (ad hoc)	• Nancy Brenner reported that the committee has not met since the last meeting. Due to meet early September.	
Quality Improve-ment/Risk	• Kathryn Jensen reported on the last QI meeting, the primary discussion being the eCW issue and what that meant for the staff. A discussion ensued on any HIPAA	

Management Committee	implications, and steps taken to mitigate that risk. Kathryn reported that the Patient Satisfaction Surveys and Diabetes Action Plan were also discussed at the June QI meeting, and are included in the Board meeting materials for Board review.	
Committee Reports	**Matt Bannister moved that the committee reports be approved. Kathryn Jensen seconded the motion.**	Committee reports presented at this meeting were approved unanimously.
Old Business	• John Follet present the By-laws and discussed updates presented at the previous meeting. A discussion ensued on section 8a for interpretation. **Lee Manchester moved to approve the By-Laws as written. Deb Leonczyk seconded the motion.**	The Board voted unanimously to approve the By-laws.
New Business	• John Follet reported on the Employee Handbook. The handbook is meant to be informational, and where there is not a written policy (as referenced) the handbook is policy. There was lawyer and staff involvement in the past two years to compile this updated handbook. **Nancy Brenner moved to accept the Employee Handbook. Matt Bannister seconded the motion.** • John requested an abbreviated agenda for the September Board meeting to allow time for the HRSA Site Visit training. • The following HR policies were reviewed. o Immunization Against Influenza Policy o Communicable Diseases Policy o Criminal Offender Record Information Policy • Board inclusion on the Immunization Against Influenza Policy was discussed. Clarification on other health center procedures, and proof needed was requested by the membership present. Language in the policy was requested to change the term vaccination to immunization. Without a majority vote on to approve the policy, this policy will be discussed at the next meeting with clarification on the above questions.	The Board voted unanimously to approve the Employee Handbook. The Board voted unanimously to approve the Communicable Diseases and Criminal Offender Record Information policies. The Board voted unanimously to approve the

	Nancy Brenner moved to accept the Communicable Diseases and Criminal Offender Record Information Policy. Deb Leonczyk seconded the motion. • The following Medical Policies were reviewed: o Acceptance of Guidelines for Evidence-Based Care policy o Assigning New Patients to a Primary Care Provider o Coordination Care Transitions Policy o Diagnostic Imaging Tracking Policy o Disposal of Outdated Controlled Substances or Prescriptions Medications Policy o Department of Transportation Physicals (DOT) Policy o Hospital/ ER Follow Up Policy o Internal Paper Chart Retrieval Request Policy o Provider On-Call Policy o Reproductive Health Services Policy o Supervision of Nurse Practitioners Policy o Tracking Patient Referrals Policy o Welcome for New Medical Patients **Kathryn Jensen made a motion to approve the entire slate of Medical Policies. Matt Bannister seconded the motion.**	Medical Policies.
Approval of new Membership	• Alan Gaitenby introduced Jenicca Gallagher tonight for Board consideration. Jenicca currently works in banking and is a valley resident, living and working close to the John P. Musante Health Center. **Alan Gaitenby moved to approve the acceptance of the new Board member. Deb Leonczyk seconded the motion.**	The Board voted unanimously to approve the nomination of Jenicca Gallagher.
Executive Committee	• **The Board moved to executive session.**	
Next Meeting	**With no further business to discuss, Nancy Brenner made a motion to adjourn this meeting and Deb Leonczyk seconded the motion. The motion was approved.** The meeting adjourned at 7:06pm. The next scheduled meeting is set for September 12, 2019 at 5:30pm in Worthington.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

HILLTOWN COMMUNITY HEALTH CENTERS
FINANCIAL SUMMARY FOR BOARD MEETING September 12, 2019

July 2019 Results

In July 2019 we had a Net Operating Deficit of $74,132 and an overall positive net result of $46,930. The Net Operating Deficit is $16,850 better than budgeted. The positive net results was due to non-operating donations of $121,062.

Regarding YTD through July 2019 we had a Net Operating Deficit of $199,428 and an overall Deficit of $62,436. The Net Operating YTD Deficit is $62,085 better than budgeted.

The YTD Visit and Net Revenue per visit are summarized as follows:

YTD Visits	**Act.**	**Bud.**	**Over (Under) Budget**
Medical	10,591	10,660	(69)
Dental	9,856	10,451	(595)
Beh. Health	2,446	2,299	147
Optometry	1,357	1,400	(43)

YTD Net Rev. Per Visits	**Act.**	**Bud.**	**Over (Under) Budget**
Medical	$144.48	$134.27	$10.20
Dental	$115.93	$113.66	$2.27
Beh. Health	$89.28	$84.66	$4.62
Optometry	$84.69	$84.59	$0.10

We continue to watch cash flows very carefully as our operating cash on-hand is only 9 days.

Please see detailed statements for more information regarding balance sheet, departmental net results, visits and ratios.

Hilltown CHC
Dashboard And Summary Financial Results
July 2019

	Actual YTD June 2018	Actual YTD Dec. 2018	Actual YTD Jan. 2019	Actual YTD Feb. 2019	Actual YTD Mar. 2019	Actual YTD Apr. 2019	Actual YTD May 2020	Actual YTD Jun. 2019	Actual YTD July 2019	Notes on Trend	Cap Link TARGET	COMMENT
Liquidity Measures												
Operating Days Cash	3	9	10	11	10	13	5	5	9	Measures the number of days HCHC can cover daily operating cash needs.	> 30-45 Days	Not Meeting Benchmark
Current Ratio	0.84	0.83	0.76	0.72	0.73	0.76	0.80	0.81	0.87	Measures HCHC's ability to meet current obligations.	>1.25	Not Meeting Benchmark
Patient Services AR Days	34	36	37	35	36	35	34	33	32	Measures HCHC's ability to bill and collect patient receivables	< 60-75 Days	Doing Better than Benchmark
Accounts Payable Days	64	29	29	36	33	38	33	45	38	Measures HCHC's ability to pay bills	< 45 Days	Meeting Benchmark
Profitability Measures												
Net Operational Margin	-5.5%	-4.8%	-15.3%	-13.6%	-9.1%	-6.2%	-3.3%	-3.1%	-4.2%	Measures HCHC's Financial Health	> 1 to 3%	Not Meeting Benchmark
Bottom Line Margin	5.6%	1.2%	-15.3%	-13.6%	-8.7%	-5.9%	-2.9%	-2.7%	-1.3%	Measures HCHC's Financial Health but includes non-operational activities	> 3%	Not Meeting Benchmark
Leverage												
Total Liabilities to Total Net Assets	26.3%	32.6%	36.0%	37.5%	38.0%	39.5%	32.7%	34.3%	33.6%	Measures HCHC's total Liabilities to total Net Assets	< 30%	Not Meeting Benchmark
Operational Measures												
Medical Visits	8,863	18,166	1,726	3,115	4,638	6,250	7,787	9,048	10,591			
Net Medical Revenue per Visit	$ 144.02	$ 143.59	$ 132.36	$ 137.66	$ 140.35	$ 141.21	$ 142.01	$ 145.41	$ 144.48			
Dental Visits	7,426	15,537	1,476	2,791	4,272	5,815	7,388	8,681	9,856			
Net Dental Revenue per Visit	$ 115.98	$ 112.76	$ 109.32	$ 111.36	$ 114.63	$ 114.28	$ 114.98	$ 115.08	$ 115.93			
Behavioral Health Visits	2,120	4,306	427	736	1,089	1,407	1,799	2,079	2,446			
Net BH Revenue per Visit	$ 89.42	$ 87.74	$ 80.11	$ 79.70	$ 78.93	$ 83.02	$ 82.26	$ 89.08	$ 89.28			
Optometry Visits	1,124	2,381	222	395	592	811	1,001	1,178	1,357			
Net Optometry Revenue per Visit	$ 85.75	$ 86.40	$ 77.49	$ 79.27	$ 83.62	$ 84.36	$ 86.95	$ 92.71	$ 84.69			

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

	July 2019 Actual	July 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	214,450	176,235	38,215	1,530,155	1,431,366	98,789	1,493,692	36,463
Visits	1,543	1,220	323	10,591	10,660	(69)	10,233	358
Revenue/Visit	$ 138.98	$ 144.45	$ (5.47)	$ 144.48	$ 134.27	$ 10.20	$ 145.97	$ (1.49)
Patient Services - Dental	143,618	176,674	(33,056)	1,142,594	1,187,883	(45,289)	1,006,794	135,800
Visits	1,175	1,543	(368)	9,856	10,451	(595)	8,719	1,137
Revenue/Visit	$ 122.23	$ 114.50	$ 7.73	$ 115.93	$ 113.66	$ 2.27	$ 115.47	$ 0.46
Patient Services - Beh. Health	33,178	24,360	8,818	218,385	194,638	23,747	222,343	(3,958)
Visits	367	280	87	2,446	2,299	147	2,441	5
Revenue/Visit	$ 90.40	$ 87.00	$ 3.40	$ 89.28	$ 84.66	$ 4.62	$ 91.09	$ (1.80)
Patient Services - Optometry	5,705	17,908	(12,203)	114,922	118,421	(3,499)	120,601	(5,679)
Visits	179	205	(26)	1,357	1,400	(43)	1,326	31
Revenue/Visit	$ 31.87	$ 87.36	$ (55.48)	$ 84.69	$ 84.59	$ 0.10	$ 90.95	$ (6.26)
Patient Services - Optometry Hardware	6,775	7,000	(225)	53,988	51,163	2,825	46,984	7,004
Patient Services - Pharmacy	10,081	16,000	(5,919)	64,013	83,717	(19,704)	68,626	(4,613)
Quality & Other Incentives	7,774	276	7,498	35,532	19,018	16,514	10,617	24,915
HRSA 330 Grant	134,041	168,659	(34,618)	959,780	1,069,191	(109,411)	910,222	49,558
Other Grants & Contracts	49,002	48,259	743	521,663	459,193	62,470	581,080	(59,417)
Int., Dividends Gain /(Loss) Investments	447	2,530	(2,083)	41,769	37,710	4,059	17,817	23,952
Rental & Misc. Income	2,574	2,567	7	18,427	17,678	749	18,210	217
Total Operating Revenue	607,645	640,468	(32,823)	4,701,228	4,669,978	31,250	4,496,986	204,242
Compensation and related expenses								
Salaries and wages	463,714	499,556	(35,842)	3,242,119	3,319,744	(77,625)	3,320,838	(78,719)
Payroll taxes	33,781	38,216	(4,435)	256,413	256,849	(436)	248,358	8,055
Fringe benefits	41,818	41,614	204	273,698	289,690	(15,992)	278,382	(4,684)
Total Compensation & related expenses	539,313	579,386	(40,073)	3,772,230	3,866,283	(94,053)	3,847,578	(75,348)
No . of week days	23	23	-	152	152	-	152	-
Staff cost per week day	$ 23,448	$ 25,191	$ (1,742)	$ 24,817	$ 25,436	$ (619)	$ 25,313	$ (496)

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

	July 2019 Actual	July 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	572	350	222	6,937	11,353	(4,416)	3,457	3,480
Bad debt	(1,972)	5,075	(7,047)	98,272	49,972	48,300	44,419	53,853
Computer support	7,125	6,537	588	49,734	45,440	4,294	49,561	173
Conference and meetings	135	405	(270)	5,695	2,514	3,181	3,331	2,364
Continuing education	1,529	3,870	(2,341)	20,287	22,250	(1,963)	10,865	9,422
Contracts and consulting	9,347	3,470	5,877	54,910	22,453	32,457	21,647	33,263
Depreciation and amortization	27,651	27,651	0	193,554	193,554	(0)	99,437	94,117
Dues and membership	5,168	3,134	2,034	20,696	20,621	75	15,185	5,511
Equipment leases	2,927	2,107	820	16,904	14,710	2,194	14,543	2,361
Insurance	2,107	2,119	(12)	14,775	14,824	(49)	13,208	1,567
Interest	1,306	1,360	(54)	9,438	9,689	(251)	10,369	(931)
Legal and accounting	2,311	2,888	(577)	16,329	18,813	(2,484)	19,357	(3,028)
Licenses and fees	4,625	4,660	(35)	28,297	30,683	(2,386)	34,542	(6,245)
Medical & dental lab and supplies	8,151	12,100	(3,949)	76,797	79,939	(3,142)	71,027	5,770
Merchant CC Fees	1,449	1,515	(66)	10,908	10,573	335	10,772	136
Office supplies and printing	2,799	3,586	(787)	20,441	23,094	(2,653)	30,336	(9,895)
Postage	172	1,575	(1,403)	8,800	10,971	(2,171)	9,722	(922)
Program supplies and materials	17,899	18,975	(1,076)	135,814	133,326	2,488	154,238	(18,424)
Pharmacy & Optometry COGS	9,731	10,340	(609)	58,030	68,482	(10,452)	53,934	4,096
Recruitment	1,042	225	817	4,024	675	3,349	284	3,740
Rent	8,752	5,538	3,214	43,306	40,218	3,088	23,698	19,608
Repairs and maintenance	8,267	13,934	(5,667)	92,655	93,000	(345)	104,750	(12,095)
Small equipment purchases	2,360	175	2,185	6,396	4,824	1,572	5,146	1,250
Telephone/Internet	14,029	13,696	333	89,652	95,797	(6,145)	75,811	13,841
Travel	1,269	2,280	(1,011)	14,603	13,894	709	14,483	120
Utilities	3,713	4,500	(787)	31,173	33,539	(2,366)	32,666	(1,493)
Loss on Disposal of Assets	-	-	-	-	-	-	-	-
Total Other Operating Expenses	142,464	152,064	(9,600)	1,128,427	1,065,208	63,219	926,788	201,639
Net Operating Surplus (Deficit)	**(74,132)**	**(90,982)**	**16,850**	**(199,429)**	**(261,513)**	**62,084**	**(277,380)**	**77,951**
NON-OPERATING ACTIVITIES								
Donations, Pledges & Contributions	121,062	-	121,062	128,919	430	128,489	32,435	96,484
Loan Forgiveness	-	-	-	-	-	-	-	-
Capital Grants	-	-	-	8,073	115,234	(107,161)	404,993	(396,920)
Net Non-operating Surplus (Deficit)	**121,062**	**-**	**121,062**	**136,992**	**115,664**	**21,328**	**437,428**	**(300,436)**
NET SURPLUS/(DEFICIT)	**46,930**	**(90,982)**	**137,912**	**(62,437)**	**(145,849)**	**83,412**	**160,048**	**(222,485)**

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

	July 2019	July Budget	Over (Under) Budget	YTD	YTD Budget	Over (Under) Budget	PY YTD	Cur. v. PY YTD
Operating								
Medical	$ (34,514)	$ (89,994)	$ 55,480	$ (209,067)	$ (311,561)	$ 102,494	$ (203,110)	$ (5,957)
Dental	(30,221)	(12,093)	(18,128)	(117,648)	(87,838)	(29,810)	(174,989)	$ 57,341
Behavioral Health	4,877	(1,649)	6,526	25,186	17,567	7,619	16,433	$ 8,753
Optometry	(10,009)	(1,692)	(8,317)	(19,059)	(19,184)	125	(4,149)	$ (14,910)
Pharmacy	9,193	14,859	(5,666)	62,516	77,368	(14,852)	62,070	$ 446
Community	1,963	(1,197)	3,160	(1,523)	(17,759)	16,236	3,779	$ (5,302)
Fundraising	(9,247)	(5,147)	(4,100)	(31,743)	(34,761)	3,018	(42,187)	$ 10,444
Admin. & OH	(6,174)	5,931	(12,105)	91,910	114,655	(22,745)	64,773	$ 27,137
Net Operating Results	**$ (74,132)**	**$ (90,982)**	**$ 16,850**	**$ (199,428)**	**$ (261,513)**	**$ 62,085**	**$ (277,380)**	**$ 77,952**
Non Operating								
Donations	$ 121,062	$ -	$ 121,062	$ 128,919	$ 430	$ 128,489	$ 32,435	$ 96,484
Capital Project Revenue	-	-	-	8,073	115,234	(107,161)	404,993	$ (396,920)
Total	**$ 121,062**	**$ -**	**$ 121,062**	**$ 136,992**	**$ 115,664**	**$ 21,328**	**$ 437,428**	**$ (300,436)**
Net	**$ 46,930**	**$ (90,982)**	**$ 137,912**	**$ (62,436)**	**$ (145,849)**	**$ 83,413**	**$ 160,048**	**$ (222,484)**

Hilltown Community Health Centers

Balance Sheet - Monthly Trend	Actual Dec 2018	Actual Jan 2019	Actual Feb 2019	Actual Mar 2019	Actual Apr 2019	Actual May 2019	Actual Jun 2019	Actual Jul 2019	Budget Jul 2019	Over (Under) Jul 2019
Assets										
Current Assets										
Cash - Operating Fund	$ 197,997	$ 233,851	$ 252,962	$ 242,277	$ 304,099	$ 121,029	$ 127,634	$ 203,663	$ 112,202	$ 91,461
Cash - Internally Restricted	6,152	1,051	12,402	12,404	12,407	16,966	16,974	105,066	5,402	99,663
Patient Receivables	945,217	1,032,027	970,729	1,013,085	1,022,798	1,030,805	1,003,848	979,376	950,000	29,376
Less Allow. for Doubtful Accounts	(109,786)	(118,366)	(128,973)	(133,664)	(138,929)	(147,664)	(182,145)	(173,750)	(120,000)	(53,750)
Less Allow. for Contractual Allowances	(317,200)	(374,895)	(344,593)	(351,978)	(362,443)	(364,592)	(322,364)	(337,355)	(350,000)	12,645
A/R 340B-Pharmacist	32,188	7,390	(1,455)	11,707	19,273	22,642	27,251	21,334	5,000	16,334
A/R 340B-State	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	1,827	-
Contracts & Grants Receivable	69,673	62,015	65,280	63,523	97,647	111,839	135,003	115,378	65,000	50,378
Prepaid Expenses	14,866	16,298	20,021	20,962	21,364	23,646	71,882	23,389	12,521	10,867
A/R Pledges Receivable	28,828	26,328	15,360	15,360	15,360	15,360	15,360	16,660	10,360	6,300
Total Current Assets	869,761	887,526	863,561	895,504	993,403	831,858	895,270	955,587	692,313	263,275
Property & Equipment										
Land	204,506	204,506	204,506	204,506	204,506	204,506	204,506	204,506	204,506	-
Buildings	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	2,613,913	-
Improvements	911,848	911,848	911,848	929,483	929,483	929,483	929,483	929,483	911,848	17,635
Leasehold Improvements	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	1,933,674	-
Equipment	1,288,156	1,288,156	1,288,156	1,293,868	1,293,868	1,293,868	1,293,868	1,293,868	1,288,156	5,713
Construction in Progress	-	-	12,348	-	-	-	-	-	115,234	(115,234)
Total Property and Equipment	6,952,096	6,952,096	6,964,444	6,975,444	6,975,444	6,975,444	6,975,444	6,975,444	7,067,330	(91,886)
Less Accumulated Depreciation	(2,430,365)	(2,458,016)	(2,485,666)	(2,513,317)	(2,540,968)	(2,568,618)	(2,596,269)	(2,623,919)	(2,623,919)	-
Net Property & Equipment	4,521,731	4,494,080	4,478,778	4,462,127	4,434,476	4,406,826	4,379,175	4,351,525	4,443,411	(91,886)
Other Assets										
Restricted Cash	53,713	53,713	53,712	53,721	53,730	53,739	53,748	53,762	53,712	50
Pharmacy 340B and Optometry Inventory	11,811	12,249	11,909	13,494	13,081	13,505	13,540	13,131	11,909	1,222
Investments Restricted	6,661	6,661	6,661	7,446	7,446	7,446	7,861	7,861	6,661	1,200
Investment - Vanguard	227,889	247,383	255,060	258,439	267,662	251,319	267,882	269,940	265,560	4,380
Total Other Assets	300,074	320,006	327,342	333,100	341,919	326,009	343,031	344,693	337,842	6,851
Total Assets	**$ 5,691,566**	**$ 5,701,613**	**$ 5,669,681**	**$ 5,690,731**	**$ 5,769,798**	**$ 5,564,693**	**$ 5,617,476**	**$ 5,651,805**	**$ 5,473,566**	**$ 178,239**
Liabilities & Fund Balance										
Current & Long Term Liabilities										
Current Liabilities										
Accounts Payable	$ 164,918	$ 180,932	$ 225,470	$ 208,209	$ 242,280	$ 213,946	$ 299,353	$ 244,976	$ 225,000	$ 19,976
Notes Payable	300,000	300,000	300,000	300,000	276,920	253,840	237,270	222,363	215,000	7,363
Sales Tax Payable	56	23	39	44	30	47	66	11	-	11
Accrued Expenses	60,334	61,951	46,717	51,693	56,753	55,562	54,879	62,812	50,000	12,812
Accrued Payroll Expenses	386,764	481,414	480,774	511,383	547,820	388,378	371,976	418,473	365,250	53,223
Payroll Liabilities	20,702	17,285	15,242	13,947	15,394	16,563	17,152	16,388	16,000	388
Unemployment Escrow	826	826	826	826	826	826	826	826	826	-
Line of Credit ($100,000 Limit)	-	-	-	-	-	-	-	-	-	-
Deferred Contract Revenue	120,296	124,247	136,693	143,579	159,171	111,322	123,018	128,698	126,693	2,005
Total Current Liabilities	1,053,896	1,166,677	1,205,760	1,229,681	1,299,194	1,040,484	1,104,540	1,094,548	998,769	95,779
Long Term Liabilities										
Mortgage Payable United Bank	167,900	166,455	165,007	163,512	162,054	159,117	159,117	157,635	158,007	(372)
Mortgages Payable USDA Huntington	176,837	175,775	174,707	173,542	172,462	171,346	170,253	169,126	169,707	(581)
Total Long Term Liabilities	344,737	342,230	339,714	337,054	334,516	330,463	329,370	326,760	327,714	(953)
Total Liabilities	**1,398,633**	**1,508,907**	**1,545,474**	**1,566,735**	**1,633,710**	**1,370,947**	**1,433,910**	**1,421,308**	**1,326,482**	**94,826**
Fund Balance / Equity										
Fund Balance Prior Period	4,292,933	4,192,706	4,124,206	4,123,996	4,136,088	4,193,746	4,183,566	4,230,497	4,147,084	83,413
Total Fund Balance / Equity	4,292,933	4,192,706	4,124,206	4,123,996	4,136,088	4,193,746	4,183,566	4,230,497	4,147,084	83,413
Total Liabilities & Fund Balance	**$ 5,691,566**	**$ 5,701,613**	**$ 5,669,681**	**$ 5,690,731**	**$ 5,769,798**	**$ 5,564,693**	**$ 5,617,476**	**$ 5,651,805**	**$ 5,473,566**	**$ 178,239**
Current Ratio	**0.83**	**0.76**	**0.72**	**0.73**	**0.76**	**0.80**	**0.81**	**0.87**	**0.69**	

QI-RISK MANAGEMENT COMMITTEE

Location: Huntington Health Center
Date/Time: 07/16/2019 9:15am

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

ABSENT: Seth Gemme, Board Representative; Jon Liebman, ANP; Cynthia Magrath, Practice Manager

Agenda Item	Summary of Discussion	Decision/ Next Steps/ Person Responsible/ Due Date
Review of June 18, 2019 Minutes	The meeting was called to order by Kathryn Jensen at 9:16 am. The minutes from June 18, 2019 meeting were reviewed. Correction noted in minutes that Kathryn Jensen submitted the minutes for the June, not Dawn Flatt. **Eliza Lake motioned to approve, Kim Savery seconded the motion.**	June 18, 2019 Minutes were approved unanimously pending correction.
Old Business	There was no old business to report.	
Risk Management	• Michael Purdy reported on the two new incident reports. The first was a patient in eye care with an infection in front of the orbit that needed antibiotics. The patient was not a medical patient and was referred to the reception office to make an appointment. The receptionist (as she had been instructed to do) informed the patient that they were not accepting new patients at this site. There was therefore a risk that the patient would not get seen but the Optometrist was informed of the conversation, and was able to do a warm hand off to assure that the patient was seen immediately and received the care needed. To mitigate the risk of this incident happening again, providers are informed to accompany the patients to reception when doing a warm transfer internally. The second incident was an abnormal lab that came back and was scanned in to wrong patient record. The wrong patient was called and informed of the abnormal lab. A nurse saw that the name on the lab did not match the record, and the incorrect patient was notified of the mistake. Meanwhile, the lab had notified the PCP about the correct patient directly, so there was no delay in care. To mitigate the risk of this happening again, all providers are reminded to check patient names on all labs to make sure it corresponds with the correct patient. • Michael Purdy reported on the eCW upgrade failure at the end of June. The incident was a direct result of eCW separating two practices that had been	

	sharing a server, and data from another practice being mixed into our database. There was a week's worth of documentation in eCW on the corrupted database that needed to be recovered. The team that came together to recover this material has been working extended hours and diligently recovering visits, referrals, billing claims, and all telephone encounters (TE). All departments, except for dental, were impacted by this incident. Eliza reported that HCHC will be working with CDH on the legal/HIPAA implication of this incident. Meanwhile there will be a time limit placed on the availability of the corrupted database before it is expunged to safe guard patient information. Efforts to recover all lost material continue, and patients continue to be seen safely. There were no adverse incidents of any kind as a result of this situation, which is a credit to the staff involved in addressing it.	
Eye Care Department	• Michael Purdy reported that there were no legal or patient complaints to report.	
Patient Satisfaction Survey Results	• Eliza Lake reported on the patient satisfaction survey results for Eye Care, Dental, BH and Community Programs. Results are combined between sites by department. There was a comparison for 2018 and 2019 for Eye Care and Dental Departments. Overall, there were positive results in all departments. Demographics were included as a review for population needs being met. It was noted that Dental had numerous positive comments included.	.
Diabetes Action Plan	• Dawn Flatt reported on the update made to the action plan, as well as to where we were at with the proposal. Dawn has vetted the patients to ensure any that needed appointments received them. This information was collected on the small subset of patients who met the criteria. Following Dawn's audits, she found that we are on task and our percentages were where they need to be at. There is a total of three goals-referrals to CHWs, Medical and Nutrition. Overall, Dawn is very happy with the efficiency in the system.	
Adjourn	Katheryn Jensen moved that the meeting be adjourned, the meeting was adjourned at 10:01am. The next meeting is scheduled for **Tuesday, August 20, 2019** at 9:15am at the Huntington Health Center.	

Respectfully submitted,
Tabitha Griswold, Executive Assistant

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

Goal Areas and Progress Reports

Goal 1: Health Care System Integration and Financing

Community Care Cooperative (C3) ACO: This month we were asked to select HCHC's risk tier for our participation in C3 for 2020. It did not take a lot of consultation to determine that we want to remain in Tier 3, which is the lowest level of risk and benefit possible. This means that we will continue to have a staff person from C3 on-site to do our comprehensive care management, and that while we will receive some federal DSRIP funding (which covers some of our costs of participation), we don't get as much as we would if we took on a lot of risk. Yesterday I was briefed on our status so far this year, and we are about where we ended up for last year – slightly negative, which means that were the year ending now, we might have to pay about $6,000. There are many ways that we could reduce this cost, and I think that some of the activities of our HMA consultant, whose assessment I sent you earlier in the week, will help. For instance, she is going to help develop better communication between our billing department and providers, enabling us to do a better job coding our patients and the complexity of their care, which means the expectation of how much money they cost MassHealth also goes up. She is also going to be helping with our tracking and addressing our quality metrics, which would also help us with obtaining more federal quality incentive program. So while we continue to learn about how to work within C3's model, and we are doing things to improve our situation both within C3 and in the larger environment.

Hospital Engagement: I spoke with **Cooley**'s CEO Joanne Marqusee yesterday, and we laughed about all the ways in which we are working together right now:

- We have a signed Non-Disclosure Agreement, which will allow us to share data so that we can better understand the case for and against a collaboration on a primary care site. The summer slowed down this conversation, but I think it will now pick up some momentum.
- We talked last week about the fact that Cooley hired away one of our doctors, and Joanne apologized and said that they had not actively recruited her away from us. I responded by telling her how detrimental this loss will be to our ability to meet the needs of our patients, and asked that Cooley do anything it can to help us recruit temporary or permanent providers. Here are some of the things she committed to and, in some cases, has already started work on: including HCHC in their efforts to recruit at conferences and other events; reaching out to retiring PCPs in their system to see if they would be interest in working for us part time; exploring whether there are other staff that would like additional hours that we could "lease" for use at our sites; and reaching out to community providers that she knows might be interested in working for us.
- Frank is working with the Cooley IT Director on the possibility of recouping some of the costs HCHC bore with the electronic health record (EHR) debacle this summer.

I brokered a meeting between **Noble Hospital**'s president, Ron Bryant, and the director of harm reduction at Tapestry last month to talk about the work Tapestry does around substance use disorder, and, in particular, the opioid crisis. Noble received a $100,000 earmark to address opioids, and I will be meeting with their VP for Community Engagament and Ron next month to talk about how Noble can do a better job of partnering with community organizations that are, or should be, in the Westfield area to address this issue. I believe I have mentioned this before, but it turns out that the majority of the people who use Noble are from the Hilltowns, not Westfield, which explains why they asked me to chair the Community Benefits Advisory Council. This has made me much more comfortable in being directive about how Noble needs to address community needs. For instance, Baystate is about to release a substantial amount of money in community benefits, and I want to make sure that Noble casts the net widely in its grant-making.

EHR Transition: As mentioned above, Frank is still working on getting reparations for the June incident. That situation occurred as part of our preparations for upgrading eCW (our EHR) to the latest software version. This upgrade was completed last weekend, and it went very smoothly. There were very few disruptions, although as staff continue to use the software, I'm sure they will discover the ways in which it is different from the previous version. Frank and his team, including and especially Briana Blanchard, our EHR specialist, did a fabulous job preparing and testing the new version, and then provided training to staff prior to the upgrade. Everyone had crossed fingers on Monday morning, and everything starting without problems was undermined by the internet in Worthington being (coincidentally) out of commission. Daniel Worpek, our IT manager, got it up and going in 30 minutes, and I haven't heard any other complaints all week about the system. Now we need to upgrade all the computers operating systems, and the team is beginning to focus on getting that done asap.

Goal 2: HCHC Expansion

John P. Musante Health Center (JPMHC): While there is always happening in Amherst, the primary focus of the management team right now is developing a plan to ensure that we can continue to see medical patients once our providers both leave this fall. It is not an easy conversation, and it has repercussions for the entire organization, as we will have to move people from other sites and cobble together a new team. We will bring the plan to the Board once it is finalized, but it seems likely that one or more sites will not be able to open five days a week, and will have to close one or two days. Providers have agreed to take on additional hours, and in addition to the conversations with Cooley outlined above, we are:

- Working with our recruiter to identify MD candidates – we are being visited by one at the end of next week who looks very promising, but at this point we could hire at least two and still not be over staffed. The recruiter also has identified a possible NP candidate, which is outside the scope of our contract, but we agreed that we would work out the details later as needed.
- Talking with a couple of NPs who might be interested in working a few days now, and potentially expanding days per week in the future.
- Talking with firms about taking on *locum tenens* MDs or NPs, which means temporary staff who would come in for a limited amount of time and be paid an hourly rate. This is a very expensive option, and we are researching to make sure that it makes sense on a whole host of levels (in terms of finances, quality, etc). We are getting pressure from some providers to do so, but we

also know that they will be the first to be upset if we do not have *locums* that meet their standards.

In the meantime, I have met with the new director of the Amherst Council on Aging, who is very interested in supporting us in any way possible, including helping resolve some of the space and internet issues we've faced with our Navigator and Behavioral Health provider.

340B Pharmacy Program: As you may remember, expansion of our pharmacy program has been on our strategic plan since 2017, but we have tabled it given the complexity of the issue and all the other expansion activities that were going on. Gail Mayeaux, our HMA consultant, has brought it back to the fore by suggesting that instead of building a brick-and-mortar pharmacy, we create a mail-order pharmacy program that would allow all of our patients better access to prescriptions while increasing our revenue substantially. She and Frank are working together on this project, and are meeting with possible venders. In many ways, this option (which we were unaware of when we wrote the Strategic Plan) makes so much sense, given that many insurances require patients to use a mail-order service instead of a local pharmacy. We will continue to report on this, but it is a very exciting, behind-the-scenes way to address some of our cash flow issues.

Integrated Behavioral Health Services (IBHS): We learned at the end of August that we were awarded funding under the federal IBHS program, and in fact received $22,000 more than we requested (as is normal with these sorts of HRSA grants). We have amended our proposed budget, and will spend the money on a new full-time behavioral health (BH) provider, a BH coordinator (a new position that will cover a range of responsibilities and will likely be a BSW-level position), and about five hours a week for a consulting psychiatrist. We are setting up a meeting with a local BH organization that is very interested in our contracting with them for the psychiatric services, which we plan will both be a resource for our medical and BH providers for consultations, and also eventually available for tele-psychiatry with our patients.

Telehealth: While there is a lot to figure out still, we have on-site our new telehealth mobile carts, which are essentially tablets on wheels. At first, we plan to use these for video translation for our patients that use American Sign Language, but as noted above, we will also focus immediately on developing a way for our patients to be at our site and have a visit with a psychiatrist. There are many other potential uses, including patients at one site (with a nurse or other clinical staff member) being seen by a provider at another site. But that scenario is very dependent upon our learning more about what is possible in Massachusetts' insurance system – we lag far behind other states in payment for such visits, and we want to make sure that whatever we do is sustainable.

Goal 3: Improved Organizational Infrastructure

The Corporate Compliance Committee met this month, and I have attached the minutes of the meeting. We reviewed our workplan, and noted issues that needed attention or were currently being addressed. As I note at most Board meetings, compliance is an everyday activity, and I am very pleased when managers immediately think of the implications of their proposals to our HRSA scope, for instance. But, with the HRSA Operational Site Visit occurring this November, we want to make sure that we are completely compliant with all of our HRSA requirements. As you will learn at the Board meeting when

you receive Mary Ellen McIntyre's training, there are many elements to track and keep on top of, and we want to make sure you that you know we are doing so.

A few other notes:

- Gail Mayeaux from HMA will be working with us to examine and reconfigure our **organizational chart**, but she has told us that she thinks that most of staffing levels are completely appropriate for our size and mission. She has identified that middle management needs attention in terms of training, accountability, job duties, etc. Next week she will meet with all of our middle managers to start team-building and training, and I am very excited about the prospect of regular and substantive conversations and support for this critical group of staff. She also going to look at the Senior Management structure, and will likely recommend that we create a Chief Operating Officer position again, but we have a lot of work to figure out how this position will interact with existing staff positions before we move forward with it.
- Gail is also developing a comprehensive **communication structure** for the organization, which will start with me and my ability to convey a message to everyone that will bring us together as an organization. She's already given me a template for monthly emails, and a procedure for making them happen, and we have discussed monthly presentations to all staff as well. We have known for a long time that this was needed, but having someone hand us ready-made systems of communication is incredibly helpful.
- Gail has also answered the Board's **question about policies** that MUST be approved by the Board, and those that do not, and Tabitha and I will explain to you either this month or next what we've learned, and how this will make all of our lives easier. We are still digesting this information, so we thought we should stay on track with the policies that are on the agenda.
- We have signed contracts with Valley Communications to install **teleconferencing equipment** at all sites, which will happen in early October. This will allow for people to participate in staff meetings, consultations, and Board meetings at different sites. The teleconferencing technology has become familiar to us over the last year (we all "Zoom" meetings every week), and now we will have the technology to do so on something other than our laptops. This will, we are sure, make our operations smoother and easier, and potentially make it easier for the Board to recruit members from further away.
- Today I attended a half day session on how to increase the **diversity of non-profit Boards of Directors**, and I will bring these resources to the RON Committee for a conversation. One thing that stood out that I would like the Board to consider: most organizations call these committees their Governance Committee, which I think is a good idea. It means that conversations about the Board's members, structure, self-evaluation, by-laws, etc, could all be held in one place. Something to consider.
- I somewhat regularly get **mail addressed to Board members**, past or present. I would like the Board to give me authorization to open this mail as I see fit, and pass on what is appropriate. Mostly it is junk mail, and I don't like to recycle something addressed to someone else, but I also don't think that you would have any interest in its contents.
- I also receive, through email, mail, and presentations at meetings, incredibly useful and relevant reports and studies that I think the Board might be interested in seeing. I would like to propose that I put links to these documents in my monthly report, so that you may peruse them as your time and interest dictate. Here is a sample:
    - The Commonwealth Fund: Health Insurance Coverage Eight Years After the ACA

- Massachusetts Health Policy Forum: Addressing the Opioid Crisis in Small and Rural Communities in Western Massachusetts
- Blue Cross/Blue Shield Foundation of MA: The Geography of Uninsurance in Massachusetts: An Update for 2013-2017 (and they have a ton of other reports about uninsurance in Massachusetts, including here and here)

CORPORATE COMPLIANCE MEETING
Date/Time: 09/03/2019 2:30pm
Worthington Health Center

PRESENT: Eliza Lake, CEO and Compliance Officer; Michael Purdy, CCCSO; Frank Mertes, CFO; Tabitha Griswold, Executive Assistant

Agenda Item	Summary of Discussion	Decisions/ Next Steps/ Person Responsible Due Date
Review of Corporate Compliance Work Plan	The Committee reviewed and discussed the Corporate Compliance Work Plan for corrections, additions and updates as needed. • Agreed to change the name of checklist to Corporate Compliance Work Plan • Gail Mayeaux is helping to train on billing/coding for billing staff, providers, etc. • The auditors check for billing accuracy during the annual audit and Gail Mayeaux is looking into claim denials. • Discussed whether supplemental income disclosure has a form and if it is done annually. This may require more training of department heads on obtaining disclosures in writing. • Discussion on disclosures of relatives of staff done annually. • The training program for staff has recently been updated with more accurate dates. There is a focus on the diversity training currently. Bridget working on learning how to upload a voice over to the training. Miranda will do that voice over. • Eliza met with Daniel to review HIPAA regulations as applied to IT, there was no new risk identified. This will be reported to the QI/RM Committee in September. • Review and updating of HRSA Form 5A to be done on September 24th. • More review and development of patient complaint process needed.	Ask Bridget whether there is a supplemental income form and if this is done annually. Ask Bridget whether disclosures of relatives of staff done annually. Frank to follow up with Bridget on learning how to add voice to the trainings on HealthStream. Add HIPAA Risk Assessment to QI/RM Committee Agenda

	• More development needed with performance review. Gail Mayeaux working with department head to develop a plan. • Corrections made to Work Plan to include all clinical staff to credentialing and privileging. • Added two new items; o Comprehensive review of compliance with 18 HRSA program requirements-assess every one and half years during the SAC and OSV, in addition to on-going monitoring. o Review Emergency Preparedness and conduct training and drills annually.	September 24th meeting to review and update HRSA Form 5A Schedule meeting to discuss patient complaint process.

Respectfully submitted,
Tabitha Griswold, Executive Assistant

Policy Title: Adverse- Event and Near- Miss Incident Reporting	**Policy Number:** ADM-01
Department: Administrative	**Policy status:** Active
Regulatory Reference: 105 CMR 130.332(c) & 105 CMR 140.308(c)	
Date Published: OCT 2015	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

To develop a culture of safety for patients, staff, and visitors at HCHC, and to ensure the appropriate documentation, response, and reporting of adverse events and near-misses. HCHC will use the information gathered through the reporting of adverse events and near misses to improve its Quality Improvement and Risk Management programs through the use of tracking, response, and root-cause analyses.

POLICY:

- HCHC endorses and supports a culture of safety and views adverse-event reporting as a means of improving systems and processes in providing healthcare services to all patients. In a continuing effort to promote a safe environment for patients, HCHC will conduct a systematic program of adverse-event reporting. Reporting is non-punitive, and all providers, employees, and volunteers are encouraged to report all patient and visitor events.

- HCHC encourages open and honest reporting of actual or potential injuries or hazards to patients, visitors, and employees at all sites and services and at all levels of care throughout the organization.

- HCHC aims to limit disciplinary action to only those individuals that engage in willful or malicious misconduct or exhibit continued noncompliance in following established policies and procedures relating to patient care and/or safety or continued failure to follow recommendations to improve skills.

- HCHC strives to facilitate education and problem resolution through forthright disclosure of process failure and/or human error.

Providers, employees, and volunteers are not subject to disciplinary action EXCEPT as follows:

a. The event is not reported as soon as possible after discovering that the event has occurred and in accordance with event-reporting procedures.
b. Providers, employees, or volunteers are directly involved in sabotage; malicious behavior; patient mistreatment, abuse, or neglect; chemical impairment; or criminal activity.
c. False information is provided on the event report or in the follow-up investigation.
d. A provider, employee, or volunteer fails to respond to educational efforts and/or to participate in the education process or other preventive plan.

Providers, employees, or volunteers who meet any of the exceptions listed above will be subject to disciplinary action in

accordance with HCHC's Personnel Policies Handbook.

Event reporting is an essential component of the risk management program and is considered part of the performance and quality improvement process. Event reports may not be copied or otherwise disseminated. While the circumstances surrounding an event, all information contained in the event report, and any follow-up reports are confidential, HCHC fully supports that patients and family members or designated representatives be fully informed of errors that reach patients under one or both of the following circumstances:

a. When some unintended act or substance reaches the patient and results in harm
b. When there is potential clinical significance of the event to the patient

In addition, consideration should be given to disclosing errors that reach patients and do not result in harm. The decision to disclose these errors will depend on the circumstances of the event and the patient. Responsibility for disclosing the error usually rests with the provider who has overall responsibility for the patient's care; however, the risk manager should be consulted regarding approaches for appropriate communication of the occurrence of adverse events or errors to patients.

DEFINITIONS:

An **adverse event** or **incident** is defined as "an undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services."
A **near miss** is defined as "an event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to lapse in verification of patient identification but caught at the last minute by chance)." Near misses are viewed by HCHC as opportunities for learning and for developing preventive strategies and actions.

Examples of situations to be reported include, but are not limited to, the following:

1. Any happening that could have caused or did cause injury to a patient (e.g., a medication error or adverse reaction, fall, delay in delivery of needed care, unexpected death)
2. Any condition or situation that could or did result in an injury to a patient (e.g., misfiling diagnostic test results, failure to follow up on abnormal test results, scheduling problem, equipment malfunction)
3. Failure to comply with established policy or protocol, with or without patient, provider, employee, or visitor injury
4. Any injury, potential injury, or unusual occurrence involving a patient, visitor, or employee on the facility grounds (e.g., due to a fall, falling object)
5. Any suggestion or threat of lawsuits, contacting legal counsel, or claims for restitution
6. Anything unusual or not in compliance with everyday activities

Questions regarding this policy or any related procedure should be directed to the Risk Manager at 413-667-3009, ext. 270.

PROCEDURE:

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. 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.

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 (M.G.L. c. 111, §51H). 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 105 CMR 130.332(c) & 105 CMR 140.308(c).

The Incident Report contains or collects the following information:

- Statement that the event report should not be filed in the patient's medical record
- Date and time of the report
- Date and time of the event
- Location of the event
- Identification of people affected (e.g., patient, visitor, employee)
- Names of people witnessing the event
- Name of the provider to whom the event was reported (if applicable) and the provider's response (e.g., orders given)
- Brief, factual description of the event
- Key observations of the event scene (e.g., if event was a fall, was there water on the floor or ice on the sidewalk)
- Manufacturer, model, and lot (or batch) number of any medical device involved
- Condition of the people affected (including any complaints of injury, observed injuries, and a brief comment on any follow-up care)

The Risk Manager will determine the severity category of the event, and record it on the Incident Reporting Form.

The CEO or Risk Manager will notify external regulatory or accrediting agencies of the event as required in accordance with state and federal statutes and regulations or accreditation standards (e.g., 105 CMR 130.332(c) & 105 CMR 140.308(c)). Examples of external reporting requirements may include reporting to the U.S. Food and Drug Administration under the Safe Medical Devices Act or to state agencies.

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.

See Incident Reporting Flow Chart for the full reporting process and responsibilities of designated staff members.

Supervisors will preserve, secure, and inspect before putting back into service all equipment (e.g., blood glucose monitors, steam sterilizers), assistive or transport devices (e.g., wheelchairs), accessories (e.g., electrocardiography electrodes), packaging, or any other items that may have been involved in the event.

SEVERITY CATEGORY:

The Department Manager or HCHC Risk Management designee will assign a severity category (A-I or U) to all adverse events, including near-miss and no-harm events. All events will be entered into a risk management spreadsheet. The purpose of this spreadsheet is for the Quality Improvement/Risk Management Committee and Senior Management to track events and to trend and analyze patterns of events for a proactive approach to quality improvement and identifying opportunities for organization wide improvements in processes or systems.

One of the following severity categories will be assigned.[1] Examples are for illustrative purposes only and are not all-inclusive:

[1] Adapted from the National Coordinating Council for Medication Error Reporting Programs (NCCMERP) and Pennsylvania Association for Healthcare Risk Management.

- ***Unsafe Conditions:***
  - ***Category A:*** Potentially hazardous conditions, circumstances, or events that have the capacity to cause injury, accident, or healthcare error. **Examples:** Inconsistent protocol or policy for recording pediatric immunizations contributes to the potential for missed or duplicate immuizations being given. Prenatal patient's glucose level is not checked when indicated.
- ***Events, No Harm:***
  - ***Category B:*** Near-miss event or error occurred but did not reach the patient (e.g., caught at the last minute or because of active recovery efforts by caregivers). **Examples:** Specimens are mislabled but recognized and corrected before leaving the health center or before reports are completed. Penicillin is prescribed for a patient with penicillin allergy, but the error is noticed by a pharmacist before medication is dispensed.
  - ***Category C:*** An event occurred and reached the patient or visitor, but there is no evidence of injury or harm. **Examples:** An adult patient has been missing medication doses due to lack of understanding about how to take the drug, but his or her condition or outcome is unaffected. A pediatric patient is observed falling in the waiting area, but no injury is found upon examination.
  - ***Category D:*** An event occurred that required monitoring to confirm that it resulted in no harm and/or required intervention to prevent harm to the patient or visitor. There were no changes in vital signs or laboratory values (if applicable). Patient's or visitor's physical and/or mental functioning is unchanged. Event does not result in any hospitalization or change in level of care. **Example:** A patient sustains a hematoma in his antecubital fosa during a phlebotomy procedure to draw blood for outpatient laboratory testing. The patient returns to the clinic provider to have his arm checked. No treatment is needed.
- ***Events, Harm:***
  - ***Category E:*** An event occurred that may have contributed to or resulted in temporary harm, required treatment and/or intervention, or required increased observation or monitoring with changes in vital signs, mental status, or laboratory values. **Examples:** A patient fall results in a scalp laceration that requires suturing; the patient is also sent for a CT of the head to rule out further injury. An incorrect dose of a medication causes ototoxicity or nephrotoxicity.
  - ***Category F:*** An event occurred that may have contributed to or resulted in temporary harm to a patient or visitor and required initial or prolonged hospitalization. **Examples:** During the flushing of a patient's ear canal, the tympanic membrane is damaged, requiring a visit to the emergency departement and subsequent treatment. Group B streptococcus status of mother is not documented, and infant does not receive appropriate treatment.
  - ***Category G:*** An event occurred that may have contributed to or resulted in permanent injury or harm to a patient or visitor. **Examples:** Patient is given an injection with a contaminated needle and acquires hepatitis C. Falls or other events result in bone fractures (e.g., broken hip, jaw, arm
  - ***Category H:*** An event occurred that resulted in near-death circumstances or required intervention necessary to sustain life. **Examples:** Patient has an anaphylactic reaction to medication requiring treatment and transfer to a hospital.
- ***Event, Death:***
  - ***Category I:*** An event occurred that contributed to or resulted in patient or visitor death. **Examples:** Patient's prescribed medication dose results in an overdose and the patient's death. Patient sustains a hip fracture or closed head injury as a result of a fall and later dies in surgery.
- ***Undetermined:***
  - ***Category U:*** Cannot assess harm at this time.

ROOT-CAUSE ANALYSIS:

Root-cause analysis is a process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event or error. A root-cause analysis should be conducted for all events or errors with a severity category of "E" or above, or near misses with the potential for an event or error with a severity category of "E" or above. The information and learning from the root-cause analysis should be used to facilitate systems improvements to reduce the probability of occurrence of future related events.

INVESTIGATIONS:

The Risk Manager, in conjunction with the Department Head (as applicable), is responsible for conducting follow-up investigations. The Manager's investigation is a form of self-critical analysis to determine the cause of the incident, analyze the process, and make improvements. The individual conducting the investigation will complete an event follow-up investigation form (see attached). All event follow-up reports will be completed within seven working days from the date of the initial event report. Depending upon the type of event, the investigation and report addresses patient- or visitor-specific factors (e.g., physical harm, immediate and ongoing treatment required), external factors (e.g., lighting, flooring, clutter, distractions), witnesses' statements, staffing, communication flow, construction or design factors, human or ergonomic factors, signage, equipment factors, and any other factors or conditions believed to be relevant to the cause of the event.

An investigation will be conducted, at minimum, for any of the following:

1. Any incident or adverse event with a severity category of "E" or above (i.e., any event that may have contributed to or caused temporary or permanent patient or visitor harm, initial or prolonged hospitalization, or death).

2. Any serious patient or family written or verbal complaint or verbalization that a lawsuit will be brought against the provider or the facility.

3. Any significant adverse drug reaction or significant medication error. A significant medication error is defined as unintended, undesirable, and unexpected effects of a prescribed medication or medication error that requires discontinuing a medication or modifying the dose, initial or prolonged hospitalization, or treatment with a prescription medication; results in disability, cognitive deterioration or impairment, congenital anomalies, or death; or is life-threatening.

4. Any incident involving police contact or reporting to external agencies or accreditors.

5. Any near miss with the potential for a high-severity level (e.g., potential to have been an event with harm [category E] and above).

DOCUMENTATION:

Documentation in the patient's chart or medical record, if necessary, shall include:

- Date and time of the event
- A factual account of what happened
- Name of provider notified and time of notification (if applicable)
- Patient's condition after the event
- Any treatment or diagnostic tests rendered to the patient

Documentation **should not** reflect that an event report was completed.

RETENTION OF EVENT REPORTS:

Event reports shall be retained for a minimum of two years. All reports of events involving minors shall be maintained until one year past the age of majority.

Policy Title: Conflict of Interest Policy	**Policy Number:** ADM-03
Department: Administrative	**Policy status:** Active
Regulatory Reference: 45 CFR 75.327 and 42 CFR Pt 51c.304(b)	
Date Published: JULY 2007	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised: SEP 2018	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal 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.

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.
5. 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.

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

Approved by Board of Directors on: _____
Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

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 or other funds that furnishes goods or services to HCHC.**

   An individual officer, agent, or identified employee who believes that he or she or an immediate member of his or her immediate family might have a real or apparent conflict of interest, in addition to filing a notice of disclosure, must abstain from:

   1. Participating in discussions or deliberations with respect to the subject of the conflict (other than to present factual information or to answer questions),
   2. Using his or her personal influence to affect deliberations,
   3. Executing agreements, or
   4. Taking similar actions on behalf of the organizations where the conflict of interest might pertain by law, agreement, or otherwise.
   5. And if a Board member, Voting or,
   6. Making motions on these measures.

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**

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

3. **No board of director member or an immediate family member shall be an employee of the health center.**

   a) Except under extenuating circumstances, as determined by the Chief Executive Officer, HCHC will not hire any individual (or assign, transfer or promote a current employee) who is related to one of its employees or contractors, if in the position being applied for (or assigned, transferred or promoted to), the applicant will supervise, be supervised by, or have a direct reporting relationship with the related employee or contractor.

   b) Every applicant for employment or consultancy with HCHC must disclose any and all family, business and personal relationships with any Individual Affiliated with HCHC.

   c) Members of the HCHC Board of Directors and their immediate family members are not eligible for employment at 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.

All disclosures of real or apparent conflicts of interest shall be noted for the record in the minutes of a scheduled Board of Directors meeting.

At the discretion of the Board of Directors or a committee thereof, a person with a real or apparent conflict of interest may be excused from all or any portion of discussion or deliberations with respect to the subject of the conflict.

A member of the Board or a committee thereof, who, having disclosed a conflict of interest, nevertheless shall be counted in determining the existence of a quorum at any meeting in which the subject of the conflict is discussed. The minutes of the meeting shall reflect the individual's disclosure, the vote thereon, and the individual's abstention from participation and voting.

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.

Policy Title: Continuity of Operations Plan	**Policy Number:** ADM-04
Department: Administrative	**Policy status:** Active
Regulatory Reference: HRSA PIN 2007-15 Health Center Emergency Management Program Expectations; CMS Final Rule for Emergency Preparedness 491.12(a)(3)	
Date Published: MARCH 2006	
Dates Reviewed: APR 201, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this plan to have a formal documented process for carrying out primary functions in the event of a catastrophic reduction of clinical staff due to biological illness, i.e. a pandemic of some sort.

POLICY:

1. HCHC will follow the procedures outlined in this policy in the event of a significant reduction in staffing.
2. Business interruptions will be handled in coordination with local (town, hospital) emergency preparedness plans.
3. The Incident Commander will be the CEO, and in his or her absence or unavailability of the Chief Financial and Administrative Officer or other designated Incident Commander.
4. Issues that would arise were there a physical impact on the health center infrastructure such as a prolonged loss of energy, disruption in water supply, fire, earthquake, or other natural or intentional disaster are addressed in the Emergency Management Plan.

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

Approved by Board of Directors on: _____
Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

The Incident Commander if the COOP is activated will be the CEO, and in his or her absence or unavailability the Chief Financial and Administrative Officer, or other designated Incident Commander.

1. The CEO, CFAO, or CCCSO will serve as the Incident Commander, depending on availability.
2. If they are not able to assume the role of coordinator, they will designate another individual as Incident Commander from the list of individuals at the end of this policy.
3. The Incident Commander will assume responsibility of coordinating and overseeing the response in all clinical and administrative operations of the health center. S/he will work closely and as possible with the Director of Clinical Operations and Practice Manager to insure adequate staffing for clinical operations.
4. HCHC core functions have been prioritized as follows:
    - medical primary care,
    - dental primary and restorative care,
    - behavioral health services,
    - optometry
5. As staff reductions due to illness become more severe during a pandemic, clinical operations will continue in each department as long as there are a minimum number of clinical providers. As necessary, one or more of the health center's three primary sites will be temporarily closed and patients directed to the remaining health center(s) for urgent care and routine care as possible.
    a. Behavioral health requires only one provider to deliver some service. He or she will continue to see urgent patients only.
    b. Dental hygiene patients can continue being seen as long as one hygienist is available. If one dentist and one dental assistant are available, dental patients will continue to be seen, consolidated into fewer sites as necessary.
    c. Medical patients will be seen at one or two sites and regular support staff will be supplemented as possible by all administrative staff who are able to work.
6. We have also identified a backup to our critical IT infrastructure through an informal arrangement with our local hospital (CDH) to provide critical IT support during the period of emergency.
7. Financial and billing records will either be posted as normally done, if possible, or will be batched and processed as staff becomes available to perform that function.
8. We have also planned for an extended period of operation with full staffing by ordering additional supplies of medical and dental equipment and these supplies are stored locally. If we are able to anticipate more staff being absent, we can increase as necessary the amount of supplies.

CRITICAL TEAM MEMBERS

CEO	Eliza Lake	617-413-8604 (cell)
CFAO	Frank Mertes	413-474-8434 (cell)
CCCSO	Michael Purdy	937-243-3148 (cell)
Medical	Jon Liebman	413-320-7706 (cell)
Dental	Mary Lou Stuart	413-584-0202 (home)
Behavioral Health	Franny Huberman	413-854-8662 (cell)
Optometry	Michael Purdy	937-243-3148 (cell)
Community	Kim Savery	413-329-8129 (cell)
Practice Manager	Cynthia Magrath	973-953-3717 (cell)
Clinical Operations	Dawn Flatt	413-214-2892 (cell)
Reception	Patti Igel	413-977-6615 (cell)
Maintenance	Russ Jordan	413-992-7021 (cell)

Policy Title: Electronic Information For Collection and Use Policy	**Policy Number:** ADM-05
Department: Administrative	**Policy status:** Active- Replaces Information for Collection and Use Policy
Regulatory Reference: None	
Date Published: SEP 2015	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for web log file data, subscription to our electronic mailing list and announcements, and email communications.

POLICY:

1. Web log file data:

We collect some basic web log file data about web site visitors. This information includes domain names, website traffic patterns and server usage statistics. This information is used for site management and administration and to improve the content and overall performance of our website.

2. Subscription to our Electronic Mailing List and Announcements:

Online subscribers to our electronic announcements are providing Hilltown Community Health Centers, Inc. with an email address, which is kept in a private email list. The email list is only used for the purposes of sending electronic announcements. HCHC may send an email communication related to any changes in our services, hours of operation, organizational updates, our electronic newsletter and other general health topics that may be of interest to the subscribers. We will not share or sell information or email addresses to any third party. To remove a name and personal information from our mailing list at any time, email info@hchcweb.org or by calling 413-238-5511 ext. 118.

3. Email Communications:

Our web site offers a contact form to contact us. Email messages, like most internet email messaging services, does not provide a secured method of delivery to communicate with us and other third parties. It is possible that your email communication, if not encrypted, may be accessed or viewed inappropriately by another internet user while in transit to us. If you wish to keep your communication completely private, you should not use email to contact us.

Hilltown Community Health Centers, Inc. does not collect an email address unless it is voluntarily

submitted it to us or a person chooses to communicate with us via email. We do not sell or rent any email addresses or personal information. We do our best to respond to email messages requiring a response within a reasonable time frame during business hours. If someone decides to use the 'Email HCHC' page to communicate with us, the message and email address will be forwarded to the appropriate department within the organization for follow up.

3. Donor Communications:

The email address of any individual who voluntarily provides an email address as part of the process of donating to HCHC through its website or through any other means may, at times, receive emails related to the health center, its activities, and further opportunities to donate. We do not sell or rent any email addresses or personal information to other organizations for the purposes of solicitation of donations, or for any other reason.

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

Approved by Board of Directors on: _____
Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Firearms in the Workplace	**Policy Number:** ADM-07
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: DEC 2015	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

Hilltown Community Health Center, Inc. (HCHC) management has adopted this policy to have a formal documented process to ensure that Hilltown Community Health Center maintains a workplace safe and free of violence for all employees and patients, the company prohibits the possession or use of firearms on company property.

POLICY:

1. The possession of firearms on corporate property is prohibited regardless of any license authorizing the individual to carry a firearm.
2. The exception to this policy will be on-duty law enforcement officers.

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

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

1. Signage, stating that firearms are not permitted on the premises, will be posted at all entrances in a location that is conspicuous to all
2. Failure on the part of an employee to comply with the policy may result in termination of employment
3. Failure on the part of a patient to comply with the policy will result in termination of appointment and personnel should follow the Disruptive Patient policy.

Policy Title: Fire Safety and Evacuation	**Policy Number:** ADM-08
Department: Administrative	**Policy status:** Active
Regulatory Reference: 42 CFR Parts 403, 416, 418, 441, and 494 and CMS Final Rule re: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; HRSA PIN 2007-15.	
Date Published: FEB 2016	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised: JUL 2019	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for ensuring staff are aware of fire safety and appropriate evacuation plans.

POLICY:

1. All HCHC facilities will have a fire inspection completed by the local official(s) on an annual basis.
2. Facilities will be equipped with fire extinguishers which are conspicuously marked and inspected annually.
3. All HCHC facilities will conduct fire drills at least two times per year.
4. All HCHC personnel will be familiar with the evacuation routes of their assigned facility. Those employees working in multiple facilities will be familiar with the evacuation plans particular to those facilities.

Questions regarding this policy or any related procedure should be directed to the Facilities Manager at 413-238-4163.

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

All HCHC facilities will have a fire inspection completed by the local official(s) on an annual basis.

1. The annual inspection will be scheduled by the Facilities Manager with the appropriate local agency.
2. The inspection will be conducted in accordance with local requirements.
3. The inspection report will be filed as follows:
    a. A copy to the Department of Health (DPH)
    b. A copy retained by the Facilities Manager
    c. A copy posted conspicuously in the lobby area of the facility

Facilities will be equipped with fire extinguishers which are conspicuously marked and inspected annually.

1. The Huntington Facility has fire extinguishers located:
    a. **Basement** (3) – Optometry exit door, outside the furnace room, inside the IT room
    b. **1st floor** (5) – Exit door, Knightville Wing, outside the stairwell door, inside reception door, exit door, Littleville Wing, in dental by the Pano
    c. **2nd floor** – staff lunch room, hallway by stairs, exit door from dietary office
2. The Worthington facility has fire extinguishers located:
    a. **Basement** (2) – By the entry door in both basements
    b. **1st floor** (8) – Dental by the Pano, Physical Therapy office, exit door in the Admin wing, on the wall by the entrance to medical reception, Medical wing between exam rooms 7& 8, lunchroom, by the exit near the provider office, in the server room
    c. **2nd floor** (2) – On the wall to the right of the Finance office, on the wall in the copy machine room
3. The John P. Musante Health Center has fire extinguishers located:
    a. **Main Hall** (2) – On the wall to the right of the Emergency Exit next to the Dental Operatories and on the wall to the left of the Community Health and Outreach Office.

All HCHC facilities will conduct fire drills at least two times per year.

1. All fire drills will be coordinated through the facilities manager
2. Drills will be pre-announced to staff to ensure they know a drill is taking place
3. Hallway doors should be closed prior to exit when possible
4. Staff will follow the evacuation plan listed below

All HCHC personnel will be familiar with the evacuation routes of their assigned facility. Those employees working in multiple facilities will be familiar with the evacuation plans peculiar to those facilities.

1. Staff will exit the building using the closest exit and rendezvous at a designated location
    a. HHC – the west end of the parking lot near the dumpster
    b. WHC – the north end of the front (patient) parking lot

c. JPMHC – in front of the Clark House Main Entrance across the lawn from the Center

In the event of a fire, the fire alarm system should be activated, alerting all individuals in the building to the hazard.

1. The Staff members and Administrators on site will be guided by the following steps:
    a. **R**escue - Remove all patients and visitors in immediate danger.
    b. **A**larm - Activate the nearest fire alarm pull box.
    c. **C**ontain - Isolate the fire, close door, windows, fire doors beginning with those nearest the fire areas.
    d. **E**xtinguish/Evacuate - Extinguish fire with the appropriate fire extinguisher, as safe and appropriate.
2. Staff will also be instructed not to use elevators, as fire involving the control panel of the elevator or the electrical system of the building can cut power in the building and cause individuals to be between floors.
3. Reception staff will notify and assist patients in the waiting rooms or public restrooms. Reception staff will also take the RED evacuation clipboard containing a staff list, a patient list and the evacuation plan and proceed to the designated rendezvous location.
4. Clinical staff will ensure they assist any patients in the exam rooms, both ambulatory and non-ambulatory, with leaving the clinical area and will be responsible for ensuring that they evacuate the building.
5. Reception will ensure that all staff sign in upon arriving at the rendezvous location. Patients should be checked against the patient list.
6. Staff will remain in the rendezvous area until given the All Clear by the On Scene commander of the responding agencies.
7. The staff will fight the fire ONLY if:
    a. The fire department has been notified of the fire, AND
    b. There is a way out and staff can fight the fire with their back to the exit, AND
    c. There is a proper extinguisher, in good working order, AND
    d. Staff have been trained to do so.
8. If staff utilize the fire extinguisher, the designated individual will choose appropriate fire extinguisher as per classification of fire as follows:
    a. ORDINARY COMBUSTIBLES (e.g., paper, grease, paint)
    b. FLAMMABLE LIQUIDS (e.g., gasoline, grease paint)
    c. ELECTRICAL EQUIPMENT (e.g., wiring, overheated fuse boxes) Note: C extinguisher (dry chemical) is an all-purpose extinguisher and can be used on Class A, B, C fires.
    d. Once proper extinguisher has been chosen, extinguish as follows:
        1) Remove the extinguisher from the wall unit.
        2) **P** - Pull the pin.
        3) **A** - Aim the nozzle at the base of the fire.
        4) **S** - Squeeze or press the handle.
        5) **S** - Sweep side to side at the base of the fire until the fire is extinguished.
9. Upon deactivation of the emergency, the Senior Administrator will ensure the replacement of the fire extinguisher.
10. The Behavioral Health providers or Employee Assistance Program will be made available to provide support to the affected family members and staff.

Policy Title: Gift Acceptance	**Policy Number:** ADM-10
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: OCT 2015	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for the solicitation and acceptance of gifts to or for the benefit of HCHC for purposes that will help HCHC to further and fulfill its mission.

The mission of HCHC is to provide high quality, accessible medical, dental, behavioral health, eye care, and community services to people in the Western Massachusetts Hilltowns and surrounding areas.

HCHC's Board of Directors has a fiduciary duty to assure that HCHC's assets are used efficiently and protected from potential liabilities and diversion to purposes other than those that further HCHC's goals. The following policies and guidelines govern acceptance of gifts made to HCHC or for the benefit of any of its programs.

POLICY:

1. The Board of Directors of HCHC and its staff solicit current and deferred gifts from individuals, corporations, and foundations to secure the future growth and mission of HCHC. We appreciate donors' consideration of any gift to HCHC. In all matters involving current and prospective donors, the interest of the donor is important to HCHC.

2. The following gifts are acceptable, but not intended to represent an exclusive list of appropriate gifts:

   a. Cash
   b. Securities
   c. Retirement Plan Beneficiary Designations
   d. Bequests
   e. Life Insurance Beneficiary Designations

   Gifts of tangible property, art, land, cars/vehicles, and in-kind will not be accepted. The Board, upon recommendation, of the Finance Committee, may make exceptions.

3. These policies and guidelines govern the acceptance of gifts by HCHC and provide guidance to prospective donors and their advisors when making gifts to HCHC. The provisions of these

policies apply to all gifts to HCHC for any of its programs. Gifts will be accepted only if they do not interfere with HCHC's mission, purpose and procedures.

4. HCHC shall accept only such gifts as are legal and consistent with organizational policy. While HCHC does not provide tax advice, every effort will be made to assist donors in complying with the intents and purposes of the Internal Revenue Service in allowing charitable tax benefits. Key principles include safeguarding the confidentiality of the donor relationship, providing full disclosure to the donor, and ensuring that gifts are recorded, allocated and used according to the donor intent and designation.

Questions regarding this policy or any related procedure should be directed to the Development Director at 413-238-4111.

Approved by Board of Directors on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

The following criteria govern the acceptance of each gift form:

1) **Cash**. Cash refers to cash equivalents, including checks, money orders, currency/coin, and credit card payments. Checks or money orders shall be made payable to "Hilltown Community Health Centers, Inc.", shall appropriately identify the donor or donors and be delivered to HCHC's administrative offices. Wire and Electronic Funds Transfer (EFT) can usually be arranged with the HCHC staff. If a donor or a company workplace matching gift program wants to send and ACH/EFT every week instead of a check, these must be authorized by the Finance Department's cash receipting manager at HCHC before the enrollment form is sent back to the constituent.

2) **Securities**. HCHC can accept both publicly traded securities and closely held securities.

Publicly Traded Securities: Marketable securities may be transferred to an account maintained at one or more brokerage firms or delivered physically with the transferor's signature or stock power attached. As a general rule, all marketable securities shall be sold upon receipt unless otherwise directed by the Finance Committee. In some cases, marketable securities may be restricted by applicable securities laws; in such instance the final determination on the acceptance of the restricted securities shall be made by the Finance Committee of HCHC.

Potential donors should note that a security must be owned by a donor for at least 12 months before it is gifted in order for the donor to maximize tax benefits. It is suggested that potential donors discuss any tax questions with a tax and/or financial advisor.

Closely Held Securities: Closely held securities, which include not only debt and equity positions in non-publicly traded companies but also interests in limited partnerships and limited liability companies, or other ownership forms, can be accepted. Such gifts, however, must be reviewed prior to acceptance to determine that:

a) there are no restrictions on the security that would prevent HCHC from ultimately converting it to cash;

b) the security is marketable; and

c) the security will not generate any undesirable tax consequences for HCHC.

If potential problems arise on initial review of the security, further review and recommendation by an outside professional may be sought before making a final decision on acceptance of the gift. The Board of HCHC with the advice of legal counsel shall make the final determination on the acceptance of closely held securities when necessary. Every effort will be made to sell non-marketable securities as quickly as possible.

3) **Deferred Compensation/Retirement Plan Beneficiary Designations**. HCHC generally will accept gifts designating HCHC as a beneficiary of the donor's retirement plans including, but not limited to, IRA's, 401(k)'s 403(b)'s and other plans. Such designation will not be recorded as a gift to HCHC until such time as the gift is irrevocable.

4) **Bequests**. Donors and supporters of HCHC will be encouraged to make bequests to HCHC under their wills and trusts. Such bequests will not be recorded as gifts to HCHC until such time as the gift is irrevocable. The criteria for the acceptance of the gift or bequest will be the same as otherwise provided herein.

5) **Life Insurance Beneficiary Designations.** Donors and supporters of HCHC will be encouraged to name HCHC as beneficiary or contingent beneficiary of their life insurance policies. Such designations shall not be recorded as gifts to HCHC until such time as the gift is irrevocable.

III. ***General Policies Relevant to All Gifts***

A. The Finance Committee

The Finance Committee is charged with the responsibility of reviewing all non-cash gifts proposed to be made to HCHC, properly screening, accepting or rejecting those gifts, and making recommendations to the Board on gift acceptance issues when appropriate.

B. Use of Legal Counsel

HCHC shall seek the advice of legal counsel in matters relating to acceptance of gifts when appropriate. Review by counsel is recommended for:

1) Closely held stock transfers subject to restrictions or buy-sell agreements.

2) Documents naming HCHC as Trustee.

3) Gifts involving contracts, such as bargain sales or other documents requiring HCHC to assume an obligation.

4) Transactions with potential conflict of interest that may involve IRS sanctions.

5) Other instances in which use of counsel is deemed appropriate by the Finance Committee.

C. Conflict of Interest

HCHC will urge all prospective donors to seek the assistance of independent personal legal and financial advisors in matters relating to their gifts and the resulting tax and estate planning consequences. HCHC and its employees and agents are prohibited from advising donors about the tax consequences of their donations. Gifts are also subject to the provisions of other HCHC policies, including adopted Conflict of Interest policies.

HCHC makes every effort to ensure accepted gifts are in the best interests of the organization and the donor. HCHC works to follow The Donor Bill of Rights adopted by the AAFRC Trust for Philanthropy, the Association of Fundraising Professionals and other professional organizations.

HCHC will comply with the Model Standards of Practice for the Charitable Gift Planner, promulgated by the National Committee on Planned Giving.

D. Restrictions on Gifts

HCHC will accept unrestricted gifts, and gifts for specified programs and purposes, provided that such gifts are consistent with its stated mission, purposes, and priorities. HCHC will not accept gifts that are too restrictive in purpose. Gifts for purposes that are not consistent with HCHC's mission or consonant with its current or anticipated future programs cannot be accepted. Examples of gifts that are too restrictive are those that violate the terms of the corporate charter, gifts that are too difficult to administer, or gifts that are for purposes outside the mission of HCHC. All final decisions on the restrictive nature of a gift, and its acceptance or refusal, shall be made by the Finance Committee of HCHC.

E. Tax Compliance

HCHC's policy is to comply with Internal Revenue Service reporting requirement and all other aspects of state and federal tax law.

F. Naming of Buildings and Physical Spaces

a. New or significantly renovated buildings, rooms, floors, wings, entry areas or other significant areas

of space can be named to recognize the generosity of donors who demonstrate their interest in and commitment to HCHC through the contribution of a significant donation. Donors whose capital gifts are designated for unrestricted use, or for unrestricted or restricted endowment for which no other naming opportunity has been given, may also be offered a naming opportunity in a building or area, the size of which is commensurate with the level of commitment made to a particular campaign.

b. The Board will determine what level of commitment is to be recognized through a naming opportunity on a case by case basis. These determinations will ideally be consistent with past named spaces.

c. Buildings and spaces may be named by the donor in the name of the donor(s), family members, or another individual of the donor's choosing, upon approval of the Board.

d. The Board may choose to name a space in recognition of influence and impact on the organization, irrespective of philanthropic commitment.

e. Signage used to recognize named spaces will be complementary to the facilities and will present a uniform and tasteful look in accordance with the interior décor of the facility.

f. Naming of a physical space is generally done upon completion of the building or renovation project and receipt of signed documentation of the donor's intent to fulfill his or her capital commitment as well as receipt of at least the initial payment on the pledge. Should the donor fail to complete payment on a pledge for which a naming opportunity has been granted, HCHC reserves the right to remove or adjust the recognition to a space commensurate with the amount paid.

g. In the case of significant renovation, alternation, or replacement of existing named spaces or buildings, every effort will be made to contact and inform the original donor and/or family members, and to provide recognition and acknowledgement of the original gift and legacy in an appropriate location within the new facility.

Policy Title: Health Center Closure Policy	**Policy Number:** ADM-10
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: DEC 2015	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for actions required when the health center closes for weather or other reason.

POLICY:

1. Unscheduled closures and/or delayed openings will be disseminated to employees using the Snow Line and All Staff email.
2. Early closures for inclement weather will be disseminated to employees by All Staff email and telephone.
3. Closures will be passed along to the answering service.
4. Closures will be noted on both the HCHC website and Facebook pages.
5. In the event of an unforeseen closure related to a natural occurrence, employees will be paid for their normal work day unless time off has already been scheduled

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

Approved on:_____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

- The CEO makes the determination when to close HCHC sites in extreme weather or other emergency circumstances; this will be as rare an occasion as possible.

- If an HCHC site closes early or has a delayed opening, employees scheduled to work that day at that location may be asked to transfer to another site to work their scheduled hours.
- If they choose not to report to another site, accrued time must be used for the hours scheduled for that day. Unused Holiday time must be used first, and then employees may elect to use Vacation, Personal, or Sick time. Should an employee not have any unused Holiday and accrued time available, they may choose to create a negative balance in Vacation or Sick time. Hourly employees may also choose to be unpaid for their scheduled time.

- If their services are not needed at another site, they will be paid for the hours they were scheduled to work during the closure.

- If an HCHC site closes for an entire day due to a declared emergency situation, employees scheduled to work that day at that location may be asked to transfer to another site to work their scheduled hours. If they choose not to report to another site, accrued time must be used for the hours scheduled for that day. Unused Holiday time must be used first, and then employees may elect to use Vacation, Personal, or Sick time. Should an employee not have any unused Holiday and accrued time available, they may choose to create a negative balance in Vacation or Sick time. Hourly employees may also choose to be unpaid for their scheduled time.

- If their services are not needed, accrued time must be used for the hours scheduled for that day. Unused Holiday time must be used first, and then employees may elect to use Vacation, Personal, or Sick time. Should an employee not have any unused Holiday and accrued time available, they may choose to create a negative balance in Vacation or Sick time. Hourly employees may also choose to be unpaid for their scheduled time.

- In some situations, employees may be asked by their supervisor to work from home; in this case, the employee will bill the hours worked as Regular time. Supervisors may approve or request that employees reschedule hours affected by a closure.

- The School-Based policy will remain unchanged, but will be superseded by the policy above only in cases where both the SBHC and HHC sites are closed.

Policy Title: Hours of Operation and After Hours Coverage-Establishment and Patient Notification	**Policy Number:** ADM-11
Department: Administrative	**Policy status:** Active
Regulatory Reference: Sections 330(k)(3)(A) and 330(k)(3)(H) of the PHS Act and 42 CFR Parts 5lc.102(h)(4) and Slc.304	
Date Published: JAN 2016	
Dates Reviewed: FEB 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for assessing, approving, and notifying patients of each health center's hours of operation and coverage for after hours.

POLICY:

1. As needed, HCHC will review the Hours of Operation to ensure that they meet the needs of the target population and community and revise them as needed.

2. The Board of Directors of the HCHC reviews and approves the hours of operation and after hours' coverage.

3. HCHC will notify patients on each health center sites' hours of operation and after hours' coverage through its website, on-site postings, etc.

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

1. Every year, or as often as deemed necessary, HCHC Senior Management, with the support of the Practice Manager, will determine if:
    a. the hours of operation assure accessibility and meet the needs of the population to be served, and are appropriate and responsive to the community's needs.
    b. the afterhours coverage provides professional coverage for medical and dental 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.

3. 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

4. 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.

5. If a life threatening emergency, patients are instructed to call 9-1-1.

Policy Title: Legislative Mandates	**Policy Number:** ADM-12
Department: Administrative	**Policy status:** Active
Regulatory Reference: Consolidated Appropriations Act (Public Law 115-141) includes provisions that restrict grantees from using their federal grant funds to support certain defined activities. These limitations are commonly referred to as the "Legislative Mandates."	
Date Published: AUG 2018	
Dates Reviewed: JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy and the associated procedures (P&P) to have a formal documented process to provide safeguards to ensure HCHC compliance with the Legislative Mandates. HCHC is committed to high standards and compliance with all applicable laws and regulations.

The current Legislative Mandates, which remain in effect until a new Appropriations Act is passed, include the following:

Division H, Title II

(1) Salary Limitation (Section 202)
(2) Gun Control (Section 210)

Division H, Title V

(3) Anti-Lobbying (Section 503)
(4) Acknowledgment of Federal Funding (Section 505)
(5) Restriction on Abortions (Section 506)
(6) Exceptions to Restriction on Abortions (Section 507)
(7) Ban on Funding Human Embryo Research (Section 508)
(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)
(9) Restriction on Distribution of Sterile Needles (Section 520)
(10) Restriction of Pornography on Computer Networks (Section 521)
(11) Restriction on Funding ACORN (Section 522)

Division E, Title VII

(12) Confidentiality Agreements (Section 743)

A complete description of the Legislative Mandates for fiscal year 2018 is included in HRSA Bulletin 2018-04 (April 4, 2018), which is attached to this P&P as Exhibit A

POLICY:

(1) Salary Limitation

HCHC shall not use federal grant funds to pay the salary of an individual at a rate in excess of Executive Level II.

The Executive Level II Salary is currently set at $189,600.

(2) Gun Control

HCHC shall not use federal grant funds to advocate or promote gun control.

(3) Anti-Lobbying

A. HCHC shall not use federal grant funds, other than for normal and recognized executive legislative relationships, for the following:

I. For publicity or propaganda purposes;

II. For the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself;

B. HCHC shall not use federal grant funds to pay the salary or expenses of any employee or agent of HCHC for activities designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive- legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

C. The prohibitions in subsections A and B include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

(4) Acknowledgment of Federal Funding

When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with federal money, HCHC shall clearly state:

A. the percentage of the total costs of the program or project which will be financed with Federal money;

B. the dollar amount of Federal funds for the project or program; and
C. percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

(5) and (6) Restrictions on Abortions, and Exceptions to these Restrictions
HCHC shall not use federal grant funds for any abortion or for health benefits coverage that includes coverage of abortion. These restrictions shall not apply to abortions (or coverage of abortions) that fall within the Hyde amendment exceptions. HCHC also maintains a Women's Reproductive Health policy relevant to this restriction.

(7) Ban on Funding of Human Embryo Research
HCHC shall not use federal grant funds for (i) the creation of human embryos for research purposes; or (ii) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(8) Limitations on Use of Grant Funds for Promotion of Legalization of Controlled Substances
HCHC shall not use federal grant funds to promote the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act.

(9) Restriction on Distribution of Sterile Needles
HCHC shall not use federal grant funds to distribute sterile needles or syringes for the hypodermic injection of any illegal drug.

(10) Restriction of Pornography on Computer Networks
HCHC shall not use federal grant funds to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(11) Restriction on Funding ACORN
HCHC shall not provide any federal grant funds to the Association of Community Organizations for Reform Now ("ACORN"), or any of its affiliates, subsidiaries, allied organizations, or successors.

(12) Confidentiality Agreements
HCHC shall not require its employees or contractors seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

Questions regarding this policy or any related procedure should be directed to Eliza Lake, CEO at 413-238-5511.

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

1. Review and Updates of this Policy and Procedure

The Chief Executive Officer shall review this policy upon the passage of a new HHS Appropriations Act or issuance of HRSA guidance regarding the Legislative Mandates, and shall ensure this policy is updated as necessary. As appropriations acts are generally enacted annually, this policy will generally require annual review. Any modifications to this policy will require review and approval by HCHC's Board of Directors.

2. Legislative Mandates Training

The Chief Executive Officer shall ensure that the key management team and finance department staff receive training regarding the Legislative Mandates and the procedures set forth in this policy.

3. Compliance Manual

This Legislative Mandates Policy will be incorporated into HCHC's Compliance Program.

4. Financial Management

The Chief Financial Officer ("CFO") shall ensure that HCHC's financial management systems and procedures are structured to ensure that no federal grant funds are used for purposes that are impermissible under this Policy. As necessary, the CFO may establish cost centers/accounts for the accumulation and segregation of such costs.

Exhibit A

HRSA
Health Resources & Services Administration

Grants Policy Bulletin

Legislative Mandates in Grants Management for FY

Bulletin Number: 2018 - 04
Release Date: April 4, 2018
Related Bulletins: Replaces 2017 - 07
Issued by: Office of Federal Assistance Management (OFAM), Division of Grants Policy (DGP)

Purpose

The purpose of this Policy Bulletin is to clarify the requirements mandated by the FY 2018 Consolidated Appropriations Act 2018 (Public Law 115-141), signed into law on March 23, 2018, which provides funding to HRSA for the fiscal year ending September 30, 2018. The intent of this Policy Bulletin is to provide information on the following statutory provisions that limit the use of funds on HRSA grants and cooperative agreements for FY 2018. Legislative mandates remain in effect until a new appropriation bill is passed setting a new list of requirements.

Implementation

FY 2018 Legislative Mandates are as follows:

Division H, Title II

(1) Salary Limitation (Section 202)
(2) Gun Control (Section 210)

Division H, Title V

(3) Anti-Lobbying (Section 503)
(4) Acknowledgment of Federal Funding (Section 505)
(5) Restriction on Abortions (Section 506)
(6) Exceptions to Restriction on Abortions (Section 507)
(7) Ban on Funding Human Embryo Research (Section 508)
(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section **509)**
(9) Restriction on Distribution of Sterile Needles (Section 520)
(10) Restriction of Pornography on Computer Networks (Section 521)
(11) Restriction on Funding ACORN (Section 522)

Division E, Title VII

(12) Confidentiality Agreements (Section 743)

Details:

Division H, Title II:

(1) Salary Limitation (Section 202)

"None of the funds appropriated in this title shall be used to pay the salary of an individual, through a grant or other extramural mechanism, at a rate in excess of Executive Level II."

The Executive Level II salary is currently set at $189,600.

(2) Gun Control (Section 210)

"None of the funds made available in this title may be used, in whole or in part, to advocate or promote gun control."

Division H, Title V

(3) Anti-Lobbying (Section 503)

" (a) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the Congress or any State or local legislature or legislative body, except in presentation to the Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government, except in presentation to the executive branch of any State or local government itself.

(b) No part of any appropriation contained in this Act or transferred pursuant to section 4002 of Public Law 111-148 shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

(c) The prohibitions in subsections (a) and (b) shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction on any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control."

(4) Acknowledgment of Federal Funding (Section 505)

"When issuing statements, press releases, requests for proposals, bid solicitations and other documents describing projects or programs funded in whole or in part with Federal money, all grantees receiving Federal funds included in this Act, including but not limited to State and local governments and recipients of Federal research grants, shall clearly state -(1) the

percentage of the total costs of the program or project which will be financed with Federal money; (2) the dollar amount of Federal funds for the project or program; and (3) percentage and dollar amount of the total costs of the project or program that will be financed by non-governmental sources."

(5) Restriction on Abortions (Section 506)

"(a) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion.

(b) None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for health benefits coverage that includes coverage of abortion.

(c) The term "health benefits coverage" means the package of services covered by a managed care provider or organization pursuant to a contract or other arrangement."

(6) Exceptions to Restriction on Abortions (Section 507)

"(a) The limitations established in the preceding section shall not apply to an abortion -(1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

(b) Nothing in the preceding section shall be construed as prohibiting the expenditure by a State, locality, entity, or private person of State, local, or private funds (other than a State's or locality's contribution of Medicaid matching funds).

(c) Nothing in the preceding section shall be construed as restricting the ability of any managed care provider from offering abortion coverage or the ability of a State or locality to contract separately with such a provider for such coverage with State funds (other than a State's or locality's contribution of Medicaid matching funds).

(d)(l) None of the funds made available in this Act may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(d)(2) In this subsection, the term "health care entity" includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan."

(7) Ban on Funding of Human Embryo Research (Section 508)

"(a) None of the funds made available in this Act may be used for -(1) the creation of a

human embryo or embryos for research purposes; or (2) research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.204(b) and section 498(b) of the Public Health Service Act (42 U.S.C. 289g(b)).

(b) For purposes of this section, the term "human embryo or embryos" includes any organism, not protected as a human subject under 45 CFR 46 as of the date of the enactment of this Act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

(8) Limitation on Use of Funds for Promotion of Legalization of Controlled Substances (Section 509)

"(a) None of the funds made available in this Act may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act except for normal and recognized executive-congressional communications.

(b)The limitation in subsection (a) shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance or that federally sponsored clinical trials are being conducted to determine therapeutic advantage."

(9) Restriction on Distribution of Sterile Needles (Section 520)

"Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law."

(10) Restriction of Pornography on Computer Networks (Section 521)

"(a) None of the funds made available in this Act may be used to maintain or establish a computer network unless such network blocks the viewing, downloading, and exchanging of pornography.

(b) Nothing in subsection (a) shall limit the use of funds necessary for any federal, state, tribal, or local law enforcement agency or any other entity carrying out criminal investigations, prosecution, or adjudication activities."

(11) Restrictions on Funding ACORN

"None of the funds made available under this or any other Act, or any prior Appropriations Act, may be provided to the Association of Community Organizations for Reform Now (ACORN), or any of its affiliates, subsidiaries, allied organizations, or successors."

Division E Title VII

(12) Confidentiality Agreements (Section 743)

(a) None of the funds appropriated or otherwise made available by this or any other Act may be available for a contract, grant, or cooperative agreement with an entity that requires employees or contractors of such entity seeking to report fraud, waste, or abuse to sign internal confidentiality agreements or statements prohibiting or otherwise restricting such employees or contractors from lawfully reporting such waste, fraud, or abuse to a designated investigative or law enforcement representative of a Federal department or agency authorized to receive such information.

(b) The limitation in subsection (a) shall not contravene requirements applicable to Standard Form 312, Form 4414, or any other form issued by a Federal department or agency governing the nondisclosure of classified information.

Resources

- Consolidated Appropriations Act, 2018
  https://www.congress.gov/bill/ l l5th- congress/house-bill/1 625

Inquiries

Inquiries regarding this notice can be directed to: Office of Federal Assistance Management
Division of Grants Policy
Policy & Special Initiatives
Branch Email: DGP@!HRSA.gov
Telephone: 301-443-2837

Policy Title: Patient Complaint and Grievance Policy	**Policy Number:** ADM-13
Department: Administrative	**Policy status:** Active
Regulatory Reference: Department of Public Health	
Date Published: DEC 2004	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised:	

PURPOSE:

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

POLICY:

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

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

Approved on:_____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

PROCEDURE:

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

Policy Title: Patient Satisfaction Surveys	**Policy Number:** ADM-14
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: JAN 2012	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for assessing patient satisfaction with respect to patient-centered medical home activities and to use the results to improve our patients' experiences at the health center.

POLICY:

1. The health center will regularly assess patient satisfaction through a survey administered no less frequently than annually. The survey tool used for Medical Patients will be the Consumer Assessment of Healthcare Providers and Systems (CAHPS) instrument. The survey tool for all other department will be surveyed using an instrument approved by the Quality Committee.
2. The results will be reported to and discussed by the health center's Quality Improvement/Risk Management Committee, which will respond as appropriate through the development of action plans to address negative results.
3. The results will be reported to the Board of Directors and staff.

Questions regarding this policy or any related procedure should be directed to the Executive Assistant at 413-238-4118.

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Policies	**Policy Number:** ADM-15
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: SEP 2007	
Dates Reviewed: JAN 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process for writing, categorizing, reviewing, approving, implementing and filing/storing policies.

POLICY:

1. All policies of HCHC will be written using a standardized template.

2. All policies will be categorized and numbered by the relevant department of subunit. They will also note the department, site, or subunit for which the policy is relevant, as appropriate and/or needed.

3. All policies and procedures will be reviewed by the appropriate Department Head on an annual basis.

4. All policies will be reviewed and voted upon by the Board of Directors annually.

5. All Department Heads will be responsible for implementing approved policies for his/her department, including training staff, monitoring and enforcing compliance, and proposing changes/addition/deletions of policies to Senior Management.

6. All approved policies will be filed electronically, as well as the signed hard copies, by the Executive Assistant.

7. Upon approval by the Board, all policies will be distributed to staff and made available on the all staff drive.

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Quality Improvement Program	**Policy Number:** ADM-17
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: APR 2010	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

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

POLICY:

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

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Procedure:

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

A. SCOPE

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

B. OBJECTIVES

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

C. QUALITY IMPROVEMENT COMMITTEE

1. Responsibilities of the Quality Improvement Committee:

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

    b. To prioritize specific performance improvement activities in each department in order to align these resources with the health centers

strategic plan.

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

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

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

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

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

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

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

2. Composition of the Quality Improvement Committee

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

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

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

h. Specifics of Quality Improvement Meeting The Committee will identify

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

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

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

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

D. MECHANISMS

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

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

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

4. Data Interpretation & Improvement plans

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

3.

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

E. CONFIDENTIALITY

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

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

F. THE PROCESS IMPROVEMENT MODEL

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

Policy Title: Social Media Policy	**Policy Number:** ADM-17
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: AUG 2015	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy to have a formal documented process to encourage open discussions including questions, feedback, stories and experiences on social media sites that are maintained by Hilltown Community Health Centers, Inc. including but not limited to: Facebook, Twitter, LinkedIn, YouTube, GooglePlus, Tumblr, and Pinterest.

POLICY:

We make reasonable efforts to monitor participation to ensure that postings are on-topic and appropriate subject matter. Our social media platforms are not intended for serious or urgent medical matters and should not be considered medical advice nor should they replace a consultation with a health care professional. For emergencies dial 9-1-1.

Commenting or posting on our social media platforms is at the user's discretion. Please be aware that your post has the potential to be seen by the world and will remain visible for some time. Exercise caution and avoid providing personal, identifiable or sensitive information about you or your family.

Hilltown Community Health Centers, Inc. (HCHC) management has adopted this policy, along with the following Terms and Conditions related to social media practices.

By commenting on or posting any type of material on Hilltown Community Health Centers, Inc. social media sites, you give Hilltown Community Health Centers, Inc. the irrevocable right to reproduce, distribute, publish, display, edit, modify, create derivative works from, and otherwise use your submission for any purpose in any form and on any media.

You agree that you will not:

1. Post material that infringes on the rights of any third party, including intellectual property, privacy or publicity rights;
2. Post material that is unlawful, obscene, defamatory, threatening, harassing, abusive, slanderous, hateful, or embarrassing to any other person or entity as determined by Hilltown Community Health Centers, Inc. in its sole discretion;
3. Post advertisements or solicitations of business;
4. Post chain letters or pyramid schemes;
5. Impersonate another person;
6. Allow any other person or entity to use your identification for posting or viewing comments;

7. Post the same note more than once or "spam";

Hilltown Community Health Centers, Inc. reserves the right (but is not obligated) to do any or all of the following:

1. Remove communications that are abusive, illegal or disruptive, or that otherwise fail to conform with these Terms and Conditions;
2. Terminate a user's access to the social media channel upon any breach of these Terms and Conditions;
3. Edit or delete any communications posted, regardless of whether such communications violate these standards.

Finally, you agree that you will indemnify Hilltown Community Health Centers, Inc. against any damages, losses, liabilities, judgements, costs or expenses (including reasonable attorneys' fees and costs) arising out of a claim by a third party relating to any material you have posted.

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Telephone Coverage Policy	**Policy Number:** ADM-18
Department: Administrative	**Policy status:** Active- Includes Telephonic Patient Access at Lunchtime
Regulatory Reference: None	
Date Published: FEB 2013	
Dates Reviewed: SEP 2018, JUL 2019	
Dates Revised:	

PURPOSE:

Hilltown Community Health Centers, Inc (HCHC) management has adopted this policy to have a formal documented process for ensuring telephone coverage.

POLICY:

1. At the close of normal business hours, phones will automatically forward to service.
2. For Saturdays and minor holidays, phones are manually forwarded on the preceding Friday evening to the site that will be open.
3. Upon closing on Saturdays and minor holidays, phones are manually forwarded to the service at the close of clinic hours.
4. For times when facilities are closed due to an emergency, inclement weather, or other unanticipated event, phones will be manually rolled to the service.
5. Phones will be forwarded to service during the scheduled lunch period at both sites. Phones will be returned to normal service at the conclusion of the lunch period at both sites. Reception will be manned by at least one employee during the lunch period in the event of emergency situations.

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Procedure:

I. Lunch time coverage procedure

1. At 1:00 PM lines will be forwarded to Crocker Communications.
2. Reception will be manned by at least one employee during the time that the phones are rolled to service.
3. Any provider/patient needing assistance immediately will be put through by Crocker Communications on back lines and reception will direct as necessary.
    a. Huntington (413) 667-8771
    b. Worthington (413) 238-5858
    c. Amherst (413) 582-3919
4. At 2:00 PM lines will be returned to normal service by reception personnel.
5. Crocker Communications will email reception staff any messages taken during lunch time.

Policy Title: Corporate Compliance Program	**Policy Number:** CC-01
Department: Administrative	**Policy status:** Active
Regulatory Reference: U.S. statutes and Federal and State Regulations	
Date Published: OCT 2012	
Dates Reviewed: OCT 2018	
Dates Revised:	

PURPOSE:

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

POLICY:

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

Corporate Compliance Program

I. Compliance Objectives

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

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

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

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

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

II. Elements of HCHC's Corporate Compliance Program

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

A. Appointment of a Compliance Officer

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

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

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

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

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

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

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

1. Annex 1: Standards of Conduct
2. Annex 2: Legal Statutes and Regulations
3. Annex 3: Billing, Claims and Records
4. Annex 4: Procurement and Referrals
5. Annex 5: Audits, Investigation and Organizational Response
6. Annex 6: Risk Management Plan
7. Annex 7: Privileging and Credentialing Program
8. Annex 8: 340-B Pharmacy Program

9. Annex 9: Emergency Operations Plan
10. Annex 10: Quality Improvement Plan

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

C. Education and Training

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

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

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

D. Maintaining Open Lines of Communication

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

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

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

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

E. Monitoring, Audits and Evaluation

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

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

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

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

revising policies and procedures, offering training, conducting audits, and imposing disciplinary action.

G. Corrective Action and Disciplinary Standards

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

III. Employee and Affiliated Individuals' Responsibilities

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

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

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

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

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

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

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors

Policy Title: Staff Compliance Committee- Charges to Members	**Policy Number:** CC-02
Department: Administrative	**Policy status:** Active
Regulatory Reference: None	
Date Published: FEB 2016	
Dates Reviewed: SEP 2018	
Dates Revised:	

PURPOSE:

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

POLICY:

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

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

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

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

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

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

Section 330 of the Public Health Service Act), and requirements imposed by commercial health plans.

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

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

Approved on: _____

Approved by:

_____ _____

Chief Executive Officer, HCHC HCHC Board of Directors